AN EVALUATION OF A FAMILY GROUP THERAPY PROGRAM FOR DOMESTICALLY VIOLENT ADOLESCENTS

by

Nancy Carole Rybski

A Dissertation Submitted to the Faculty of the

SCHOOL OF FAMILY AND CONSUMER RESOURCES

In Partial Fulfillment of the Requirements
For the Degree of

DOCTOR OF PHILOSOPHY

In the Graduate College

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GRADUATE COLLEGE

As members of the Final Examination Committee, we certify that we have read the dissertation prepared by Nancy Carole Rybski entitled "An Evaluation of a Family Group Therapy Program for Domestically Violent Adolescents"

and recommend that it be accepted as fulfilling the dissertation requirement for the Degree of Doctor of Philosophy

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	Date

Final approval and acceptance of this dissertation is contingent upon the candidate's submission of the final copy of the dissertation to the Graduate College.

I hereby certify that I have read this dissertation prepared under my direction and recommend that it be accepted as fulfilling the dissertation requirement.

Dissertation Director Carl Ridley, Ph.D.	5-1-98 Date

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SIGNED: Nancy Carole Rybski

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DEDICATION

This dissertation is dedicated with deepest love to my husband, Dr. Jim Rybski, and our daughters, Danika and Karli Schultz ("The Weasel Children"). It's been a long and winding road, this doctoral trip, but it has always been interesting, and you've kept it fun. The adventure has ended: We did it!

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ABSTRACT

Youth-perpetrated domestic violence is one type of family violence that has lacked rigorous investigation (Paulson, Coombs, & Landsverk, 1990). Although recognized as a social problem for approximately 40 years, scant attention has been devoted to treating this problem. Only recently have researchers begun to explore the characteristics and dynamics within youth-instigated parent abuse (Livingston, 1986; Lystad, 1986; Monahan, 1981). This project seeks to add to the font of knowledge of youth-to-parent domestic violence.

Social learning, stress, and family systems theories were used to form an integrative framework which identified individual and family deficiencies in anger management, stress reduction, and communication skills. This program modified and condensed Neidig and Friedman's (1984) couples conflict containment program into a family-focused treatment regimen of four, two-hour weekly group sessions, with family interview sessions pre- and post-treatment. The three areas of deficiencies were addressed within treatment.

Specifically, this research evaluated the effectiveness of a family therapy group program for domestically violent adolescents and their single mothers. Conditions anticipated to change as a function of treatment were measured at intake and again at program closure. The outcome variables were measured by self-report scales on the youths' and parents' psychological and physical acts of abuse, and the youths' and

parents' self-reported anger. The clinician completed a measure assessing the youths' psychosocial and emotional functioning pre- and post-treatment, also.

Simple factorial analyses of variance reflected significant reduction in youth physical abuse, youth psychological abuse, parent physical abuse, parent psychological abuse, and youth multidimensional functioning scores for the treatment groups, as compared to the waiting list control group.

Overall, this program demonstrated modest levels of effectiveness. It was successful in reducing psychological and physical violence for both parents and youth, and in improving the youths' psychosocial and emotional functioning. It did not, however, reduce anger for either youth or parent. These findings suggest that while anger may still be an issue for these families, acting it out in violence against one's family member can be deterred by teaching alternative methods of anger expression and stress management, and intrafamily communication.

CHAPTER ONE: INTRODUCTION

Since the early 1970s, researchers and mental health practitioners have shown interest in problems of the family, especially when those problems involve intrafamily violence (Carlson, 1990; Evans & Warren-Solberg, 1988; Glaser, Sayger, & Horne, 1993; Straus, Gelles, & Steinmetz, 1980; Walker, 1979). To date, such research on violence has typically focused on spousal abuse or parent-to-child abuse (Mangold & Koski, 1990) and not on child-to-parent aggression (Livingston, 1986). Relatively little research has been conducted on child-to-parent abuse, even though the phenomenon was first identified almost 40 years ago (Sears, Maccoby, & Levin, 1957). However, closer attention has been paid to child-to-parent domestic violence since the early 1980s, when statistics of youth-to-parent violence indicated it to be an emergent family problem (Office of Juvenile Justice and Delinquency Prevention, 1993). Although the concept of child-to-parent domestic violence has been legitimized, the primary focus in domestic violence research continues to be on interspousal violence.

Background of Youthful Violence

The limited literature on child-to-parent violence has focused largely on theoretical underpinnings of such violence, attempting to explain the existence of the phenomenon. Initial forays into this area of concern have discussed the applicability of such theories as social learning, stress, and the like. Such theoretical development has created appropriate frames of understanding but these frames, to date, lack rigorous testing to determine their validity when applied to the concept of child-to-parent domestic violence.

Beyond theoretical bases, not much is known about the dynamics of youthful domestic violence--systematic studies of parental assault by minor offspring are needed (Bandura, 1973; Gelles, 1983; Herzberger, 1983). More refined areas of interest such as frequency of parental abuse, the range of violence enacted by child or adolescent perpetrators towards parents, gender-specific issues of both assailants and victims (Kratcoski, 1987), and multiple causality behind the aggression (Tolan, Guerra, & Kendall, 1995) are still under-investigated and largely speculative (Paulson, Coombs, & Landsverk, 1990).

Domestic Violence Literature

As the literature on child-to-parent violence is still too sparse to draw upon for much conclusive information, many of the practical positions have been inferred from the literatures of adult domestic violence and aggressive youth. A significant body of domestic violence literature has focused on the intergenerational transmission of violent behaviors. More specifically, it has been suggested that youth who are exposed to interparental violence have a significantly greater incidence of clinical dysfunction and adjustment problems than non-observing children (Jaffe, Wolfe, & Wilson, 1990; Reuter & Conger, 1995). Observation of spousal abuse in early childhood has been found to be associated with problems of juvenile substance abuse, anxiety, personality disorders, and internalizing behaviors such as depression (Grice, Brady, Dustan, Malcolm, & Kilpatrick, 1995; Novaco, 1986), and externalizing behaviors of aggression (O'Keefe, 1994; Rosenbaum, 1987; Simons, Wu, Johnson, & Conger, 1995). These youth are also likely to display aggression towards a female adult within the home on multiple occasions

(Evans & Warren-Solberg, 1988; Salts, Lindholm, Goddard, & Duncan, 1995); and are more likely to continue using those assaultive behaviors into adulthood (Lowrey, Sleet, Duncan, Powell, & Kolbe, 1995; Roscoe & Callahan, 1985; Walker, 1983).

Aggressive Youth Literature

While the domestic violence literature frequently tends to attribute child-to-parent violence to the observation of interparental violence, the literature on aggressive youth tends to associate violent behavior with the youth's intrapersonal characteristics (Carlson, 1990; Lochman & Dodge, 1994); and/or parenting deficits (Doumas, Margolin & John, 1994; Hirschi, 1969; Lowrey et al., 1995; Zastowney & Lewis, 1990). Intrapersonal characteristics of aggressive youth tend to derive from social-cognitive deficiencies. Lochman and Dodge (1994) suggested that aggressive youth display hostile attributional bases, resulting in poor means-end problem-solving, and failure to generate competent problem solutions. As those youth anticipate hostility from others, they may preemptively act in kind (Rabiner, Lenhard, & Lochman, 1990).

Hostile and aggressive behavior in youth may be mediated by four main societal factors: Media-supported violence; use of alcohol and other drugs (Department of Health and Human Services, 1992); access to weapons and firearms; and lower socioeconomic status (Lowrey et al., 1995). All factors listed may attribute, in part or sum, to the social construction of aggression as the exercise of control over others, triggered by challenges to self-esteem or integrity (Campbell, Munson, & Coyle, 1992); or as a loss of self-control resulting from the build-up of stress (Campbell & Muncer, 1987).

Aggression is most often classified as a personality variable, with relative stability over time (Walder, Eron, Huesmann, & Lefkowitz, 1990). Negative early experiences may form an individual's basic personality, predisposing him/her to incorporate those experiences into his/her own behavioral patterns (Kratcoski & Kratcoski, 1982). Hence, a child exposed to early hostile and aggressive environments may assimilate those tendencies into subsequent interactions.

As mentioned above, parenting deficits which may drive juvenile aggression can be defined by inconsistent authority and discipline by the parent (Patterson, 1982, 1989; Schroeder, 1983); indifference to or rejection of the child (Lowrey et al., 1995); and lack of positive support for the growth of the child's self-esteem (Herrenkohl, Herrenkohl, & Toedter, 1983).

Paulson et al. (1990) posited that the domestically violent youth are clinically marked by general unhappiness and low self-esteem that derive from inadequate social reinforcement by parents. Herrenkohl et al. (1983) suggested that the major contributory condition for abusive behavior by adolescents is an "inner deficit" (p. 130) resulting from parental rejection and lack of nurturance. That "inner deficit"--the intrapersonal characteristics that support aggressive behavior--may be comprised of attributional biases, problem-solving deficiencies, and inadequate coping mechanisms, all of which sum to favor aggression as a situational outcome (Lochman & Dodge, 1994). As aggressiveness develops in childhood, it remains fairly stable over time and through life stages of

adolescence into adulthood (Caspi & Moffitt, 1992; Eron, Huesmann, & Zelli, 1991; Farrington, 1991; Patterson, 1992; Quay, 1986; Sampson & Laub, 1993).

Treatment Considerations for Child-to-Parent Violence

It is apparent from the literature described above that child-to-parent violence is commonly considered a family problem with roots in early exposure to social and familial aggression and parental under-involvement. Outcomes to early childhood exposure to those types of intrafamily dysfunction include psychopathology in children, and behavioral aggression. Treatment efforts that attempt to ameliorate youthful domestic violence, to date, include individual child, individual parent, or conjoint child-and-parent therapies in various combinations of communication skills training (Whitchurch & Pace, 1993), anger and stress management training (Dishion & Andrews, 1995), and parenting and social skill development (Patterson, 1982, 1989; Tremblay, Kurtz, Masse, Vitaro, & Phil, 1995), designed to redress family dysfunction. However, simply addressing the aggressive behaviors on an individual, versus a family, basis fails to fully incorporate causal family conditions into treatment. As the youth's aggression is considered a family problem--not just an individual problem--it is essential to include family members in treatment (Borduin et al., 1995; Haley, 1976; Minuchin, 1974; Veenstra & Scott, 1993). Very few interventions described in the literature actually incorporate all three areas of skill training within one program--even fewer programs apply these skill-building modules within a family therapy format for parents and violent youth.

The literature is largely in agreement that youthful domestic violence is multifaceted, comprised of cognitive, behavioral, and emotional components (Hall, 1984; Greene, 1993; Kiselica, Baker, Thomas, & Reedy, 1994; Lochman & Dodge, 1994; Neidig, 1986). It follows, then, that a program designed to address juvenile domestic violence would incorporate cognitive, behavioral, and affective components into treatment (Davis & Boster, 1992; Hains, 1992; Hall, 1984; Valliant, Jensen, & Raven-Brook, 1995; Veenstra & Scott, 1993). Each of the components listed above--anger and stress management, and communication skill building--is manifested in cognitive, behavioral, and affective aspects.

For families of domestically violent youth, the cognitive component can be approached by teaching members to communicate more effectively (Infante, Sabourin, Rudd, & Shannon, 1990); to identify angering stimuli and each person's reactions (Neidig & Friedman, 1984); and to discern personal stressors and learn coping strategies to reduce stress (Garbarino, Kostelny, & Dubrow, 1991; Hart, 1991). Behaviorally, the family members can be trained to change communication patterns (Patterson, 1978); respond to angering stimuli less aggressively (Feindler, Ecton, Kinsley, & Dubey, 1986); and to manage stress by physical relaxation or other means (Goldstein, Glick, Reiner, Zimmerman, Coulty, & Gold, 1986). Finally, members also learn to express affect more appropriately in communication (Infante, Chandler, & Rudd, 1989); to identify and reduce anger aroused by situations (Hains, 1992; Huebner, 1988; Kiselica et al., 1994), and manage frustration and stress more effectively (Compas, 1987; Deffenbacher, 1988).

As mentioned above, however, few programs incorporate all these aspects into a family-focused treatment program.

In 1984, Neidig and Friedman published a manual for the treatment of spousal abuse. Originally developed for the military and then routinely applied to a civilian population, the program has undergone repeated empirical tests for efficacy, with consistently demonstrated success in the elimination of domestic violence within couples. The treatment addresses the behavioral, cognitive, and affective aspects within modules of anger management, stress reduction, and communication skill building--three areas of personal competence consistently lacking in violent offenders (Davis & Boster, 1992; Infante et al., 1990; Tremblay et al., 1995).

While the language of Neidig and Friedman's (1984) program is framed for couple interaction, the underlying concepts address the basic personal and relationship dynamics listed above. By redirecting the focus of interactions from spousal to parental/child, it seemed reasonable that this multimodal program could be tailored to parent/child interactions as the essential ingredients of treatment were all included. A different alternative would be to blend a number of existing, monomodal programs--an undesirable option since the newly merged program would not have the empirically demonstrated effectiveness of Neidig and Friedman's (1984) program.

The focus of this research, then, is to test the effectiveness of this multimodal treatment program for parents and domestically violent youth. It is understood that literature on child-to-parent violence is scant, and empirical findings on the treatment of

child-to-parent violence even more rare. By testing the effectiveness of this program within a scientific framework, the most deficient area of knowledge--empirical testing of treatment effectiveness--will be addressed.

This dissertation reports the theoretical justification for, and empirical testing of, a family group therapy program for domestically violent adolescents. Chapter One herein provides the background and justification for the program evaluation, giving a brief overview of critical issues and justifying the need for this program evaluation. Chapter Two discusses substantive literature on relevant theories which suggest how violence in families may develop. Once the general literature is reviewed, current treatment programs for aggressive youth are examined. Neidig and Friedman's (1984) couples' conflict containment program is suggested as a viable option for implementation and evaluation. The chapter concludes with statements of hypotheses for this program evaluation.

Chapter Three outlines the methods of the project, detailing the characteristics of the sample, and procedures followed within the program. Measures used to test variables of interest are discussed, as well. Chapter Four presents findings from this evaluation as determined from the statistical analyses of the pretest-posttest measures and families' reports of satisfaction. Chapter Five discusses the implications of those findings in terms of current effects on program participants. Null effects are examined and suggestions for future research/implementation are developed.

Background and Justification

It has been suggested above that child-to-parent domestic violence is a serious social problem, not only because of the immediate effect of violence, but also because it implicates family problems that exist both prior and subsequent to the violence. Antecedent conditions may include observation of intrafamilial and social violence which serve as templates for the child's aggressions (Fantuzzo & Lindquist, 1989), dysfunctional personality characteristics that arise from the observation of violence (Kempton, Thomas, & Forehand, 1989), and truncated social and relational skills due to an overall dysfunctional home with inadequate parenting (Gottfredson & Hirschi, 1990; Long, Forehand, Fauber, & Brody, 1987). Subsequent conditions involve the continuation of violence into adulthood (Patterson & Yoerger, 1993), with violent behaviors against one's partners and children (Simons et al., 1995), and the maintenance of inadequate social and interpersonal skills (Lochman & Dodge, 1994). It seems clear that child-to-parent violence can be a complex problem with far-reaching implications.

This section will briefly summarize why an urgent need for effective treatment of child-to-parent domestic violence exists. Child-to-parent violence will be identified as a critical social problem that demands an immediate response from the research and clinical communities. The three foremost theories--social learning theory, stress theory, and family systems theory--will be briefly overviewed, creating an integrative frame from which to assess the multifaceted situations and derive effective solutions. A proposed solution for the treatment of child-instigated violence: Neidig and Friedman's (1984)

couples' conflict containment program, modified to address family violence. The strengths of this program will be weighed *vis a' vis* contemporary therapies for family dysfunction.

Family Context

The dynamics of child-to-parent aggression indicate that the violence occurs in interactions within the context of a family (Kratcoski & Kratcoski, 1982; Reuter & Conger, 1995; Smith & Thornberry, 1995; Steinberg, 1987). As such, examination of the youth solely as violent perpetrator outside the context of the family seems to have limited value (Compas, Slavin, Wagner, & Vannatta, 1989; Menard & Huizinga, 1994; Stanger, Achenbach, & McConaughy, 1993; Wilson-Brewer & Jacklin, 1991). Therefore, theories and treatments considered in this dissertation will examine interactions by persons within a family context.

Family context, however, can be a fairly general descriptor. This study will present theories that pertain to fairly nebulous families--parents and offspring--but will make specific applications of those theories to female-headed households with adolescents. The treatment program, however, has been tailored to address the problems of domestically violent adolescents, who acted aggressively against their single parent mothers.

The participants in this study--adolescents and their unmarried mothers--have been selected as the family context of interest for a number of reasons: First, fully half of all juveniles arrested for domestic violence in Pima County, Arizona, in 1995 resided with

their single mothers (Superior Court of Arizona, 1996)--thus, single-parent families were accessible in sufficient numbers to meet the research design requirements of this study. Beyond that, however, single mothers as parental participants in treatment were a viable option. First, mothers of aggressive youth tend to be the single family member most frequently assaulted (Evans & Warren-Solberg, 1988). Also, mothers tend to be the parent more invested in seeking help for a troubled child (Montemayor, 1984). For the purposes of this study, mothers as heads of households were more clearly identified as the adult fulfilling the parental role, as opposed to either parent in a two-parent family. Therefore, this study will be examining changes in youthful and parental behaviors as family dyads--mothers and adolescents--receive group treatment.

Family and Youth Violence Statistics and Characteristics

It has been suggested above that certain family and youth characteristics and dynamics may be present in violent families. More specifically, in 1980, the National Department of Justice Survey reported that 1.2 million episodes of parent/child violence occurred within that year (Office of Juvenile Justice and Delinquency Prevention, 1993). Of those reported episodes, over 74,000 incidents were parent-to-child assault; 47,000 violent episodes were child-to-parent violence (Kratcoski, 1984). The child-to-parent assaults included such behaviors as slapping, kicking, biting, punching, beating the parent with an object, threatening him/her with a knife or gun, or actually using a weapon against the parent (Kratcoski & Kratcoski, 1982). Of the abused parents, one in ten suffered physical injury severe enough to require medical attention (Straus, 1980). From

the type of violence enacted and frequency of injury suffered, it is clear from these findings that youthful aggression is a serious social problem in terms of threat to the family members.

The abusive episodes tend not to be isolated events, either. Violent youth are accountable for 17.2% of all violent crimes for both adults and juveniles. However, those youth comprise only 5% to 6% of the delinquent juvenile population (Federal Bureau of Investigation, 1992). These youth, moreover, are responsible for 66% of juvenile violent offenses (Office of Juvenile Justice and Delinquency Prevention, 1993), which includes parental assault.

Severe, recurring domestic violence not only occurs on a national level: It occurs locally, as well. In Pima County, Arizona, over 1,000 youth were arrested for domestic violence in 1995. Approximately 70% of those youth arrested for domestic violence were charged with physical assault against a parent (Superior Court of Arizona, 1996)--the data on type and severity of injury is not available. If Arizona's juvenile population criminal data is consistent with the data from the National Survey (1980), it is likely that a significant number of youth will be arrested multiple times for domestic violence and other juvenile crimes. These violent youth tend to be at risk for other delinquent behaviors, as well, such as drug and alcohol use (Licitra-Kleckler & Waas, 1993); school and family offenses (Fantuzzo & Wolf, 1987; Lindquist, 1989), and other serious antisocial acts (Lochman & Dodge, 1994; Lowrey et al., 1995). Simons et al. (1995) noted that youth arrested for domestic violence often have contact with police for a

variety of criminal behaviors. This finding corroborates the report from the Office of Juvenile Justice and Delinquency Prevention (1993) that a minority of youth tend to commit the majority of criminal offenses. It is apparent, then, that youth-instigated domestic violence may be a complex and serious social problem in terms of repeat criminal activity.

As mentioned above, there is a paucity of research in the area of child-to-parent domestic violence. Certainly, the problem is gaining prominence, and researchers are beginning to study a number of relevant perspectives: Identification of personality characteristics of domestically violent youth (Evans & Warren-Solberg, 1988; Livingston, 1986; Paulson et al., 1990; Salts et al., 1995; Streit, 1981; Weatherly, 1990); dysfunctional family interaction patterns that contribute to the frequency and severity of violence (Forgatch, 1989; Haley, 1976; Minuchin, 1974; McColloch, Gilbert, & Johnson, 1990); and parental or family of origin characteristics that serve as precursory or contemporary support for child-to-parent abuse (Cappell & Heiner, 1990; Gelles & Cornell, 1990; Paulson et al., 1990; Rybarik, Dosch, Gilmore, & Krajewski, 1995; Salts et al., 1995; Smith & Thornberry, 1995). In order to understand these perspectives, theories from the fields of domestic violence and aggressive youth have been considered.

Theory-Oriented Research

A limited number of theories attempt to develop an interpretive framework from which to view the phenomenon of youth-instigated domestic violence. Contemporary theories include social control theory (Hirschi, 1969; Rosenbaum, 1987); the subculture

of violence theory (Felson, Liska, South, & McNulty, 1994; Wolfgang & Ferracuti, 1967); stress theory (Boss, 1988; Kratcoski, 1984; McCubbin & Patterson, 1982); social learning theory (Bandura, 1977; Patterson, 1982; Rybarik et al., 1995); and family systems theory (Broderick, 1993). Of these five theories, only the social control and subculture of violence theories do not support the premise of intergenerational transmission of violence, or the occurrence of violence within the family of origin. Since youthful violence has been strongly associated with interparental violence, this dissertation will use the latter three theories as an integrative frame for the discussion of youthful violence--that is, this study evaluates theory-oriented treatment effectiveness, but does not test the theories directly.

There are three reasons that justify conducting theory-oriented treatment effectiveness research: Discovery, research design, and knowledge application (Lipsey, 1993). *Discovery* integrates the use of supporting theoretical inferences with a conceptual basis for refining and improving existing treatment by identifying relevant factors, patterns, and dynamics in the phenomena of interest. Well-conceived theory serves as a clear guide to those areas of improvement, both in terms of conceptualizing the problem issues, and recognizing potential change mechanisms.

Research design, guided by theory, suggests questions of samples, measures, and the like. A theoretically-driven design, further, is more likely to detect treatment effects, permit causal inference, and produce more interpretable and generalizable results. Finally, *knowledge and application* require theory in order to give meaning and explanation to

relevant concepts. Theory also supports new findings and the exploration toward new solutions. Understanding the "why" of phenomena through theory, application addresses the "how" of successfully using treatment. Use of a well-thought-out theory, then--or an integration of equally plausible theories (Bickman, 1987)--substantially strengthens the causal analysis of the nature and details of the concepts of interest.

Problem and Treatment Theories

Chen and Rossi (1990) suggested two kinds of theory relevant to clinical science: Theory that models the processes that produce problems needing amelioration, such as family dysfunction; and theory that models ameliorated process, such as treatment or programs. While the two types of theory have different foci, they can, indeed, be the same theory--as is the case with the three theories briefly described as relevant in this study.

The three theories--social learning theory, stress theory, and family systems theory--as problem theories all contribute to the understanding of youthful domestic violence as a dysfunctional family phenomenon. Very simply, social learning theory suggests that aggressive behavior can be learned and used by juveniles who observe it and, if the behavior is retained and cognitively accepted, can continue as a fairly stable behavior pattern across one's lifespan (Lowrey et al., 1995; Olweus, 1984). Stress theory posits that violent persons are ill-equipped to appropriately manage stress, and act out aggressively in maladaptive responses to over-accumulations of stress (Eron et al., 1991). Family systems theory, finally, holds that violence may erupt when the parents

are unable to maintain authority due to weakened, diffuse boundaries between generations. Hence, the usual vertical hierarchy in a family with the parent as authority is skewed and out of order, and the child is in control, rather than the parent. Since the natural family order is upset, the child acts out in order to bring attention to the family chaos and force reorganization of the family into an orderly hierarchy (Broderick, 1993; Colapinto, 1991).

Reframing each of the three theories as treatment theories, each theory deals with the change mechanism in treatment which can affect the identified problems. Lipsey (1993), and Chen and Rossi (1990) suggested that treatment theory include: (1) A problem definition that specifies what conditions are treatable, for whom, and under what conditions; (2) specified treatment components; (3) important stages of the treatment process, along with mediating variables and personal or program differences; and (4) specified expected outcomes.

Again, all three theories fulfill the requirements of treatment theory. As problem theories, these theories identify specific processes. As treatment theories, they identify the treatment mechanisms necessary to ameliorate youthful domestic violence--as there is a good deal of overlap among these theories, it is expected that overlap would exist among the treatments, as well. For example, in order to retrain aggressive youth from using assaultive behavior, anger management and communication skills need to be taught, according to social learning theory (Patterson, 1982). Stress theory indicates that persons erupt in violence from over-accumulations of frustration and stress--anger and stress

management, and communication skills would be central to this treatment (McCubbin & McCubbin, 1987). Family systems theory would suggest that in order to correct a skewed family hierarchy with blurred boundaries, the parent needs to be directed in re-assuming the parental role, clarifying boundaries and realigning the family's hierarchy (Haley, 1974; Colapinto, 1991).

As mentioned above, the theories on domestically violent youth have been extensions from the literatures of spousal abuse and aggressive youths. This research project does not attempt to test the underlying theories; however, those theories have been instrumental in defining specific constructs to be considered in a multidimensional treatment program. This program evaluation, then, will determine if treatment was successful in changing the outcomes of initial constructs over time. If change occurs within those constructs over time, it is necessary to rule in the treatment as a plausible change agent (Corday, 1986). Finally, a very limited number of studies have attempted to define characteristics of individuals and families with domestic violence histories. As mentioned, there is a dearth of information on type and severity of assault, gender-specific issues, and personal/causal factors in violence. A secondary focus within this study is the identification of subject characteristics and demographics, which can add to the literature's information base.

This chapter has developed the justifications that the study at hand has two appropriate and reasoned functions: First, this research will evaluate a program based on the change mechanisms identified by three central theories and, second, it will identify

characteristics of youth and their families who report child-to-parent domestic violence. The next chapter discusses the literature on the above-mentioned theories in greater detail. Contemporary therapy programs are identified, and the program selected for this research trial is reviewed.

CHAPTER TWO: LITERATURE REVIEW

The first chapter provided a brief background summary outlining the serious implications of child-to-parent domestic violence in terms of physical risk to family members (Ney & Mulvihill, 1982; Straus, Gelles, & Steinmetz, 1978), increased family dysfunction (McComb, Forehand, & Smith, 1988; Reuter & Conger, 1995; Smith & Thornberry, 1995), and the development of enduring antisocial behaviors over the lifespan of the youth (Patterson & Yoerger, 1993; Sampson & Laub, 1993; Simons et al., 1995). The three relevant problem and treatment theories--social learning theory, stress theory, and family systems theory--were examined as being appropriate approaches from which to explore the concepts of discovery, research design, and knowledge and applications. Further, they were discussed as being salient theories by which to identify change mechanisms in treatment. Using the three theories to support this program evaluation, Neidig and Friedman's (1984) treatment for couples' conflict was suggested as a viable treatment option, fitting the treatment needs identified by the theories. While the three theories provide an integrative frame by which to view the phenomenon of child-to-parent domestic violence, it should be noted that this study does not seek to test or substantiate those theories.

This chapter, then, describes the theories referred to above in greater detail. Contemporary treatments for family dysfunction, and aggressive youth are evaluated in terms of satisfying the family or individual deficiencies identified by the three theories. It is suggested that Neidig and Friedman's (1984) program, modified to reflect parent-

child interaction, is an appropriate choice for treating what has been argued to be a serious social problem.

Theories of Family Violence

The critical issue examined in this study is youth-to-parent domestic violence. A number of theories address the issues of aggressive youth, such as subculture of violence (Felson et al., 1994; Wolfgang & Ferracuti, 1967), or social control theory (Hirschi, 1969; Rosenbaum, 1987), but few directly address the specific problem of violence by youth towards parents. Theories which discuss this type of intrafamilial violence must look at the youth as a violent actor within the family system (Borduin et al., 1995; Dishion & Andrews, 1995)---thereby invalidating both theories of subculture of violence and social control, since those theories do not address the potential for the youth being violent toward his/her family members. This requirement of family interaction does move three theories--social learning theory, stress theory, and family systems theory--to be preeminent in examining youth-to-parent domestic violence. These theories are described below.

Social Learning Theory

Basic Concepts of Social Learning Theory

Social learning theory is a theory widely accepted as central in the understanding of domestic violence--it is the "most influential and most cited explanation" (Feldman, 1996). Social learning theory, as applied to the construct of child-to-parent violence, suggests that aggression and violence are learned behaviors for domestically violent youth

(Bandura, 1973; Feshbach, 1974; Tolan, Guerra, & Kendall, 1995). Observational learning, as the theory is also known, is based on the premise that observers cognitively note behavioral activity by others, along with the outcome of those behaviors. The observed interactions may be modeled by different sources: By media (Lowrey et al., 1995); within peer interactions (Davis & Boster, 1992); or by family of origin members (Emery, 1982; Fantuzzo & Lindquist, 1989; Grych & Fincham, 1990). In order to be learned, a specific behavior is modeled by a party, and observed by an actor. The actor replicates the behavior and, based upon the rewards associated with the behavior, retains or abandons the activity (Bandura, 1973, 1977, 1979, 1986).

The re-enacted behavior may elicit a variety of responses for the actor: Positive rewards, negative sanctions, or null reactions. Positive reactions obviously condone the behavior; negative reactions reject the behavior. Null reactions, however, may be interpreted as either accepting or rejecting, based upon the actor's attitude (Bandura, 1986). Consistent reactions to a behavior may validate its enactment, making the behavior morally justifiable to the person, and more resistant to extinction (Gelles & Cornell, 1990).

Beyond positive or negative reactions from others, mediating cognitions and attitudes help the actor decide whether or not to continue an aggressive behavior. Bandura (1977) suggested that a number of cognitive appraisals determine the degree of acceptability of the behavior. *Justification of behaviors* and *projection of responsibility* to external factors decrease personal culpability, especially for noxious behavior. This

also infers an external locus of control for the actor, taking responsibility for the activity out of his/her hands (Bandura, 1979). *Minimization* and *normalization* of the behavior attempt to rationalize the behavior as being non-deviant, and socially acceptable. *Depersonalization of the victim* lessens the impact of the behavior since the victim becomes an object, not a human being. Any or all of these rationalization tactics may interact to justify a noxious behavior.

However, a juvenile's ability to thoroughly assess the social desirability of a behavior is frequently inadequate. Aggressive youth, especially, may be unable to objectively use the appraisal review due to information-processing deficiencies (Dodge, 1986; Dodge, Pettit, McClasky, & Brown, 1986). These deficiencies may predispose youth to leap to abusive conclusions, based on simple behavioral repetition of observed violence, rather than actively using reasoned logic (Lochman & Dodge, 1994).

Coercive Patterns of Interaction

The family environment is a primary source of early observational learning (Hammock & Richardson, 1992). Patterson, DeBaryshe, and Ramsey (1989) suggested a developmental perspective from which to view youthful and adult aggression, within the rubric of social learning theory. Certain developmental variables have been identified as covariates for aggression. These variables include socially unskilled and inept parents, who exercise harsh and inconsistent discipline--frequently with physical abuse. As a result of sporadic and inconsistent parenting, the youth learns to manipulate or coerce others, rather than learn appropriate social skills. A coercive pattern may develop: The

parents discipline harshly, and the child uses aversive behavior--either avoidance or retaliation--to terminate family intrusions. The parents positively reinforce the child's aggression by temporarily backing down, but then escalate their behaviors into physical attacks on the child. The reinforced coercive pattern is maintained or escalated among family members (Felson & Russo, 1988; Patterson et al., 1989). The child exposed to extreme punishment for inappropriate or aggressive behaviors learns and retains aggression in his/her interactions with others (Eron & Huesmann, 1984), as the child has learned that aggression can be used to control others (Davis & Boster, 1992).

Observation of Parental Violence

Another explanation of learned violent behavior may be the observation of parental violence, as opposed to experienced parent-child violence. That observation may place youth at risk for re-enacting violent behavior. According to Kalmuss (1984), two types of modeling *vis a' vis* parental violence can occur: Generalized and type-specific. Generalized modeling refers to the demonstration of non-specific aggression--that is, aggression is not limited to one role or situation. While the observation of generalized aggression may, indeed, give rise to re-enacted abusive behaviors in society, it typically is not transmuted to violence within the home (Eron et al., 1983; Lowrey et al., 1995).

Type-specific modeling, on the other hand, re-enacts the original behavior in like situations. For example, children who observe interparental violence may associate the acts of abuse with relational situations. Type-specific modeling serves as a key explanation for the intergenerational transmission of abuse, especially when the child who

had observed violence acts out violently towards a family member he/she has observed being abused. Type-specific modeling is also used to explain the situation of an observer child becoming abusive in his/her own intimate relationships as an adult (Emery, 1982; Grych & Fincham, 1990). In sum, children learn to aggress by observing aggression, especially from parents who are familiar and powerful models (Doumas et al., 1994; Feldman, 1996). The observation and subsequent re-enactments of aggression legitimizes violence with loved ones (Kalmuss, 1984; Simons et al., 1995).

Not all youthful observers of domestic violence enact the behaviors themselves (Doumas et al., 1994; Kaufman & Zigler, 1987), of course. Some youthful observers of violence may act as "unintended victims" (Fantuzzo & Lindquist, 1989, p. 78) of interparental violence. Those victim/observers then cognitively note the violence but internalize the negative consequences into such symptomology as enuresis, nightmares, and depression (Licitra-Kleckler & Waas, 1993; Schroeder & Costa, 1984), rather than replicate the violence. Other observers may be adaptive enough to identify the violence but cognitively reject it as a personal behavior, refusing to legitimize the violence within relationships and choosing to simply not use violence as a personal behavior (Doumas et al., 1994).

Another alternative suggested by Hotaling and Sugarman (1986) is that children may be unaffected by interparental violence in the short run and, in fact, may show no symptomology until adulthood. In their own intimate relationships, however, the previously unaffected observers can become abusive, reenacting their parents' violence.

The observed and re-enacted violent roles are readily recalled, and supported over time with social and moral justification (Gelles & Cornell, 1990). While not applicable in all domestic violence cases, observation of family of origin violence remains the most consistent risk marker for domestic violence for both spouses (Carlson, 1990).

Application to Single-Parent Families

The above discussion of learned aggression was based on general, intergenerational family dynamics. Focusing more closely on single-parent families, it has been suggested that the same patterns of interactions apply: Harsh and inconsistent discipline acts as a template for retaliatory coercion and violence. The violence becomes a reinforced behavior, as a means by which to control others. Observation of adult inter-parental or parent-child violence sets a precedent for subsequent juvenile aggression (Salts et al., 1995). In either event, aggression has been learned as a control mechanism in relationships.

Social learning theory provides a perspective from which to view the etiology of violent behaviors toward family members. The second theory discussed herein, stress theory, suggests individual and family dynamics that give rise to assaultive situations.

Stress Theory

Basic Concepts of Stress Theory

Family stress theory (Hill, 1958) suggested that how families--and the individuals within them--react to stressful situations is dependent on three variables: (a) The type of provoking event; (b) the family's resources and strengths at the time of the stressful

event; and (c) the meaning attached to the event by the family, both collectively and individually (Boss, 1988). Provoking events can encompass a universe of stressful situations, from the daily stress of living in society to any type of acute or chronic stress. Stress, further, does not need to have a negative valence--eustress (e.g., positive stress) can add to the cumulative total of mounting stress (Selye, 1974).

The family's resources at the time of stress, likewise, include a wide range of tangible and intangible factors for dealing with stress. Resources can include financial and physical assets; intellectual, physical and emotional strengths; social and personal support; and the family's armory of coping skills (Boss, 1988; McCubbin & McCubbin, 1989; Patterson & McCubbin, 1987). The acquisition of coping skills seems critical to stress management (Compas, 1987), by enlarging the range of intellectual resources. With these skills, each person has additional positive options to utilize in stressful situations (Hains, 1992; Johnson, 1986). The greater the repertoire of positive responses to stress, the more likely that those positive coping responses will be used effectively to cope with stress (Tolor & Murphy, 1985).

Finally, the meaning attached to the stresses by family members acts as a directive for coping with the stress. This analysis of stress is the family's perception as to whether its resources are sufficient to reduce the stress, coping with it appropriately. If the stressful situation is determined to be overwhelming for the family or the individual's capabilities, judgment of the situation may result in inadequate attempts to resolve the stress, frequently leading to even greater stress and frustration.

The "Double ABC-X Model" of Family Stress

McCubbin and Patterson's (1982) model of adaptation and adjustment to stress, dubbed the "Double ABC-X model," suggested that families--and individual members of those families--employ fairly sophisticated methods of assessing and coping with stress. In this model, "Aa" is the accumulation of stress, which can be any number of factors. Stressors can involve a unique, acute situation; a chronic, ongoing strain; leftover consequences of previous coping attempts; or even normative individual transformations. The family's adaptive resources--"Bb"--can either be existing personal resources or the expanded family resources. How the family perceives the stress *vis a' vis* their resources is "Cc:" The definition and meaning given to the accumulation of stressors. "Xx" is how the family reacts to the stress, balancing resources against the accumulation of stress, resulting in either bonadaptive or maladaptive outcomes. In this model, a bonadaptive response might be an effective coping activity that reduces the impact of the stress without negative repercussions. A maladaptive response, on the other hand, is unable to cope with the demands of the stressor in a satisfying and effective fashion, resulting in heightened frustration and greater accumulation of stress.

Outcomes of Inadequate Coping

The juvenile's lack of sophistication in gathering personal resources or correctly evaluating the stressor impairs his/her ability to cope with stress (Ebata, Peterson, & Conger, 1990; Licitra-Kleckler & Waas, 1993). Without this ability to successfully diminish stress, maladaptive outcomes such as either internalizing or externalizing

problems can develop (Achenbach, Howell, Quay, & Conners, 1991; Sternberg et al., 1993; Tolor & Murphy, 1985). The accumulation of stress, then, spirals with each maladaptive outcome creating more stress and frustration (McCubbin & Patterson, 1982).

Externalized maladaptive reactions to stress drive outward manifestations of anger and frustration, such as aggressiveness and violence (Paulson et al., 1990); delinquency behaviors (Baer, Garmezy, McLaughlin, Pokorny, & Wernick, 1987; Compas, Howell, Phares, Williams, & Giunta, 1989; Vaux & Ruggiero, 1983); and increased oppositional and defiant behaviors (McCloskey, Figueredo, & Koss, 1996). Internalized behaviors, on the other hand, are self-directed adjustment problems such as lower self-esteem (Paulson et al., 1990); depression and anxiety (Curry, Pelissier, Woodford, & Lochman, 1988; Friedrich, Reams, & Jacobs, 1982; McCloskey et al., 1996; Schroeder & Costa, 1984); and suicide (Cohen-Sandler, Berman, & King, 1982). Characteristics which may not fall into either internal or external categories, but are also frequently observed include underdeveloped social competency (Rosenberg, 1987; Wolfe, Jaffe, Wilson, & Zak, 1985); and alcohol and other drug use (Elliott & Morse, 1989; Evans & Warren-Solberg, 1988). Tolor and Murphy (1985) suggested that divergent problems--both internalized and externalized--are different manifestations of the same problem, mainly, an inability to cope effectively with life stress.

Family Relationships and Coping

To effectively cope with stress, the adolescent must achieve a fit between him/herself and various nested social systems, such as family and peers (Patterson &

McCubbin, 1987)--that is, social support is critical in order for the youth to feel competent and capable in handling stressful situations. Family support has emerged as the single most important type of social support for adolescents (Cauce, Felner, & Primavera, 1982).

The nature of the parent-child relationship bears an impact on the child's development of coping skills (Roscoe & Callahan, 1985). A warm, nurturing relationship allows the child room to explore situations and outcomes. Positive parental interactions assist in the development of the child's self-esteem, helping him/her develop personal competence in problem-solving areas, including coping strategies (Goldstein, 1988). Without perceived family support acting as a "powerful buffer" (Cauce et al., 1982, p. 427), the adolescents tend to be more vulnerable to physical and psychological symptoms of stress (Compas et al., 1986).

Non-supportive or underdeveloped parent-child relationships may negatively impair the child's ability to develop coping skills. A poor relationship between the parent and child can be highly indicative of the youth's feelings of incompetence with stressful situations (Patterson, 1982; Paulson et al., 1990; Rosenbaum, 1987; van Vooris, Cullen, Mathers, & Garner, 1988). If the relationship between the child and parent is disengaged and non-nurturing, the child may lack the self-esteem and self-confidence necessary to develop positive coping skills. On the other hand, if the parent-child relationship is enmeshed and too involved, the child may develop a hostile dependency upon the parent, refusing to develop personal coping skills at the expense of the parent. This unstable

relationship may catalyze the child to either enraged interactions or outright rebellion against the parental figure (Kratcoski, 1984).

Application to Single-Parent Families

Stress theory offers strong justification for the development of symptomology in adolescents. For single-mother families, daily, ongoing family stressors may act as a foundation for the adolescents' impaired functioning. Certainly parenting demands are greater, since the demands are not shared with a partner (van Vooris et al., 1988). Financial, social, and educational concerns may be present. The cumulative stress facing the family may simply overtax the parent's ability to appropriately supervise and care for the adolescent (Hirschi, 1969).

The adolescent's level of functioning may be impaired in a number of areas such as school, social interactions, and home environment. The youth may be at heightened risk of substance abuse and delinquent behaviors due to insufficient parental monitoring, or the "psychological unavailability" of the mother (Egeland & Erickson, 1987; Gross & Keller, 1992).

Thus far, it has been argued that social learning theory describes etiological factors that may predispose juveniles to become violent, namely, intrafamily violence or deficient parenting in the family of origin. Stress theory suggested that persons who have underdeveloped coping abilities may react to stressful situations by using violence themselves.

Family Systems Theory

Basic Concepts of Family Systems Theory

The third theory which addresses youth-parent domestic violence is family systems theory. A family system is a concept that identifies the family as a collection of interdependent individuals, with assigned roles, tasks, and identities (Broderick, 1993; McIntyre, 1966; Zastowney & Lewis, 1990). This system has four defining properties, the first being *differentiation of members*. Differentiation is a process whereby roles of each member are developed and recognized within the family. Roles may be defined by such terms as age, sex, generation, or economic position. Further, characteristics of each role are defined. For example, the role of "parent" may be associated with authority, wage-earning capability, and the ability to discipline offspring (Colapinto, 1991).

Second, *organization* is central to family systems--the placement and stability of each person into his/her role, and the position of those roles within the family system. Highly organized families tend to experience some flux in the relationships among the members, but display fairly stable role definitions overall (Kurdek & Fine, 1993). Parents in well-organized households maintain authority and reinforce other family members' roles by overseeing and maintaining the integrity of the family (Kempton et al., 1989).

Third, family systems are also recognized by *boundary maintenance*--the system's ability to define and maintain the level of communication among subsystems, or between the family system and the outside social system. Boundaries are perceived as lines of

responsibility and authority (Colapinto, 1991). Flexible, clear boundaries support the healthy development of subsystems, and individual growth of family members. Inflexible, obscure boundaries reduce the effectiveness of the family as it interacts with the outside world, or with members within the family itself.

Finally, family systems also display *equilibrium tendency*, which are the built-in mechanisms that operate to hold the system in some sort of steady state over time. Families with high equilibrium tendencies typically display a reasonably stable organization. As the family experiences some stress or change in circumstance, the mechanisms that bring the family back to equilibrium work more actively to achieve this goal. These mechanisms may include parental roles of authority becoming more (or less) rigid; boundaries within the system becoming more (or less) defined, and the like (Weltner, 1982). Equilibrium tendency can be viewed as a dialectic challenge of maintenance and growth (Colapinto, 1991). As a family changes over time, it has the potential to diversify further while increasing its availability of alternatives. The alternatives, in turn, favor the growth and socialization of family members.

Boundaries in Family Systems

Two areas within family systems that warrant further discussion are boundaries and hierarchies. Boundaries are the degree of "connectedness" among family members--"who participates and how" (Minuchin, 1974). The most important boundaries are between generations of the same family, and between the family and society (Tavantzis, Tavantzis, Brown, & Rohrbaugh, 1985). Boundaries, as suggested above, prescribe the

amount of information-sharing among members, and their relative emotional closeness or distance (Zastowney & Lewis, 1990). Although human boundaries can be quite complex, common attributes include *variability*, *selectivity*, and *permeability* (Constantine, 1986).

Variability describes how boundaries may differ between subsystems or as perceived by individuals. Boundaries within a marital dyad, for example, may be more relaxed than boundaries between a parental-child subunit. Likewise, the boundary between the family unit and society may be more defined and rigid than boundaries within a marital dyad. The degree of variability is a function of the relationship between two subunits within a system, or between two different systems.

Selectivity impacts the pathways of information-sharing--with whom information is shared, and the nature of that information. Permeability indicates how much--and how clearly defined--information or emotional impact passes among family members. Clear boundaries are those that identify each person's role in the family, and the types of information, emotion, and so forth that are associated with that role. Diffuse boundaries, on the other hand, obfuscate role definition, confusing relational paths and information-sharing. Problems arise when boundaries are "either too permeable or too rigid, or when people are either too involved (enmeshed) or not involved enough (disengaged)" (Tavantzis et al. 1985, p. 73).

These problematic situations are called boundary breaches (Haley, 1976). Boundaries among subsystems may be breached in a number of ways. First, a cross-

generational coalition may exist, in which a parent-child subsystem dismisses the other parent. Triangulation is a second breach wherein a child is caught between parents, or the child's symptomology detours parental conflict. According to Vogel and Bell (1960), this "scapegoating" tactic functions as a diversion of the parents' marital problems, allowing them temporary stability as they focus on the child's problems. The child, on the other hand, acts as a public deflector of the couple's marital problems, since his/her symptomology comes under the scrutiny of public attention, not the marital conflict.

The third boundary breach, role reversal, is probably most applicable to youth-to-parent domestic violence. Intergenerational boundaries in this situation are circumvented by a collapse or reversal of parent-child roles, with the child taking care of the parent, or becoming a peer of the parent. In this situation, the child takes over the role of decision-making authority from the parent. Evans and Warren-Solberg's (1988) study on youth who assaulted parents suggested that aggression was an explicit marker of power struggles between the child and the parent, and a clear indication of a problematic parent-child relationship. In order to reduce the level of dysfunction in problematic families, it is necessary to re-establish a structure in which the parental subsystem or marital dyad is in authority, rather than the child.

Hierarchy in Family Systems

Another major concept in family systems theory is one of hierarchy. Hierarchy is a term associated with rules that dictate varying degrees of decision-making power for various individuals and subsystems. The family's structure can be stratified into vertical

levels (Haley, 1976; Minuchin, 1974). Within the vertical strata, the higher the placement, the greater that person or dyad's decision-making authority and power (Broderick, 1993). Typically, a functional hierarchy is one where the parental subsystem and/or the marital dyad serve as the foundation of the family, overseeing its functioning with the greatest amount of power and control among the members. These two subsystems--parental and marital--serve as the authority structures of the family, and are responsible for the establishment and maintenance of family boundaries. Nondominant subsystems such as sibling subsystems respond to family boundaries, and assist in change of the boundaries over time. That is, as the children grow, they are influenced by--and, in turn, influence--the boundaries set by the parents. In short, a functional family adapts and changes in order to "enable the realization of the individual potential of its members, as well as a collective whole" (Kantor & Lehr, 1975, p. 23).

A functional family system, then, has the parent(s) in an authority role, placed hierarchically superior to and dominant over the children's subsystem with clear role definitions in each system and boundaries delineating each subsystem (Constantine, 1986; Haley, 1976; Minuchin, 1974). In less functional families, ambiguity about role--that is, who is in control within the family--leads to unclear boundaries between family members. Role ambiguity increases stress in an already stressed environment (Ahrons, 1980; Zastowney, & Lewis, 1990) and can bring the family to crisis. Families with confused organizations of hierarchy most frequently present with clinical problems (Haley, 1976; Madanes, 1981). When the parents' subsystem is not appropriately elevated within the

family structure and the children's subsystem is in control, a case of "generational inversion" (Broderick, 1993, p. 178) is said to occur, maintaining chaos in the family and placing the children at risk of developing symptomology.

Haley (1976) suggested that children who are acting as authority in the family are incapable of maintaining a non-chaotic family. The children are unable to keep control and, therefore, act out behaviorally in order to focus attention on the family in crisis. It is assumed that the attention directed on the family will assist the family in reasserting appropriate hierarchy, and will direct the parents in taking authority out of the hands of the children and back into the rightful hands of the parents (Haley, 1976).

Application to Single-Parent Families

Family systems theory is an important approach to understanding child-to-parent violence. The emphasis of this theory is on family process (Broderick, 1993); that is, this theory focuses on how problems are maintained as an aspect of current disturbances, rather than how the problems originated (Minuchin, 1974; Tavantzis et al., 1985; Weakland, Fisch, Watzlawick, & Bodin, 1974). For single-parent families with assaultive adolescents, the parent is identified as the parental authority subsystem and the youth as a subordinate subsystem. Problems arise when the authoritarian parent's attempts at control are defied by the youth (Zastowney & Lewis, 1990). With a power struggle ongoing between the two subsystems, boundaries determining family rules become blurred (Weltner, 1982). Thus, intergenerational boundary maintenance suffers and family roles lose definition (Hunter & Schuman, 1980; Wallerstein, 1983).

Violence is likely to erupt during stressful times of boundary ambiguity. It may escalate in terms of frequency and severity, as the ineffectively-controlling parent attempts further control behavior which, in turn, increases the youth's oppositional behavior. For single-parent households, the time of adolescence may be especially difficult. The adolescent is in the process of individuation, separating from the parent and emerging from the previous role of child (Evans & Warren-Solberg, 1988). Roles and their respective definitions within the home are changing. Therefore, the family system as a whole is in flux (Zastowney & Lewis, 1990). The relative instability of the family system as it transitions with adolescence leaves it especially vulnerable to boundary breaches (Haley, 1974), particularly the breach situation of generational inversion (Broderick, 1993).

Treatment Programs

In order to be selected for this project, a treatment must meet a number of criteria. Borduin et al. (1994) stressed that any intervention must be child-centered and family-focused. The content of a treatment program must be comprehensive, incorporating cognitive, behavioral, and communicative factors known to be associated with adolescent antisocial behaviors into the program. Further, the program should be readily reproducible, and empirically validated for effectiveness (Borduin et al., 1994). With these parameters for treatment in mind, the following programs are briefly reviewed.

Social Learning Theory-Oriented Treatment Programs

Aggressive youth frequently develop the violent behavior from observational learning; to decrease violence, alternative behaviors need to be taught. One of the programs reviewed as a candidate for this study was Whitchurch and Pace's (1993) communication skills training, which provided alternatives to violence. That program was eliminated from consideration due to its relatively narrow focus. Further, that program was for interspousal violence, not intergenerational abuse, and failed to incorporate family of origin aspects. Finally, that program lacked empirical validation and was unable to demonstrate effectiveness.

A second program reviewed focused on the intergenerational transmission of domestic violence. Wagar and Rodway (1995) evaluated a group treatment approach for observers of domestic violence. While the program was fairly comprehensive in scope, participants were not actually abusive; rather, they only had the propensity to become violent based upon family history. Thus, that program was excluded due to the difference in violence levels between those participants and this study's subjects of interest. Further, the treatment itself was not family focused; children were treated outside the context of the family interactions. That program was also discarded since it lacked experimental design and empirical validation of effectiveness.

Another program designed by Wilson, Cameron, Jaffe, and Wolfe (1989) intervened with children who had observed domestic violence but who were not violent

themselves. That intervention failed to involve the family and violence aspects addressed in this study and, therefore, has been excluded from consideration for this program.

The next program, designed by Valliant et al. (1995), utilized a randomized experimental design with violent youth. In that study, youth within a control group were matched with experimental subjects in order to test the effectiveness of treatment. Unfortunately, that program failed to have family treatment as a central focus, removing it from consideration for this study.

Stress Theory-Oriented Treatment Programs

Hains' (1992) stress management program for aggressive youth reduced anger and stress but failed to incorporate a family focus into the treatment. The Hains program (1992) also maintained a fairly narrow focus, rather than attempting to incorporate all three cognitive, behavioral, and communication aspects into treatment. Failing to meet Borduin et al.'s (1994) criteria, that program was not considered further.

Conger, Patterson and Ge (1995) trained parents to reduce stress and improve the type and consistency of parenting. That program was instrumental in helping parents regain authority in the family and improve communication with their children. However, the intervention, treating only parents, did nothing to directly address the juveniles' violence. Rather than measure and directly remediate the youths' aggressiveness, that program focused on adult family members' competence in managing stress. Without a broader focus, and without any family interaction, that program was passed over.

Family Systems Theory-Oriented Treatment Programs

Hall (1984) devised a comprehensive, multi-modal, family-focused program which appeared to meet the criteria described by Borduin et al. (1994). However, that program is not available for replication. That program, further, lacked empirical verification of effectiveness.

Another initially viable option for consideration in this study was Davis and Boster's (1992) "treatment paradigm" (page 557). That program addressed four primary domains: Cognitive, affective, and behavioral processes, and social-environmental influences, all of which were implemented within a family therapy context. This very comprehensive program incorporated all necessary parameters specified by Borduin et al. (1994), except for empirical validation. However, art therapy is central to that program, and is outside the professional training of this researcher. Ethical standards, moreover, preclude a practitioner from conducting treatment in which he/she is not competent (AAMFT, 1994). Ethical considerations, therefore, removed that program from consideration.

With consideration of Borduin et al.'s (1994) explication of necessary treatment parameters, the above-described programs were deleted from consideration of usage. One empirically validated program, detailed and available for replication, was considered to be viable and easily adaptable for adolescent/single mother family interactions. The program is described below.

Neidig and Friedman's Domestic Violence Program

Neidig and Friedman's (1984) conflict containment program presented a "primary goal of immediate and complete cessation of violence" (p. 1). The original core curriculum was multifunctional, and directed participants in a number of exercises, which included accepting personal responsibility for violent behavior and contracting for a commitment to change. As the clients committed to change, they were directed in developing and utilizing times-out and other security mechanisms, and understanding the factors (such as stress) involved in the violence sequence. The clients were assisted in mastering anger control and stress reduction skills, and developing more effective communication skills.

The skills training approach in Neidig and Friedman's (1984) program included three basic components within a group context: Instruction, behavioral rehearsal, and feedback. Instruction was accomplished by use of brief lectures and demonstrations. Lessons were well-structured modules, with clearly defined goals and sequentially ordered steps. Each module had group exercises and homework assignments to facilitate learning.

Behavioral rehearsal encouraged couples to apply what they had learned from instruction, and took place during group exercises or homework assignments. Rehearsal allowed the clinician to observe participants' levels of mastery and compliance with treatment overall. If, for example, behavioral rehearsal had not been attempted, then the module was reviewed again with the couple and the homework was reassigned.

Obviously, the couples needed to stay fairly contemporaneous with the group format or risk falling out of treatment.

Feedback by the clinician was a critical component in the process of social learning. Care was taken to be positive, specific, and focused on the performance of group participants. Compliance of couples with treatment was continually monitored, and positive achievement and expectations were noted and reflected often by the clinician.

Neidig and Friedman's (1984) criterion for success for the couples' conflict containment program was the elimination of domestic violence by program participants--a criterion that was achieved by "most couples" (p. 275). Outcome measures of dyadic adjustment and locus of control both revealed "significant results" (p. 276) when pre- and post-treatment scores were compared. Further, a change in attitude towards the program was used to demonstrate effectiveness. Initially, most program participants were hostile and resentful. By program's end, however, participants rated the program a mean score of 5.4 on a continuum ranging from 1 to 6, with 1 having a very negative valence, and 6 assigned a highly favorable value.

While Neidig and Friedman's original program (1984) focused closely on spousal interaction, as mentioned, a careful review of the program suggested that the modules were amenable to revision into parent-child interactional sequences. The revision was tailored to fit into current Arizona Superior Court allowances for juvenile therapeutic treatment, which is ten hours of service per youth (Superior Court of Arizona, 1996). Within those ten hours of treatment, the three main identified maladaptations were

addressed: Deficiencies in anger management, stress reduction, and communication. The four weekly group sessions focused on remediating those deficiencies. A fuller explication of the program exists below, in "Procedures."

Summary

By now the arguments have been developed that: First, surprisingly little research has focused on the social phenomenon of child-to-parent violence. Second, very few programs currently available attempt to ameliorate the specific problems of child-to-parent violence from a child-centered, family-focused, empirically validated format. Third, ample justification exists to substantiate the testing of a modified cognitive-behavioral program for effectiveness in reducing youthful domestic violence. The remainder of this chapter identifies specific questions and hypotheses that were addressed in this program evaluation.

Questions and Hypotheses

Stemming from the theories discussed above, there are a number of questions and hypotheses presumed in this program evaluation. By each theory, they are:

Social Learning Theory: Violence can be intergenerationally taught through the observation of violence (Emery, 1982; Fantuzzo & Lundquist, 1989; Grych & Fincham, 1990; Hotaling & Sugarman, 1986), whether through parental conflict, harsh discipline, or through other social contexts. Lacking positive appropriate interpersonal skills with which to resolve conflict, persons who have observed violence as a model for conflict will use violence as a conflict tactic.

Question 1: Will completion of this program result in reduced frequencies of psychologically and physically abusive behaviors for both youth and parents in the treatment group, compared to the no-treatment waiting list group?

Hypothesis 1: Since these youth have been arrested for domestic violence, it is presumed that they have developed abusive behaviors as responses to anger. Alternative behaviors to violence can be taught, replacing the aggressive responses to anger (Feindler et al., 1986; Hains & Szyjakowski, 1990). Therefore, it is anticipated that the teaching of anger management, and communication skills (Edleson, 1984; Infante et al., 1990; Whitchurch & Pace, 1993) will reduce the number of psychologically and physically abusive acts the family members use against each other.

Stress Theory: Violence can be enacted in response to an over-accumulation of stress by a person who has under-developed coping skills with which to defuse stress appropriately (Ebata et al., 1990; Licitra-Kleckler & Waas, 1993; McCubbin & Patterson, 1982; Patterson & McCubbin, 1987). Maladaptive coping attempts exacerbate feelings of anger and frustration, and can result in decreased functioning in numerous areas, including school, home, and the community (Achenbach et al., 1991; Baer et al., 1987; Compas et al., 1989; Sternberg et al., 1993; Tolor & Murphy, 1985).

Question 2: Will completion of this program result in lower levels of anger for youth and parents in the treatment group, compared to the no-treatment waiting list group?

Hypothesis 2: Anger can frequently be a by-product of unresolved stress. Individuals who have inadequate coping mechanisms for reducing stress can experience high levels of anger and frustration. Therefore, teaching stress and anger management in this program will increase the abilities of youth and their parents to cope effectively with stress, and will decrease the level of anger reported by youth and their parents (Hains, 1992; Hains & Szyjakowski, 1990; Kiselica et al., 1994). Hence, the treatment group members--both youth and parents--who complete stress and anger management training will report lower levels of anger than will waiting list control members who have not completed such training.

Question 3: Will completion of this program result in higher levels of psychosocial and emotional functioning in home, school, and community for youth in the treatment group, compared to the no-treatment waiting list group?

Hypothesis 3: The treatment program will assist youth and parents in developing more effective coping strategies for reducing stress and anger. This will, in turn, result in higher functioning of the youth in the psychosocial and emotional areas of home, school, and community (Garbarino et al., 1994; Goldstein et al., 1986; Hodges, 1995). Hence, the treatment group members--youth only--who complete stress and anger management training will be assessed with higher levels of psychosocial and emotional functioning than will waiting list control members who have not completed such training.

Family Systems Theory: Violent youth compete with parents for authority and the parental role (Haley, 1976; Madanes, 1981, 1991). Violence erupts when the parents

are not in the role of authority, and when the hierarchy of the parental subsystem and the offspring subsystem is not in a normal alignment (Colapinto, 1991; Haley, 1987).

Question 4: Will completion of this program result in reduced frequency of psychological and physical abuse for youth and parents in the treatment group, compared to the no-treatment waiting list group?

Hypothesis 4: Parents who learn to communicate with their offspring effectively will also learn to use authority appropriately, and regain control within their homes. Youth who are relegated to the appropriate subordinate subsystem within the family system will not compete as actively for control within the family system (Colapinto, 1991; Haley, 1991; Madanes, 1991). Hence, the treatment group members--youth and parents--who complete communication skills training will report more effective communication among members. This will be demonstrated by reduced conflict, with lowered rates of frequency of psychological and physical abuse between youth and parents than waiting list control members who have not completed such training.

The instruments used to measure change in these conditions, as well as descriptions of the research design and methods, are described below in Chapter Three: Methods.

CHAPTER THREE: METHODS

Chapters One and Two have developed the background and justification for this research project, and described the relevant literature on assaultive youth and their families. This Chapter Three, then, explains the research design of the project. Descriptions of subjects, procedures, and measures comprise this chapter.

Research Design

Subjects

Subjects were referred to this program by Pima County, Arizona, Juvenile Probation officers under specified criteria. The criteria were that the referrals must be: Adolescent males or females, between the ages of 13 and 18, who have a recent arrest on domestic violence charges, and whose listed guardian is female--in all cases, this female guardian was the youth's birth mother. Criminal charges for domestic violence were any of three types: Physical assault, wherein the youth physically harmed another person; property damage, without physical harm to another; or disorderly conduct, which constitutes antisocial or disruptive behavior. In this study, criminal charges were divided into two main types: Physical assault and non-physical assault.

After arrest, each of the youth was processed through criminal intake at Pima County Juvenile Correctional Center ("PCJCC"), and then released to his/her parents. As a misdemeanor crime or first offense, each case was referred to the Family Violence Prevention Program ("FVPP") at PCJCC.

The Family Violence Prevention Program at the Pima County Juvenile Correction Center receives domestic violence referrals from the central intake center. FVPP, in turn, places those eligible referrals into a diversion program for first-time criminal offenders, which permits an arrested youth to remain detached from the judicial system (Davidson, 1989). In order to be eligible for the diversion program, the youth must admit to the charges against him/her; the youth and his/her parents must agree to participate in therapeutic treatment; and the youth must not be arrested for any further illegal activity while in the program (Superior Court of Arizona, 1996). This program received all its referrals from FVPP's diversion rosters.

If the family met the criteria listed above, the probation officers notified each family (youth and mother) that, if they agreed, the youth would be referred to a research program offered in conjunction with Juvenile Court services--there would be no fee for the treatment program. If the youth and/or parent initially refused to participate in this research program, they were referred by the probation officer to another agency for service.

Arizona Children's Home Association, a non-profit mental health agency centered in Tucson, Arizona, underwrote the costs of this pilot program in order to evaluate a potentially marketable program for the juvenile justice system. As a pilot program, the services described were offered to Pima County Juvenile Court and its referrals at no cost. All services were provided by this writer, a doctoral candidate in the School of Family and Consumer Resources, Division of Family Studies. This writer is also

certified by the State of Arizona Board of Behavioral Health Examiners as a Marriage and Family Therapist (MFT #0419). This clinician conducted all family sessions with assessments and group therapies at ACHA, and completed the CAFAS assessment on each minor. Likewise, this writer maintained all clinical and research files, and completed all data entry and analysis, as well.

Between October and December, 1996, 57 families were referred to Arizona Children's Home Association for inclusion in this research project. Of the 57 families, four families refused treatment as described to them at the first telephone contact by this writer, and their referral information was sent back to Probation. The remainder of families were randomly assigned to the two types of group: 27 families were assigned to the treatment group, and 26 families were assigned to the waiting list control group. In the treatment group, four families were screened out at the initial family interview due to the youth either being under the age of 13 (one family) or the youth having extreme mental health problems outside the scope of this program (three families). One family dropped out of treatment due to relocation. Otherwise, there was no attrition from either group during treatment or during the waiting period.

No families were screened from the waiting list control group. However, within approximately one week of each family being placed onto a waiting list, 12 families in the waiting list group contacted this researcher and requested immediate treatment. Each mother asserted that the current family situation was so volatile that the family could not endure waiting for treatment. Ethical considerations prohibited withholding treatment

from these families (AAMFT, 1994), so each of those 12 families was reassigned to the next forthcoming group. Since the reassignments occurred over the life of the program, no one group had more than two families reassigned to it.

Consideration of these reassigned waiting list control subjects as treatment resulted in quite uneven *n* sizes between the treatment and control groups. The original treatment-to-waiting list *n* ratio was 26 to 27. The reassignment of waiting list control subjects to treatment groups resulted in a new treatment *n* of 35, and a waiting list control *n* of 14. To determine if there were any differences between groups, this writer performed a one-way analysis of variance (ANOVA) for each dependent variable and all family and youth demographic variables. There were no significant differences between groups on any of the variables tested. Therefore, since the groups were not significantly different at the onset, this writer maintained the ability to test either of two possible divisions of groups: (a) The waiting list control group versus the treatment group, or (b) a comparison of the waiting list control, the reassigned subjects, and the treatment group.

Table 1 details demographics of youth in this study, divided by group and gender. Giving a rough overview of the participants in this study, 32 of the youth referred were male, 17 were female. The median age for males was 14 years old; females were typically age 15 at time of arrest. Both genders were predominantly Caucasian (19 males, 13 females), with Hispanics comprising the second largest racial group (10 males, 2 females). Only a very limited number of subjects were either African American or Native American (3 males, 2 females).

These referrals were, overall, a violent group. 78.1% of males were arrested for at least physical assault; 70.6% of females were arrested on similar charges. Further, for 43.8% of males and 52.9% of females, this was not a first arrest. 25.0% of males and 11.8% of females admitted gang involvement.

The majority of youths attended regular school (males, 65.6%, females 76.5%), but a substantial number attended alternative schools in which they have been placed for behavioral problems (28.1% males, 17.6% females). Two males (6.3%) and one female (5.9%) had been expelled from school and were not attending any academic program.

Table 2 describes family characteristics. The youths' families, as described before, consisted of the youth, a single mother and, typically, siblings. 84.4% of the males' households and 82.4% of females' households had observed interparental domestic violence. In 78.1% of the males', and 82.4% of females' homes, substance abuse was historically or currently a problem. The families were, generally, lower-income. Five families (10.2%) of the 49 had incomes over $30K; 22 families (44.9%) had incomes between $20K and $30K, the remaining 22 families (44.9%) had incomes below $20K.

A stress factor for families is complexity which, in this study, is an aggregate value consisting of the absence or presence of three factors: Number of children (the higher the number, the greater the stress), chronological spacing of children (closer than three years apart was an indicator), and gross family income. The vast majority of families displayed low complexity. That is, there were two or fewer children in the home, spaced at least three years apart, and the family income for three people exceeded

the 1996 federal poverty level of $12,984 (U.S. Department of Health and Human Services, 1996).

Variables

Independent Variable

As described above, the independent variable was group, divided into treatment and waiting list control groups. Treatment was Neidig and Friedman's (1984) domestic violence treatment program, modified to treat families with domestically violent youth. The waiting list control group constituted a "no treatment" group. Within the program itself, however, an interesting phenomenon arose: Over the life of the program, 12 families were reassigned from waiting list control to the treatment group at their requests. Hence, a third group arose within this program: A "reassigned treatment" group, which was ultimately compared statistically to the waiting list control and the treatment groups. This reassigned group, however, did not receive any treatment different from the original treatment group.

Dependent Variables

There are a number of variables which are measured to determine if this treatment was effective. Neidig and Friedman (1984) assessed program effectiveness to be immediate cessation of physical and psychological violence. Likewise, this program measured frequency of physical and psychological violence for both youth and parents to determine program effectiveness. The treatment program, further, attempted to achieve outcomes of reduced anger for both parents and youth, and improved psychosocial and

emotional functioning for the youth. These outcomes, too, were measured to assess change over time.

If this program were effective, the three skills--anger management, stress reduction, and communication--taught to parents and youth should result in better anger management, reduced stress, and better communication. Ultimately, these attained skills should result in less anger, and less violence for both parents and offspring, and better psychosocial and emotional functioning for the youth overall. Therefore, in order to test the effectiveness of this program, seven dependent variables were defined: (1) Psychosocial and emotional functioning of the youth; (2) youth psychological abuse; (3) youth physical abuse; (4) youth anger; (5) parent psychological abuse; (6) parent physical abuse; and (7) parent anger.

It has been previously stated that youthful violence occurs within a family context, thereby necessitating family treatment (Borduin et al., 1994). To determine if change occurred within the family, the youths' mothers completed the assessments at the same times as the youths.

Measures

Psychological and Physical Abuse

The Abusive Behavior Inventory (the "ABI;" Shepard & Campbell, 1992) is an expansion upon Straus and Gelles' (1979) Conflict Tactics Scale, which is the most widely used assessment measure for relational violence. [Permission to use this instrument was granted by the author and is reproduced herein (Appendix B).] This

instrument measures the psychological and physical abuse persons in relationships use against their partners. Verbal/psychological abuse was defined as non-physical tactics used to gain control and guarantee submission (Graham, Rawlings, & Rimini, 1988). Physical abuse was defined as assault used in order to keep or gain dominance.

The ABI contains 30 items, using a 5-point Likert-type scale to measure frequency of abusive behaviors over a defined time period. Twenty items of verbal and psychological abuse fall within subcategories of emotional abuse, isolation, intimidation, threats, use of male privilege, and economic entitlement. "Assaultive behavior" is the sole category for physical abuse, and contains ten items.

Reliability based on analysis of variance procedures can be calculated to provide an estimate of agreement between raters. Guidelines for interpreting those calculations are as follows: Values greater than .75 indicate good reliability; values between .75 and .50 reflect fair reliability; and values below .50 suggest poor reliability (Spitzer, Fleiss & Endicott, 1978). Reliability of the ABI was assessed by examining the alpha coefficient and the standard error of measure ("SEM") for the two subscales. The smaller the SEM, the more reliable the measure. The SEM for four sample groups ranged from .04 to .12, and the alpha coefficients ranged from .75 to .92, indicating good reliability.

Criterion-related and construct validity were both demonstrated. Criterion-related validity for this instrument distinguishes between groups of people who are known to have differing levels of abuse in relationships. An analysis of covariance between types

of relationships and the ABI subscales were completed. For men, the differences between the group means were .55 and .42; for women, the differences were .80 and .55--in both cases, the differences were significant at .001.

Construct validity is displayed by how well a scale relates to other variables within a system of theoretical relationships (Rubin & Babbie, 1989). Variables related to abuse in a relationship were clinical assessment of abuse, youth assessment of abuse, and prior arrest history for domestic violence. These items should correlate more strongly to the types of relationship than other non-related items such as age or household size. The correlations for abuse-related items were, indeed, stronger, ranging from .19 to .51 for abusive male categories, comparing to .05 to .17 for age and household size.

This instrument was designed for use with adult male batterers and female victims. While there are a limited number of instruments available to measure relational violence (Gondolf, 1987; Straus, 1979; Tolman, 1989), this researcher did not locate any similar measures that assessed type and frequency of psychological and physical abuse within a family--to be used by adolescents as well as parents. The two subcategories of emotional abuse and intimidation appeared most relevant to child-to-parent interactions, and were selected herein to measure psychological abuse, as the assaultive behavior subscale was used to measure physical abuse. These subscales maintained the focus on power and authority struggle between the adolescent and the parent--as evidenced by the use of violence to achieve one's ends.

In order to get an actual count of behaviors for this project, this writer followed the method employed by Straus (1979) to calculate responses. Rather than the Likert-type scale, seven frequency response categories of 0, 1, 2, 3-5, 6-10, 11-20, and 21 or more were coded with approximate midpoints of 0, 1, 2, 4, 8, 15, with the last category set to 25 to reduce skewness. The total frequency of psychologically violent acts was calculated by summing the response values across the two categories described above. Likewise, the total frequency of physical acts was calculated by summing responses of physical abuse items

Parents and adolescents completed this instrument on two occasions. Each person completed the instrument, reporting on his/her own behavior over the previous two-month time period. The responses for psychological and physical abuses were summed separately and entered as data.

Psychosocial and Emotional Functioning

Observation of domestic violence can result in the formation of either internalizing or externalizing behavioral symptoms (Licitra-Kleckler & Waas, 1993; Paulson et al., 1990; Schroeder & Costa, 1984). Those symptoms can significantly influence the child's functioning in a number of areas: School, home, and community role performances; the child's social or antisocial behaviors; moods and general affect; the child's propensity to abuse substances and, in some cases, the organization of thought processes.

The Child and Adolescent Functioning Assessment Scale (the "CAFAS;" Hodges, 1995) is a clinician-completed assessment of the youth's functioning on five subscales,

with an assessment of caregiver functioning on an additional scale. This instrument assesses the degree of impairment in children and adolescents secondary to emotional, behavioral, or substance abuse problems. [This instrument was purchased by the author; permission to include the instrument in this dissertation was not given (Appendix C).] The CAFAS is scaled on: (1) Role performance, with subscales of school/work, home, and community; (2) behavior toward others; (3) moods/self-harm, with subscales of moods/emotions and self-harmful behaviors; (4) substance abuse; and (5) thinking. There is an additional scale of caregiver resources, which evaluated material needs and family/social support. The child's household composition is assessed, based upon the defined caregiver (primary family, non-custodial family, or surrogate family). In general, the higher the score, the poorer the degree of functioning. Youth with higher CAFAS scores are much more likely to display high risk behaviors of harming self or others, have poor social relationships, display difficulties in school, and have involvement with the juvenile justice system, than youth with lower scores (Hodges & Wong, 1996).

Hodges and Wong (1996) evaluated reliability of the CAFAS. Good reliability--that is, correlations equal to or greater than .75 (Spitzer, Fleiss, & Endicott, 1978)--was demonstrated on the total CAFAS scale at intake and subsequent service utilizations at six and twelve months post-intake. The CAFAS score predicted restrictiveness of care, and total number and cost of in- and outpatient services (Hodges & Wong, 1996). Testing reliability of this measure over four samples displayed the following:

Correlations for total score and the Substance Use scale were high, .92 or higher. Correlations for Behavior Towards Others/Self and Role Performance were consistently high: .83 to .93, and .79 to .90, respectively. Moods/Emotions and Caregiver/ Family/Social Support all were characterized by moderately high reliability of .73 or higher. Construct validity was tested in a series of waves, as the correlations between the five scales were moderate over time: Cronbach's alpha for the CAFAS at Waves 1, 2, 3, and 4 were .63, .68, .67, and .67, respectively. Validity was also established by correlations between the Child Behavioral Checklist (the "CBCL;" Achenbach & Edelbrock, 1983), the Child Assessment Scale (the "CAS;" Hodges, 1990a, 1990b), and the Burden of Care Questionnaire (the "BCQ;" Brannan, Heflinger, & Bickman, 1995). The results suggested that the CAFAS total scores were significantly related to all related constructs at different waves. The patterns of correlations were similar for the different waves; for example, zero-order correlations between the CAFAS and the CBCL were .42, .49, .48, and .47 at Waves 1, 2, 3, and 4, respectively.

A number of measures have been created to test child functioning in multiple domains: The Child Behavior Checklist (Achenbach & Edelbrock, 1983) or the Child Assessment Scale (Hodges, 1990), but this instrument appears to be superior to those measures in that it also surveys multiple domains for a wider age-range of subjects. Further, clinical risk for self- or other-harm is included in this scale, while not in others--and this risk factor is especially relevant to the study at hand. The CAFAS is also unique in its utility as a diagnostic tool for DSM-IV decision-making, supporting differential

diagnosis of psychological disorders (American Psychiatric Association, 1995). The clarity with which this instrument defines severity and type of behaviors greatly simplifies diagnosis and reporting of symptomology.

Anger

The Siegel Multidimensional Anger Inventory (the "MAI;" Siegel, 1986) is a 38-item self-report instrument that measures the following dimensions of anger: Frequency, duration, magnitude, range of anger-arousing situations, mode of expression, and hostile outlook. [Permission to use this instrument was granted by the author and is reproduced herein (Appendix D).] Each of the statements is rated in terms of how self-descriptive they are, with responses ranging from *completely undescriptive* (1) to *completely descriptive* (5). The instrument was administered to college students, with a test-retest reliability of .75. Internal consistencies of the MAI factor derived scales all display acceptable levels of reliability (range of alpha = 0.51 to 0.83). Overall alpha (0.84) indicated that the scale has a high degree of internal consistency.

Internal validity was demonstrated by computing correlations of responses of the MAI to responses to the Harburg (Harburg, Erfurt, Hauenstein, Chape, Schull, & Schork, 1973), Novaco (1975), and Buss-Durkee (Buss & Durkee, 1957) anger inventories. Validation would be substantiated if two conditions were met. First, significant correlation would be found between the MAI dimensions and scores from the other inventories selected to measure the same dimension. Second, the correlations between the MAI and conceptually dissimilar dimensions should be lower than similar

dimensions. Accordingly, significant correlations at the .05 level were computed to be .17 or greater; at the .01 level, correlations of .23 or greater were significant. Duration and magnitude scores were derived from the Harburg (1973) inventory and correlated at .23 and .34, respectively.

The State-Trait Anger Scale (Spielberger, Jacobs, Russell, & Crane, 1983) and the Novaco Anger Inventory (Novaco, 1975) are both widely used self-reported measures of anger. This particular instrument was selected above those two partly because of its multidimensionality in assessing anger, and partly because of its emerging importance in assessing anger in domestic violence situations (Dutton, 1989, 1994). Further, this researcher has had experience administering and scoring the instrument, facilitating its use.

Procedures

Following the directives of the Human Subjects Committee at The University of Arizona, a request for approval of this study was submitted to the Committee. On 08 October, 1996, the Committee granted approval for this research project HSC #96-166 (Appendix A). Immediately thereafter, recruitment of subjects was commenced with the Juvenile Probation Department of the Pima County Superior Court, Tucson, Arizona.

As mentioned above, the subjects were adolescent males and females, between the ages of 13 and 18, who resided with their single mothers. Each youth had been referred from Pima County Juvenile Court subsequent to the juvenile's arrest for domestic violence. Referrals and each youth's brief informational summary were faxed to this

writer at the Center for Family Therapy ("CFT"), an outpatient branch of the Arizona Children's Home Association, by probation officers. Within 24 hours of receiving the faxed referral, this writer contacted the family and made arrangements to conduct an initial assessment/structured interview session at CFT. Those intake sessions were scheduled within one week of the initial contact with the youth's family.

Intake Session

At the intake session, the family completed formal agency intake documents, as well as the research instruments (the Abusive Behaviors Inventory and the Multidimensional Anger Inventory) described above. The Subject's Consent Form (Appendix E), in conformation with the requirements of the Human Subjects Committee at The University of Arizona (Human Subjects Committee, 1995), was reviewed and completed. An in-depth clinical interview was performed by this researcher, with information noted on the Family Descriptors form (Appendix F). This writer completed assessment of the youth with the CAFAS instrument within one week of the initial session.

Group Sessions

As sufficient numbers of families completed their intake sessions, they were placed in groups consisting of four to six families (eight to twelve individual group members), which commenced within two weeks of intake. Groups met at different days of the week and at different times--the families were typically able to choose between a couple of different sessions. The majority of the groups met on weeknights between 7:00 and 9:00

p.m. Weekend groups met on Saturdays or Sundays from 10:00 a.m. to 12:00 p.m., or Saturday afternoons from 1:00 to 3:00 p.m.

The group sessions were held in the conference room at Arizona Children's Home Association, 2820 South Eighth Avenue, in Tucson, Arizona. Group members were provided with soft drinks and pizza (or juice and bagels, for morning sessions) for each session, due to the therapy time overlap with meal times. Groups typically started within five minutes of the anticipated start time, and lasted two full hours. Frequently, members would meet outside the building after the sessions for up to an hour, informally discussing that meeting's applications to current life experiences.

The treatment groups participated in a modified family version of Neidig and Friedman's (1984) group therapy focusing on development of anger management skills, communication skills, and stress reduction skills. The waiting list control subjects were evaluated at the same times as the treatment subjects, but were not given therapy until the matched time period--four weeks between pre- and post-treatment assessments--had passed.

As mentioned above, the group format was a modification of Neidig and Friedman's (1984) couples conflict containment program. Language was modified to reflect parent-child interaction, as opposed to interspousal communication. Likewise, a module on sexual intimacy was deleted. Otherwise, the main focus of the modules remained essentially intact, although somewhat abbreviated. Permission for the use of

program language and materials was granted by the estate of Dr. Peter Neidig (Appendix G). The following is a brief synopsis of the curriculum for each week.

Week One

Handouts were given for this session: Program Principles (Appendix H); Anger Lessons Worksheet (Appendix I); Violence Cycle Worksheet (Appendix J); Time-Out Contract (Appendix K); and Anger Log I (Appendix L).

Introduction of members of the group and the therapist took place. The reason for all families being present was reviewed--all juvenile members had arrests for domestic violence. Confidentiality of sessions was stressed.

The therapist reviewed the program principles in detail, emphasizing that the domestic violence was a crime--whether or not youths admitted it, the people they had hurt really are among the most important people in the world to them. The premises of social control, social learning, and family systems theories were briefly discussed. Members of the group completed the Anger Lessons worksheet, then talked about patterns they saw--or failed to see--between their families of origin and the present nuclear families. Members were encouraged to review their own behaviors. The premise of cyclical violence was discussed--if the cycle is not broken, it is destined to be repeated.

Each person completed the Violence Cycle worksheet, listing at least three stressors, cues, triggers, and evidences of remorse. The "corkscrew" spiral of violence was described, with each repetition becoming more frequent, more intense, with less of a "honeymoon period" occurring between violent outbreaks.

Each family then completed two copies of the Time-Out Contract--one copy for them to keep, one to be handed in to the therapist.

The therapist reviewed Anger Log I, describing an angering incident and completing it on the Log. All families were requested to detail a minimum of three incidents over the next week on Anger Log I.

Week Two

Handouts of Anger Log II (Appendix M) and Anger Control Self-Analysis Worksheet (Appendix N) were given out to all group members.

Time-Out Contracts from the previous week were collected. General discussion of family conflict behaviors over the past week ensued. Each member then selected the more intense, higher-point-value episode from Anger Log I to use in completing the Anger Control Self-Analysis Worksheet. Anger Log II, with three detailed incidents minimum, was assigned for next session. The focus on positive communication and problem-solving was continued.

Week Three

Handouts were given: Stress Symptoms (Appendix O); Anger Management Self-Statements (Appendix P); and Nonassertive, Assertive, and Aggressive Behaviors (Appendix Q).

Each person's Anger Log II and personal progress was reviewed. The sheet of behaviors was discussed, defining both nonassertive and aggressive behaviors' cost in

terms of lost personal benefits and increased stress. Each person described a brief situation of each type of behavior and evaluated the outcomes.

The Stress Symptoms hand-out was reviewed, noting common etiology in frustration due to nonassertive or aggressive behaviors. Current and past symptomology of group members was discussed, along with the "snowball" effect of stress-induced symptomology, and interactional effect with nonassertive or aggressive behaviors. Progressive relaxation directives were given, incorporating positive self-directive statements into calming statements during the relaxation segment.

The Anger Log II was again assigned, describing a minimum of three angering situations. Three, 10 minute sessions of self-directive relaxation exercises were assigned as well, reinforcing both cool thoughts and self-actualization statements.

Week Four

Handouts were given: Feelings List (Appendix R); Feeling Talk (Appendix S); Making Positive Requests (Appendix T); and Positive Expressions (Appendix U).

Assignments from the previous week were reviewed, as was the hand-out, Making Positive Requests, tieing same into the previous week's discussion of nonassertive, passive and aggressive behaviors. Members role-played feelings talk within each family dyad. At the end of this session, feedback--both positive and negative--was encouraged by all group members regarding this therapy program, and individual family areas of need were discussed. The family assessment and closure sessions were held at Arizona Children's Home within one week after the termination of group.

Closure Session

The families were debriefed on the group therapies, with feedback on performance, current levels of functioning, and the like. This clinician's perception of each family's level of accomplishment was discussed, and if the family was perceived to be in need of additional treatment, that perception was shared with them. The mothers were given Arizona Children's Home Association's Consumer Satisfaction Survey (Appendix V). Each woman was asked to complete the evaluation of the program. Each parent was informed that the results of each Consumer Satisfaction Survey would not be reviewed by this writer until after each youth's termination summary had been forwarded to his/her probation officer. Therefore, the parents' feedback could not influence this clinician's perception of program completion.

The families were thanked for their participation, and the youths were given certificates of achievement, indicating that they had successfully completed the Family Violence Program at the Arizona Children's Home Association.

Instruments completed by the families at closure were the Abusive Behavior Inventory (Shepard & Campbell, 1992) and the Multidimensional Anger Inventory (Siegel, 1986). This researcher completed the CAFAS (Hodges, 1995) within one week of the last session. Termination summaries outlining each youth's participation in treatment were sent to the appropriate probation officers.

Thus far, this dissertation has reviewed the theoretical underpinnings of youth-to-parent domestic violence. It has described the research design of a program formulated

to treat families of youthful domestic violence. The next chapter, then, discusses the statistical analyses of that program.

CHAPTER FOUR: RESULTS

The original research design for this project was quasi-experimental, with subjects from an identified parent population randomly assigned to either a treatment or a waiting list control group--as noted above, a "reassigned" treatment group arose from the waiting list control group. The reassigned treatment group is included in analyses as a separate treatment group. The seven dependent variables are, again: Youth psychological abuse; youth physical abuse; youth anger; parent psychological abuse; parent physical abuse; parent anger; and the youth's multidimensional--that is, psychosocial and emotional--functioning.

Preliminary Analyses

The assessments completed by both the youth and his/her mother were the Multidimensional Anger Inventory (the "MAI," Siegel, 1986) and the Abusive Behaviors Inventory (the "ABI," Shepard & Campbell, 1992), which was divided into two subscales, psychological abuse and physical abuse. A basic premise of this treatment program is that family violence occurs within the context of, and as a function of, a family system. Therefore, the presumed relationships between the youths' and parents' aggressive dynamics were of interest. To determine if relationships exist between youths' and parents' reports of anger, psychological abuse, and physical abuse, intercorrelations among those variables were computed, pre-treatment (see Table 3).

For the pre-treatment analysis, significant correlations were found among all three youth variables of anger, psychological abuse, and physical abuse. Likewise, significant

relationships existed among the same three parent variables. However, no relationships were apparent between the youths' and parents' sets of variables. What this would seem to suggest is that, for the youths and for the parents separately, both psychological and physical abusive behaviors occur concurrently. However, the frequencies of parental abusive behaviors do not seem to be tied to the frequencies of youthful abusive behaviors, or vice versa.

As mentioned previously, this writer was concerned that between-group differences, pre-treatment, might be present, given the unanticipated requests by twelve mothers to provide immediate treatment. Accordingly, a one way analysis of variance (ANOVA) by group was performed on the seven dependent variables. No significant differences were found between groups for any of the seven dependent variables; all three groups appear to be from one parent population.

Likewise, to determine if any demographic variables differed between groups, a one way ANOVA was computed on all demographic variables, by group. Again, no significant differences between groups were observed on any demographic variable for either youth or family, indicating a fairly homogeneous sample.

Main Analyses

Having determined homogeneity between groups pre-treatment, statistical analyses were performed to determine differences between groups over time, using the computer program *SPSS for Windows* (Norusis, 1994). The analyses and results are detailed below.

Dependent variables by group. Simple factorial analyses of variance (ANOVAs) were conducted on each of the seven dependent variables at post-test, between treatment, reassigned, and waiting list control groups, with pre-test scores serving as covariates (see Table 5). Main effects by group were present for the variables: Youth psychological abuse, $F(2, 45) = 4.00$; $p = .025$; youth physical abuse, $F(2, 45) = 3.72$, $p = .032$; parent psychological abuse, $F(2, 45) = 15.20$; $p < .000$; parent physical abuse $F(2, 45) = 13.49$; $p < .000$; and CAFAS, $F(2, 45) = 5.96$; $p = .005$. There were no significant main effects for the dependent variables youth anger, and parent anger.

Post Hoc Analyses

The main variables of interest in this program evaluation were the dependent variables listed above; decreased scores in those variables for the treatment groups--but not the control group--would suggest efficacy of treatment. Statistical analyses by group indicated significant levels of change for groups on all variables but anger. The significant F values suggested that the group means were not equal, but failed to explicate which group mean was unequal to the others. Hence, Bonferroni's test was run to determine which group mean(s) differed from the other(s) (Hinton, 1995).

The Bonferroni multiple comparison procedure was run on all seven dependent variables, by group. Three dependent variables displayed differences between groups. For youth psychological abuse, the reassigned treatment group was significantly different from the waiting list control group, but not the treatment group. The treatment group was not significantly different from the waiting list control group for this variable, either.

For parent psychological abuse, the reassigned treatment group and the treatment group were both significantly different from the waiting list control group. The same significant differences were displayed for the parent physical abuse variable, as well.

Analyses of Hypotheses

To examine the above statistics and their conclusions more closely, the hypotheses of this program evaluation are reviewed. Accordingly, each question and its associated hypothesis will be briefly restated and answered.

Question 1: Will completion of this program result in reduced frequencies of psychologically and physically abusive behaviors for both youth and parents in the treatment group, compared to the no-treatment waiting list group?

Hypothesis 1: Since these youth have been arrested for domestic violence, it is presumed that they have developed abusive behaviors as responses to anger. Alternative behaviors to violence can be taught, replacing the aggressive responses to anger (Feindler et al., 1986; Hains & Szyjakowski, 1990). Therefore, it is anticipated that the teaching of anger management, and communication skills (Edleson, 1984; Infante et al., 1990; Whitchurch & Pace, 1993) will reduce the number of psychologically and physically abusive acts the family members use against each other.

Hypothesis 2: Parents who learn to communicate with their offspring effectively will also learn to use authority appropriately, and regain control within their homes. Youth who are relegated to the appropriate subordinate subsystem within the family system will not compete as actively for control within the family system (Colapinto,

1991; Haley, 1991; Madanes, 1991). Hence, the treatment group members--youth and parents--who complete communication skills training will report more effective communication among members. This will be demonstrated by reduced conflict, with lowered rates of frequency of psychological and physical abuse between youth and parents than waiting list control members who have not completed such training.

Analyses of variance (ANOVAs) by group displayed change in the areas of youth psychological abuse, youth physical abuse, parent psychological abuse, and parent physical abuse (Table 5). Examination of means (Table 4) revealed that both parents and youths used fewer psychological and physical violence acts after treatment than before. Referring to the Bonferroni test, however, only the reassigned treatment group showed significant difference from the waiting list control group for youth psychological abuse. Parents from both the treatment and the reassigned treatment groups had significantly different scores from the waiting list control group for both psychological and physical abuses.

Question 2: Will completion of this program result in lower levels of anger for youth and parents in the treatment group, compared to the no-treatment waiting list group?

Hypothesis 3: Anger can frequently be a by-product of unresolved stress. Individuals who have inadequate coping mechanisms for reducing stress can experience high levels of anger and frustration. Therefore, teaching stress and anger management in this program will increase the abilities of youth and their parents to cope effectively

with stress, and will decrease the level of anger reported by youth and their parents (Hains, 1992; Hains & Szyjakowski, 1990; Kiselica et al., 1994). Hence, the treatment group members--both youth and parents--who complete stress and anger management training will report lower levels of anger than will waiting list control members who have not completed such training.

Reviewing the ANOVA statistics reveals that, no, the treatment program did not result in lower levels of anger for youth and parents overall. Examining means (Table 4) suggests that of the parents' groups, only the reassigned treatment group's parents reported decreased anger. However, Bonferroni's test did not indicate significant difference among any of the three groups for either youth or parents.

Question 3: Will completion of this program result in higher levels of psychosocial and emotional functioning in home, school, and community for youth in the treatment group, compared to the no-treatment waiting list group?

Hypothesis 4: The treatment program will assist youth and parents in developing more effective coping strategies for reducing stress and anger. This will, in turn, result in higher functioning of the youth in the psychosocial and emotional areas of home, school, and community (Garbarino et al., 1994; Goldstein et al., 1986; Hodges, 1995). Hence, the treatment group members--youth only--who complete stress and anger management training will be assessed with higher levels of psychosocial and emotional functioning than will waiting list control members who have not completed such training.

The ANOVA statistics suggest that youths' psychosocial and emotional functioning did change, by group, over time. Examining the groups' means (Table 4), overall, the CAFAS scores reflecting youths' levels of functioning decreased for both the treatment and the reassigned groups, indicating higher levels of psychosocial and emotional functioning in school, home, and in the community. However, the Bonferroni test did not reveal differences among groups. It may be that since even the waiting list control group's p value approached significance for this variable, all three groups demonstrated change over time in psychosocial and emotional functioning.

Secondary Analyses

As noted above, the juvenile subjects were an overwhelmingly violent lot, with 78.1% of males and 70.6% of females having been arrested for physical assault. It was considered that type of assault history (non-physical assault, versus physical assault) might impact on treatment effectiveness. Therefore, secondary analyses were performed by computing analyses of variance on type of assault by group. These analyses are described below.

Dependent variables by group and gender. Two-way factorial analyses of variance (ANOVAs) were conducted on each of the seven dependent variables, by group and gender (see Table 6). There were no main effects for gender. Only one two-way interaction effect for group and gender was presented: Parent psychological abuse, $F(2, 42) = 3.48$; $p = .040$. No other variables were observed to have significance in two-way interactions.

Dependent variables by assault type and group. Two-way factorial analyses of variance (ANOVAs) were computed (see Table 7). Two-way interactions were found to be significant for one variable: Youth psychological abuse, $F(2, 42) = 4.94, p = .012$. Parent psychological abuse approached significance: $F(2, 42) = 3.17, p = .052$. No other variables were observed to have significance in two-way interactions.

The above measures and analyses were used to determine if treatment was effective. The following measure was used to determine if treatment was considered effective by the participants; if it was palatable; and to identify areas of strength and weakness through participants' feedback.

Consumer Satisfaction Survey

Thirty of 35 (85.7%) treatment families completed and returned this ACHA-required Consumer Satisfaction Survey, although all 35 families had received the survey (see Table 8). Forms were completed by the mother.

The parents, overall, were very pleased with the treatment received. 100% rated quality of service as positive; 73.3% considered the treatment to be "excellent," and 26.7% rated it "good." 60.0% would "definitely" refer friends to the program if needed; 40.0% "would be likely" to refer.

50.0% of parents were "very satisfied" with the amount of help received; 50.0% were "mostly satisfied." The services helped families deal more effectively with problems "a great deal" (60.0%) or "somewhat" (40.0%). 44.2% of parents reported that interactions between parents and children within the family were "much better."

53.6% of families reported getting along "somewhat better;" and one parent (3.3%) believed her family got along "somewhat worse."

Each mother was asked if she or her child changed for better or worse (in behaviors, attitudes, feelings, or handling of problems) since service began. 36.7% of parents reported that they, themselves, were "much better," 53.3% were "somewhat better," and 10.0% were "the same." The parents reported overall that 26.7% of the youth were "much better," 53.3% were "somewhat better," while 20.0% remained "the same."

Statistical analyses of the dependent variables of anger, psychological and physical abuse, and multidimensional functioning, consisting of psychosocial and emotional functioning, between the treatment and no-treatment groups seem to suggest that the treatment had positive effects on certain behaviors of parents and youth in assaultive families. The Consumer Satisfaction Survey responses suggest, further, that the treatment was well-received by families. These findings and their implications are discussed below in Chapter Five: Discussion.

CHAPTER FIVE: DISCUSSION

Analysis of Findings

As mentioned above, this treatment program for domestically violent youth and their mothers was based upon three treatment modules: Training in anger management, stress management, and communication skill building. It was anticipated that, by attaining a higher skill level in each of those areas of deficiency, decreases in the presenting symptomology of youth and parents would occur. If this program were successful, youth would display improved overall psychosocial and emotional functioning, and both youth and parents would report diminished frequencies of psychological and physical abuse against each other. Further, both the youths' and the parents' levels of self-reported anger would decrease.

The quasi-experimental research design had been selected in order to empirically demonstrate differences between treatment and no-treatment conditions. Therefore, the differences between the waiting list control and the treatment groups were most likely a result of the treatment itself, rather than nonspecific effects (Corday, 1986). Effectiveness of treatment was, again, tested by measuring change in seven dependent variables, between groups. Simple factorial analyses of variance (ANOVAs) by group for all seven dependent variables were performed. Five of the dependent variables revealed change over the course of treatment for the treatment groups. Youths' multidimensional functioning, youths' psychological abuse and physical abuse, and parents' psychological and physical abuse all displayed changed scores between program

intake and closure. The fact that there were significant findings when those dependent variables were analyzed by group suggests that this domestic violence program may have an impact on reducing the frequency of youths' and parents' psychological and physical abusive behaviors, and on increasing the youths' psychosocial and emotional functioning.

In summary, this pilot program may be considered effective in some, but not all, areas of interest. Measures such as the Abusive Behavior Inventory (Shepard & Campbell, 1992), and the Child and Adolescent Functional Assessment Scale (Hodges, 1995) that assessed specific behaviors reflected appropriate directional change--the scores decreased over time. Like Neidig and Friedman's (1984) program, a primary goal of this treatment was to cease all interpersonal violence within family dyads. As evidenced by the scores of the ABI (Shepard & Campbell, 1992) for both parents and youth, psychological and physical abuse within the parent-child dyads did significantly decrease--however, total and immediate cessation of violence did not occur. Treatment subjects and their parents reported significant reductions in the use of psychological and physical violence. Waiting list control subjects and their parents, on the other hand, did not report reductions in either type of violence.

More specifically, three areas of change can be examined to determine change and impact on outcome with this program. They are: Psychological and physical abuse; psychosocial and emotional functioning; and anger.

Psychological and Physical Abuse

The first area of change examined was the frequency of violent activity of parents and youth who underwent treatment, compared to waiting list subjects. The dependent variables of psychological and physical abuse showed a decrease in frequency for both parents and youth from intake through the completion of the program. According to all three theories--social learning theory, stress theory, and family systems theory--that result could be anticipated. Social learning theory suggested that alternative responses to violence as a learned behavior could be taught. In this treatment, those alternatives included positive communication and anger management skills development, which diminished violent family interactions (Patterson & Yoerger, 1993).

Stress theory also suggested that violence was a maladaptive response to anger and frustrations. Violence erupted as over-accumulation of stress swamped each individual's inadequate coping abilities (McCubbin & McCubbin, 1982). By enhancing participants' stress management skills, maladaptive responses such as violence would be reduced.

Finally, family systems theory suggested avenues of violence. Youth-to-parent violence is viewed as a direct power struggle for control within the parent-child dyad, with the parent and child occupying competing roles. In this program, communication skills were demonstrated and taught to family members, ostensibly reducing conflict and positioning the parent back into the authority role within the parental subsystem (Broderick, 1993). That presumed realignment of family vertical structure may have

strengthened the parental role for the mother, reducing conflict primarily (Colapinto, 1991), and psychological and physical abuse secondarily.

These explanations, however, do not hold for the youth who did not decrease physical violence at significant levels between groups. Examination means on Table 4 suggests an interesting situation: Both pre- and post-treatment, the reassigned youth display levels of anger, psychological and physical abuse lower--but not significantly so--than the other two groups. The reassigned parents, on the other hand, display higher levels of anger than the two other groups. It may be, therefore, that the reassigned group came into being not because the youth were acutely symptomatic. Rather, the parents may have requested earlier treatment because they themselves needed and/or wanted therapy. Being open and receptive to treatment, those parents may have taken advantage of treatment and made significant reductions in their levels of anger, as well as their psychological and physical abuse behaviors.

Psychosocial and Emotional Functioning

The second major difference between groups is that, overall, youth who underwent treatment achieved higher psychosocial and emotional functioning in home, school, and community, while waiting list control subjects did not. Again, these findings were expected given the program format with its theoretical underpinnings. Social learning theory suggests that positive alternative behaviors can be taught to replace antisocial behaviors--educating youth and parents in prosocial conflict behaviors was central to this treatment (Patterson, 1982; Patterson, DeBaryshe & Ramsey, 1989). Additionally, since

parental frequency of psychological and physical abuse was decreased, youthful aggression that might have been reactive to parental aggression could be decreased (Conger, Patterson, & Ge, 1995).

Those prosocial conflict skills also underlie stress theory. As the participants learn bonadaptive coping skills, maladaptive behaviors and symptoms are expected to subside (McCubbin & McCubbin, 1982). Stress no longer would accumulate in unmanageable, unwieldy burdens, since improved coping mechanisms would enable one to handle stress more appropriately. As mentioned, this program used active stress-reduction modules to stimulate bonadaptive coping primarily, and elevated multidimensional functioning secondarily.

Finally, family systems theory suggested that symptomology within families originally appeared as a functional device of the offspring, calling attention to the family's crisis of a severely skewed hierarchy with generational inversions (Haley, 1974, 1976). As boundaries are clarified and roles re-assumed appropriately, the family hierarchy is righted (Colapinto, 1991). Therefore, symptomology is no longer needed and simply dissipates. Since symptomology decreased significantly for the treatment groups--but not the waiting list control group--any or all of the above explanations can be accepted. Since no change in functioning occurred for the waiting list control group--and appropriately so, since no intervention occurred--the explanations seem plausible.

Anger

A third anticipated result was a change in anger reports. Under the context of this pilot program, self-reported anger levels should have decreased for the treatment groups. However, except for the parents of the reassigned treatment subjects, youths' and parents' anger levels did not decrease over time.

In accordance with social learning theory, conflict behaviors without anger were modeled in order to be retained and used by youth and parents (Conger, Patterson, & Ge, 1995; Infante et al., 1990). Stress theory suggested that positive coping behaviors be developed to reduce anger and frustration, avoiding unwieldy accumulations of stress (Ebata et al., 1990). Family systems theory's realigned hierarchies should have reduced role confusion and the power struggle for authority, along with the anger generated by that struggle (Broderick, 1993; Madanes, 1991). None of the youths and parents in any of the three groups demonstrated significant change.

It is unknown whether the null results in this area are artifacts of instrumentation, program, or subject. If instrumentation is faulty, a central issue could be validity of the measure with this population. That is, Siegel's MAI is purported to measure both situational (state) and enduring (trait) anger. However, neither state or trait anger attributes were clearly demonstrated. It is possible, also, that this instrument was simply too sophisticated for this population to use easily.

If the program were faulty, it could be that the amount of time spent on anger management was simply not sufficient. A two-week module on containing anger may be

inadequate to allow for the appropriate development of mature anger management skills.

A third alternate hypothesis for this null finding is that the subjects may simply not be very angry people. Siegel (1986) does not specify defined ranges of low, moderate, or high anger. Average reported scores of 50.25 to 60.55 would fall within a speculatively moderate range of scores, given Siegel's scoring criteria and values. Those moderate scores may not actually require remediation. Hence, rather than not providing enough anger management training, perhaps no anger training was needed at all.

For any of the above reasons, use of the MAI in this study was inconclusive. In future applications of this study, the Spielberger State-Trait Anger Inventory (Spielberger et al., 1983) may be a preferable instrument to use in detecting anger change over time.

Secondary Analyses

As mentioned above, review of the data prompted analyses of two factors, gender and assault type, to determine if patterns of relationships exist between those two factors and the effectiveness of treatment. These analyses are briefly discussed below.

Gender

For gender, no main effects were detected when performing ANOVAs, group by gender. A two-way interaction for group and gender, however, was noted for parent psychological abuse. Campbell, Muncer and Coyle (1992) suggested that gender differences may be present for physical and psychological aggression. While males are more physically aggressive, females are more verbally aggressive (Feshbach, 1970). A

reciprocal dyadic pattern may be present between mothers and daughters--as one female reduces her primarily psychological-type of abuse, the other female matches the reduction in frequency of abuse. With only one finding on the interaction of group by gender, this writer is reluctant to expound on parent-daughter interactional dynamics. Gender analyses, especially for violent youth, is a relatively unexplored area of research--the study of delinquency thus far has been almost exclusively been a study of male juvenile delinquency (Chesney-Lind, 1989).

Assault Type

As mentioned above, the majority of youth were arrested on domestic violence charges of physical assault, as opposed to non-physical assault charges. A secondary point of interest focused on whether physically violent youth experienced treatment differently than non-physically violent youth. To that end, ANOVAs of assault type by group were performed. Assault type, as a main effect, showed no significant results. As a two-way interaction, however, assault type by group results were significant for youth psychological abuse, and approached significance for parent psychological abuse. What may have occurred for physically assaultive youth is that they decreased psychological abuse, but maintained some level of physical violence. It may be that physical violence as a behavior is simply more resistant to extinction.

Limitations of the Study

Although the program has demonstrated a number of strengths, such as the amelioration of psychological and physical abuse behaviors for both youth and parents,

there are areas of concern that should be addressed. Those areas are ones which, if not carefully monitored, might compromise the integrity or direction of the program in this performance or in future extantiations. They are briefly discussed below.

Objectivity of the Clinician

The majority of the instruments completed by youth and parents in this study were self-report, pencil-and-paper measures. The Abusive Behavior Inventory (Shepard & Campbell, 1992), and the Multidimensional Anger Inventory (Siegel, 1985) were instruments completed by youth and/or parent. Therefore, experimenter error or bias was minimal, given that data scoring and recording were the only forms of processing used by this experimenter.

The Child and Adolescent Functioning Assessment Scale (Hodges, 1995), on the other hand, was completed by this clinician on each of the program youth on two occasions: Pre- and post-treatment. At the post-treatment assessment the clinician knew, of course, to which group the subjects had been assigned, and what the initial level of functioning had been. It is possible that a less-than-ethical clinician could manipulate subsequent scores to reflect significant change--or lack thereof, in order to effect the significance of the program outcome. This writer strongly asserts, however, that the highest ethical standards were maintained throughout this program.

While outright manipulation of CAFAS data is always possible, it would also be easily detected by an auditor. The CAFAS is a highly objective instrument, and the assessor simply indicates in which category of behavior the subject is currently

functioning. If a question of validity of the CAFAS arose, it could easily be eradicated by an interview with a close family member of the subject being assessed, to see if the indicated behaviors were, indeed, being enacted.

This study was, essentially, a "one-person show" since the primary researcher, clinician, data entry person, and statistician were solely this writer. In order to prevent the potential for data contamination in the future, additional staff and clear definition of roles within the study would further aid in lowering any risk of contamination.

Focus on Outcome

As was mentioned above, this study focused on the outcome of a program designed to treat domestically violent adolescents. Within the course of the program, however, additional concerns arose. While the theories discussed were woven into an integrative framework, they were not used to clearly identify change mechanisms--those mechanisms were presumed from the studies, and there was no theory testing to substantiate those presumptions. This study tested the outcome of the program--not the internal workings themselves.

The "internal workings"--process analysis and components analysis--would be a very potent next step of treatment design for this project. Review of the program itself suggested a number of process factors that would be quite interesting to track over time, such as the Anger Logs. For example, substantive change could be assessed by quantifying the responses to the Anger Logs over time, indicating the levels of anger in connection with family stimuli, and how those levels change. It may be that such process

analysis might more closely evaluate anger reduction over time, than would an instrument that measures range of emotion or hostility.

Likewise, assessment of components over the performance of a program would be tremendously helpful in strengthening that program. While most of the worksheets in this program appear to be well-received, we do not know the impact any particular worksheet might have had. Further assessment on the usefulness and impact of each worksheet could make a significant difference in overall effectiveness of treatment, as well.

Roles of Mediating and Moderating Variables

A number of potential mediating or moderating variables were identified in this program, but no effort was made to determine the interaction of those variables with any of the outcome variables. Rather, this study focused on analyzing change over time within the dependent variables alone. However, it is likely, according to the adult domestic violence literature, that a mediating variable--observation of interparental violence--has a causal link with the aggressiveness of offspring. As noted above, the majority of both males and females have observed interparental violence--there was no attempt to link those observations with the youths' initial aggressive behaviors.

A second generation of this program, then, would be well-advised to conduct path analysis studies on the interactions of mediating variables with outcome behaviors. Likewise, multiple regression analyses reflecting the strength of the relationships between

the moderating and mediating variables with outcome behaviors would be interesting, as well.

Assessment of Anger

As mentioned above, it was surprising to note that anger levels for both youth and parents did not change over time for the treatment groups. Anger, in particular, has been considered to be an integral ingredient in conflictual or aggressive situations--anger reduction, then, also is a central tenet in the treatment programs designed to treat those problems. It may be that the measurement of anger as perceived in this program was inadequate. Anger, as reported by the program participants, did not appear to be elevated either before or after treatment. Yet, in the clinical sessions, virtually all family members reported that they were, indeed, very angry during the conflict episode that resulted in the youth being arrested.

Perhaps "anger" is not the actual change mechanism here--it appears likely that some other mitigating factor might be at play. If persons are angry, but some more inclined than others to be assaultive, it would imply that there is something that differentiates the assaultive persons from the non-assaultives. Deeper investigation into what those differences might be may reveal a change mechanism entirely separate from anger yet commonly confounded with it--say, poor impulse control. Again, a second generation of research into this program would be well advised to investigate "anger" as currently defined more deeply to determine co-incidental behaviors or attitudes.

Directions for Future Research

While behavioral measures demonstrated change over time for participants in treatment, an attitudinal measure (the MAI) reflected no such change for either youth or parents in either treatment condition. This change in behavior only, and not in attitude, could have implications for only short-term compliance, as opposed to long-term, substantive change (Kazdin, 1987). If compliance is the change mechanism here in treatment, then it must be considered that treatment, itself, may not be a causal factor in the reported differences in the measures. If treatment itself is not responsible for changes in psychological and physical abuse, perhaps the process of being arrested and placed in a diversion program is responsible for those changes. The very acts of being arrested and having treatment assigned can be powerful acts of social control, serving to at least temporarily dampen antisocial behaviors (Voldt & Bernard, 1985). It was not within the scope of this evaluation, however, to determine if either external social control, or perhaps the program itself directly, effected change.

A second area of concern involved procedures. As noted above, all the instruments used to survey youths' and parents' responses were paper-and pencil self-report measures, with the exception of the CAFAS, which was completed by the clinician. A shortcoming in this program may have been the reliance on one type of measure. Initially, video-taped interactions, coded for family interactional sequences, were to have been part of the program. Unfortunately, the video-taping segment was met with great resistance by the families, and less than half of the families agreed to be taped

in an interaction. Had this particular component of the program actually been completed, it could have comprised a rich store of information on how domestically violent families problem-solve and communicate. Not only could the encoded sequences have given information on the type and nature of family communication patterns, they would have allowed outsiders an *in vivo* look at how families negotiate family hierarchy and boundaries.

Another concern about this program's procedures involved duration of treatment. This program was a greatly compacted and more tightly focused version of Neidig and Friedman's (1984) couples' treatment, which is a 12-week treatment regimen. Given the constraints of Superior Court funding for juvenile treatment, this writer attempted to provide treatment that could be performed within the allocated ten hours of service. It could be that this amount of time is simply too brief to make substantive changes in attitudes and belief systems, but is sufficient to allow for immediate behavioral changes.

We are informed, from Neidig's 1985 review, that the couples' containment program as a 12-week regimen is effective. As mentioned above, this program was condensed to four weekly sessions of two hours each, with family interview sessions pre- and post-treatment. The brevity of treatment was a concern of two mothers who completed the Consumer Satisfaction Survey. One woman suggested that the program "needs to be longer. Make it 12 weeks." Another mother concurred: "Make it longer. Problems are just getting reached at 3 - 4 weeks."

On a similar track, another parent suggested having "groups more often so that the chance of other problems happening would be minimized." Having groups meet twice weekly, instead of one time weekly, could also allow for closer monitoring of family participation and completion of homework assignments for sharing within the group.

This program was an example of basic research, seeking to determine if change occurred over a select few dependent variables. As such the range of questions asked was limited, and the depth of analysis kept very simple. Beyond this basic research, however, a wealth of applications and further research awaits further exploration.

The next logical extantiation of this project, for example, would be to "fix" the obvious flaws in this study. One point: Anger measurement appears to be problematic. In another generation of treatment, this writer would suggest using a state/trait anger instrument which could more widely capture anger reactivity across a wider range of situations and durations. As mentioned above, it is uncertain whether high levels of anger were not reduced--or whether the anger levels were even elevated to begin with.

Stress reduction was an integral part of this treatment, yet was not measured directly. Rather than presume second-generation attainment of stress reduction by improved functioning, direct measurement of stress would be preferable. Compas et al.'s stress scale for adolescents--the Adolescent Perceived Events Scale (1987)--would remedy this lack of direct reporting by subjects, while rendering empirical data for one of this pilot program's central constructs.

All the statistics performed were on dependent variables, evaluating change over time. A "black box" causation is presumed--and this writer hastens to add that, for a simple program evaluation, simple statistics to determine outcome can be sufficient (Cook, Anson & Walchli, 1993). However, care was taken to measure numerous demographic youth and family factors. Another extantiation of this study might enlarge the focus from measurement of general outcomes, to elucidation of causal paths with moderating and mediating variables. For example, the majority of youth reportedly observed interparental violence. That early observation of domestic violence may, indeed, be precursory to present-day domestic violence. Causal path analyses, using early observation of domestic violence as a mediating variable, might have suggested some powerful causal relationships. However, multiple regressions to determine influence of mediating factors on outcomes were not a part of this study and are left to the inquisitiveness of a next generation of analysts.

In summary, the purpose of this research reached a positive conclusion: The effectiveness of a family group therapy program for domestically violent adolescents was demonstrated. The treatment program designed to reduce psychological and physical violence within families did so for both youth and parents. Also, this family-focused intervention was intended to elevate psychosocial and emotional functioning of the youth in home, school, and the community. That change occurred, as well. The last purpose--to reduce anger in youth and parents--was not achieved and it is unknown whether this failure to reduce anger is a function of faulty measurement or ineffective treatment.

Overall, however, it appears that this treatment program was at least partially effective in reducing domestic violence within families.

TABLE 1. Frequencies and Percentages of Youth Demographic Variable Subgroups, by Group and Gender.

		Waiting List Control				Treatment				Reassigned			
		Male		Female		Male		Female		Male		Female	
Variable	Subgroups	No.	%	No.	%	No.	%	No.	%	No.	%	No.	%
Age	13 years	3	30.0	0	0.0	0	0.0	3	27.3	3	30.0	0	0.0
	14 years	3	30.0	0	0.0	4	33.3	0	0.0	3	30.0	0	0.0
	15 years	1	10.0	2	50.0	2	16.7	5	45.5	3	30.0	2	100.0
	16 years	1	10.0	0	0.0	3	25.0	1	901	0	0.0	0	0.0
	17 years	2	20.0	2	50.0	3	25.0	2	18.2	1	10.0	0	0.0
Ethnicity	Caucasian	7	70.0	3	75.0	5	41.7	8	72.7	7	70.0	2	100.0
	African American	0	0.0	1	25.0	1	8.3	0	0.0	1	10.0	0	0.0
	Hispanic	3	30.0	0	0.0	5	41.7	2	18.2	2	20.0	0	0.0
	Native American	0	0.0	0	0.0	1	8.3	1	9.1	0	0.0	0	0.0
DV Charge	Non-Physical Assault	2	20.0	1	25.0	2	16.7	3	27.3	3	30.0	1	50.0
	Physical Assault	8	80.0	3	75.0	10	83.3	8	72.7	7	70.0	1	50.0

TABLE 1. Frequencies and Percentages of Youth Demographic Variable Subgroups, by Group and Gender, *continued.*

		Waiting List Control				Treatment				Reassigned			
		Male		Female		Male		Female		Male		Female	
Variable	Subgroups	#	%	#	%	#	%	#	%	#	%	#	%
Gang Activity	Yes	2	20.0	0	0.0	3	25.0	2	18.2	3	30.0	1	50.0
	No	8	80.0	4	100.0	9	75.0	9	81.8	7	70.0	1	50.0
Previous Arrest	Yes	5	50.0	3	75.0	6	50.0	5	45.5	5	50.0	1	50.0
	No	4	50.0	1	25.0	6	50.0	6	54.5	5	50.0	1	50.0
Previous Therapy	Yes	5	50.0	3	75.0	5	41.7	5	45.5	5	50.0	1	50.0
	No	5	50.0	1	25.0	7	58.3	6	54.5	5	50.0	1	50.0
School Type	Traditional	4	40.0	4	100.0	9	75.0	9	81.8	6	60.0	2	100.0
	Alternative	4	40.0	0	0.0	3	25.0	2	18.2	2	20.0	0	0.0
	Expelled	2	20.0	0	0.0	0	0.0	0	0.0	2	20.0	0	0.0
Special Education Class	No	4	40.0	4	100.0	9	75.0	9	81.8	6	60.0	2	100.0
	Yes: SED	4	40.0	0	0.0	3	25.0	2	18.2	2	20.0	0	0.0
	Yes:GATE	2	20.0	0	0.0	0	0.0	0	0.0	2	20.0	0	0.0

TABLE 1. Frequencies and Percentages of Youth Demographic Variable Subgroups, by Group and Gender, *continued.*

		Waiting List Control				Treatment				Reassigned			
		Male		Female		Male		Female		Male		Female	
Variable	Subgroups	No.	%	No.	%	No.	%	No.	%	No.	%	No.	%
Alcohol Usage	Yes	4	75.0	3	75.0	4	33.3	6	54.5	6	60.0	1	50.0
	No	6	25.0	1	25.0	8	66.7	5	45.5	4	40.0	1	50.0
Drug Usage	Yes	4	40.0	1	25.0	4	33.3	6	54.5	5	50.0	0	0.0
	No	6	60.0	3	75.0	8	66.7	5	45.5	5	50.0	2	100.0
Tobacco Usage	Yes	5	50.0	3	75.0	6	50.0	9	81.8	4	40.0	1	50.0
	No	5	50.0	1	25.0	6	50.0	2	18.2	6	60.0	1	50.0
Referred for Further Services	Yes	N/A		N/A		3	25.0	5	45.5	4	40.0	0	0.0
	No					9	75.0	6	54.5	6	60.0	2	100.0

TABLE 2. Frequencies and Percentages of Family Demographic Variable Subgroups, by Group and Gender.

		Waiting List Control				Treatment				Reassigned			
		Male		Female		Male		Female		Male		Female	
Variable	Subgroups	No.	%	No.	%	No.	%	No.	%	No.	%	No.	%
Com-plexity	High	2	20.0	0	0.0	2	16.7	3	27.3	3	30.0	0	0.0
	Low	8	80.0	4	100.0	10	83.3	8	72.7	7	70.0	2	100.0
No. of Children	< 2	6	60.0	2	50.0	11	91.7	5	45.5	4	40.0	1	50.0
	> 2	4	40.0	2	50.0	1	8.3	6	54.5	6	60.0	1	50.0
Spacing of Children	≥ 3 years apart	7	70.0	3	75.0	10	83.3	8	72.7	4	40.0	2	100.0
	2 to 3 years apart	3	30.0	1	25.0	1	8.3	2	18.2	4	40.0	0	0.0
	< 2 years apart	0	0.0	0	0.0	1	8.3	1	9.1	2	20.0	0	0.0
Income	≥ $30K	1	10.0	1	25.0	3	25.0	0	0.0	1	10.0	0	0.0
	$20K-$30K	7	70.0	2	50.0	3	25.0	3	27.3	5	50.0	1	50.0
	$10K-$20K	2	20.0	0	50.0	4	33.3	6	54.5	1	10.0	0	0.0
	≤ $10K	0	0.0	0	0.0	2	16.7	2	18.2	3	30.0	1	50.0

TABLE 2. Frequencies and Percentages of Family Demographic Variable Subgroups, by Group and Gender, *continued.*

		Waiting List Control				Treatment				Reassigned			
		Male		Female		Male		Female		Male		Female	
Variable	Subgroups	No.	%	No.	%	No.	%	No.	%	No.	%	No.	%
Mom's Education	< High School	3	30.0	0	0.0	4	33.3	4	36.4	1	10.0	0	0.0
	High School	5	50.0	3	75.0	7	58.3	4	36.4	7	70.0	2	100.0
	College or Technical	2	20.0	1	25.0	1	8.3	3	27.3	2	20.0	0	0.0
History of Spouse Abuse	Yes	9	90.0	3	75.0	8	66.7	10	90.9	10	100.0	1	50.0
	No	1	10.0	1	25.0	4	33.3	1	9.1	0	0.0	1	50.0
History of Drug Abuse	Yes	8	80.0	3	75.0	8	66.7	10	90.9	9	10.0	1	50.0
	No	2	20.0	1	25.0	4	33.3	1	9.1	1	10.0	1	50.0
Religious Affiliation	None	5	50.0	1	25.0	10	83.3	7	63.6	3	30.0	2	100.0
	Protestant	4	40.0	1	25.0	0	0.0	2	18.2	4	40.0	0	0.0
	Catholic	0	0.0	0	0.0	2	16.7	2	18.2	2	20.0	0	0.0
	Jewish	1	10.0	2	50.0	0	0.0	0	0.0	1	10.0	0	0.0

TABLE 3. Intercorrelations of Youth and Parent Dependent Variables, Pre-Treatment.

Variables	1.	2.	3.	4.	5.	6.
1. Youth Anger (MAI) (n = 49)	1.00					
2. Youth Psychological Abuse (ABI) (n = 49)	.43**	1.00				
3. Youth Physical Abuse (ABI) (n = 49)	.38**	.71***	1.00			
4. Parent Anger (MAI) (n = 41)	-.16	-.14	.20	1.00		
5. Parent Psychological Abuse (ABI) (n = 49)	.01	.11	.15	.43**	1.00	
6. Parent Physical Abuse (ABI) (n = 49)	-.13	.08	.26	.69***	.78***	1.00

* $p \leq .05$
** $p \leq .01$
*** $p \leq .001$

TABLE 4. Means and Standard Deviations of Dependent Variables at Pre- and Post-Test Assessment by Group.

	Waiting List Control			Treatment			Reassigned		
Variable	n	Pre	Post	n	Pre	Post	n	Pre	Post
Psychosocial and Emotional Functioning (CAFAS)	14	109.29 (36.68)	103.57 (34.78)	23	109.13 (41.66)	79.56 (43.95)	12	123.33 (46.97)	95.00 (36.05)
Youth Anger (MAI)	14	91.57 (10.48)	89.28 (11.15)	23	95.96 (20.64)	90.57 (16.17)	12	85.50 (13.30)	83.92 (16.48)
Youth Psychological Abuse (ABI)	14	30.86 (21.45)	22.71 (22.74)	23	27.35 (26.73)	10.35 (13.47)	12	12.83 (7.91)	6.75 (6.93)
Youth Physical Abuse (ABI)	14	13.43 (12.66)	11.21 (10.83)	23	17.78 (29.68)	6.91 (18.26)	12	8.75 (8.94)	7.25 (13.07)
Parent Anger (MAI)	12	80.17 (17.07)	85.36 (19.05)	18	83.44 (13.70)	81.14 (14.94)	11	87.55 (11.24)	81.50 (19.39)
Parent Psychological Abuse (ABI)	14	14.28 (11.87)	16.00 (13.90)	23	21.16 (20.88)	5.17 (8.79)	12	20.33 (20.52)	3.91 (2.87)
Parent Physical Abuse (ABI)	14	9.29 (11.89)	9.29 (13.90)	23	8.70 (11.99)	0.96 (2.34)	12	12.75 (13.56)	2.67 (4.03)

TABLE 5. Analysis of Variance, by Group on Post-Test Dependent Variable Scores, Using Pre-Test Scores as Covariates.

Dependent Variables	Source of Variation	Sum of Squares	DF	Mean Square	*F*	*p*
Psychosocial and Emotional Functioning (CAFAS)	Covariate	52894.68	1	52894.68	121.30	.000
	Main Effects (Group)	5198.57	2	2599.29	5.96	.005
	Explained	58275.55	3	19425.19	44.55	.000
	Residual	19622.41	45	436.05		
Youth Anger (MAI)	Covariate	1030.89	1	1030.89	4.99	.030
	Main Effects (Group)	180.01	2	90.01	.44	.649
	Explained	1389.46	3	463.15	2.24	.096
	Residual	9290.54	45	206.46		
Youth Psychological Abuse (ABI)	Covariate	5749.87	1	5749.87	47.37	.000
	Main Effects (Group)	971.35	2	485.67	4.00	.025
	Explained	7701.54	3	2567.18	21.15	.000
	Residual	5462.47	45	121.39		
Youth Physical Abuse (ABI)	Covariate	7790.89	1	7790.89	118.86	.000
	Main Effects (Group)	487.07	2	243.53	3.72	.032
	Explained	7966.98	3	2655.66	40.52	.000
	Residual	2949.58	45	65.55		

TABLE 5. Analysis of Variance, by Group, on Post-Test Dependent Variable Scores Using Pre-Test Scores as Covariates, *continued.*

Dependent Variables	Source of Variation	Sum of Squares	DF	Mean Square	*F*	*p*
Parent Anger (MAI)	Covariate	69.60	1	69.60	.30	.586
	Main Effects (Group)	26.59	2	13.30	.06	.944
	Explained	218.72	3	72.91	.31	.813
	Residual	8521.47	37	230.31		
Parent Psychological Abuse (ABI)	Covariate	1690.77	1	1690.77	29.20	.000
	Main Effects (Group)	1759.99	2	879.99	15.20	.000
	Explained	2970.46	3	990.15	17.10	.000
	Residual	2605.47	45	57.90		
Parent Physical Abuse (ABI)	Covariate	797.12	1	797.12	33.42	.000
	Main Effects (Group)	642.52	2	321.26	13.49	.000
	Explained	1419.71	3	473.24	19.88	.000
	Residual	1071.36	45	23.81		

TABLE 6. Analysis of Variance, by Group and Gender, on Post-Test Dependent Variable Scores Using Pre-Test Scores as Covariates.

Dependent Variables	Source of Variation	Sum of Squares	DF	Mean Square	*F*	*p*
Psychosocial and Emotional Functioning (CAFAS)	Covariate	43383.83	1	43383.83	96.79	.000
	Main Effect (Group)	4289.34	2	2144.67	4.76	.014
	Main Effect (Gender)	314.61	1	314.61	.69	.408
	2-Way Interaction	619.04	2	309.52	.69	.509
	Explained	58954.21	6	9825.70	21.78	.000
	Residual	18943.75	42	451.04		
Youth Anger (MAI)	Covariate	896.11	1	896.11	4.61	.038
	Main Effect (Group)	39.79	2	19.89	.10	.903
	Main Effect (Gender)	145.14	1	145.14	.75	.393
	2-Way Interaction	321.89	2	160.95	.83	.444
	Explained	2209.27	6	368.21	1.89	.105
	Residual	8173.26	42	194.60		
Youth Psychological Abuse (ABI)	Covariate	5537.50	1	5537.50	42.68	.000
	Main Effect (Group)	920.44	2	460.22	3.55	.038
	Main Effect (Gender)	9.86	1	9.86	.08	.784
	2-Way Interaction	3.43	2	1.72	.01	.987
	Explained	7714.94	6	1285.82	9.91	.000
	Residual	5449.06	42	129.74		

TABLE 6. Analysis of Variance, by Group and Gender, on Post-Test Dependent Variable Scores Using Pre-Test Scores as Covariates, *continued.*

Dependent Variables	Source of Variation	Sum of Squares	DF	Mean Square	*F*	*p*
Youth Physical Abuse (ABI)	Covariate	7461.71	1	7461.71	110.11	.000
	Main Effect (Group)	381.58	2	190.79	2.82	.071
	Main Effect (Gender)	46.36	1	46.35	.68	.413
	2-Way Interaction	23.88	2	11.94	.18	.839
	Explained	8070.26	6	1345.04	19.85	.000
	Residual	2846.27	42	67.77		
Parent Anger (MAI)	Covariate	3266.23	1	3266.23	40.55	.000
	Main Effect (Group)	21.29	2	10.65	.13	.877
	Main Effect (Gender)	7.99	1	7.99	.09	.755
	2-Way Interaction	.35	2	.78	.00	.998
	Explained	4099.25	6	683.21	8.48	.000
	Residual	2657.85	42	80.54		
Parent Psychological Abuse (ABI)	Covariate	1286.57	1	1286.57	34.18	.000
	Main Effect (Group)	920.65	2	460.33	8.65	.001
	Main Effect (Gender)	15.06	1	15.06	.28	.598
	2-Way Interaction	369.95	2	184.98	3.48	.040
	Explained	3341.15	6	556.86	10.47	.000
	Residual	2234.77	42	53.21		

TABLE 6. Analysis of Variance, by Group and Gender, on Post-Test Dependent Variable Scores Using Pre-Test Scores as Covariates, *continued.*

Dependent Variables	Source of Variation	Sum of Squares	DF	Mean Square	*F*	*p*
Parent Physical Abuse (ABI)	Covariate	614.01	1	614.01	27.44	.000
	Main Effect (Group)	350.36	2	175.18	7.83	.001
	Main Effect (Gender)	37.09	1	27.09	1.21	.277
	2-Way Interaction	99.75	2	49.88	2.23	.120
	Explained	1551.32	6	258.55	11.56	.000
	Residual	939.74	42	22.38		

TABLE 7. Analysis of Variance, by Assault Type and Group, on Post-Test Dependent Variable Scores, Using Pre-Test Scores as Covariates.

Dependent Variables	Source of Variation	Sum of Squares	DF	Mean Square	*F*	*p*
Psychosocial and Emotional Functioning (CAFAS)	Covariate	52513.39	1	52513.39	136.11	.000
	Main Effect (Assault)	723.16	1	723.16	1.87	.178
	Main Effect (Group)	1949.00	2	974.50	2.53	.092
	2-Way Interaction	2024.51	2	1012.26	2.62	.084
	Explained	61693.17	6	10282.20	26.65	.000
	Residual	16204.79	42	385.83		
Youth Anger (MAI)	Covariate	1149.77	1	1149.77	5.44	.025
	Main Effect (Assault)	26.67	1	26.67	.13	.724
	Main Effect (Group)	103.17	2	51.59	.24	.784
	2-Way Interaction	1.11	2	.55	.00	.997
	Explained	1511.53	6	251.92	1.19	.329
	Residual	8871.00	42	211.21		
Youth Psychological Abuse (ABI)	Covariate	5842.62	1	5842.62	56.53	.000
	Main Effect (Assault)	206.06	1	206.06	1.99	.165
	Main Effect (Group)	129.54	2	64.77	.63	.539
	2-Way Interaction	1020.66	2	510.33	4.94	.012
	Explained	8822.89	6	1470.48	14.23	.000
	Residual	4341.11	42	103.36		

TABLE 7. Analysis of Variance, by Assault Type and Group, on Post-Test Dependent Variable Scores Using Pre-Test Scores as Covariates, *continued*.

Dependent Variables	Source of Variation	Sum of Squares	DF	Mean Square	*F*	*p*
Youth Physical Abuse (ABI)	Covariate	7759.42	1	7759.42	112.00	.000
	Main Effect (Assault)	.95	1	.95	.01	.907
	Main Effect (Group)	295.13	2	98.38	2.13	.131
	2-Way Interaction	37.46	2	147.57	.27	.764
	Explained	8006.95	6	18.73	19.26	.000
	Residual	2909.58	42	1334.49		
Parent Anger (MAI)	Covariate	3565.16	1	3565.16	45.89	.000
	Main Effect (Assault)	21.16	1	21.16	.27	.605
	Main Effect (Group)	27.69	2	13.85	.18	.838
	2-Way Interaction	63.86	2	31.93	.41	.666
	Explained	4193.82	6	698.97	8.99	.000
	Residual	2563.28	33	77.68		
Parent Psychological Abuse (ABI)	Covariate	1527.44	1	1527.44	29.45	.000
	Main Effect (Assault)	164.91	1	164.91	3.18	.082
	Main Effect (Group)	2072.73	2	1036.36	19.98	.000
	2-Way Interaction	328.97	2	164.49	3.17	.052
	Explained	3397.82	6	566.30	10.92	
	Residual	2178.10	42	51.86		

TABLE 7. Analysis of Variance, by Assault Type and Group, on Post-Test Dependent Variable Scores Using Pre-Test Scores as Covariates, *continued.*

Dependent Variables	Source of Variation	Sum of Squares	DF	Mean Square	*F*	*p*
Parent Physical Abuse (ABI)	Covariate	589.79	1	589.79	26.38	.000
	Main Effect (Assault)	48.78	1	48.78	2.18	.147
	Main Effect (Group)	707.61	2	353.81	15.83	.000
	2-Way Interaction	102.04	2	51.02	2.28	.115
	Explained	1552.08	6	258.68	11.57	.000
	Residual	938.98	42	22.36		

TABLE 8. Rates and Percentages of Responses to the Consumer Satisfaction Survey.

1. How would you rate the quality of the service you received?

4: Excellent	3: Good	2: Fair	1: Poor
22 responses	8	0	0
73.3%	26.7%	0.0%	0.0%

2. Did you get the kind of service you wanted?

1: No, definitely not.	2: No, not really.	3: Yes, generally.	4: Yes, definitely
0 responses	0	16	14
0.0%	0.0%	53.3%	46.7%

3. To what extent has our program met your needs?

4: Almost all have have been met.	3: Most of them have been met.	2: Only a few have been met.	1: None have.
15 responses	9	6	0
50.0%	30.0%	20.0%	0.0%

4. If a friend were in need of similar help, would you recommend our program?

1: No, definitely not.	2: No, don't think so.	3: Yes, I think so.	4: Yes, definitely
0 responses	0	12	18
0.0%	0.0%	40.0%	60.0%

5. How satisfied are you with the amount of help you have received?

1: Quite dissatisfied.	2: Indifferent or mildly dissatisfied	3: Mostly satisfied	4: Very satisfied
0 responses	0	15	15
0.0%	0.0%	50.0%	50.0%

TABLE 8. Rates and Percentages of Responses to the Consumer Satisfaction Survey, *continued*.

6. Have the services you received helped you to deal more effectively with your problems?

4: Yes, they helped a great deal.	2: Yes, they helped somewhat.	3: No, they really didn't help.	4: No, they got worse.
18 responses	12	0	0
60.0%	40.0%	0.0%	0.0%

7. In an overall, general sense, how satisfied are you with the services you have received?

4: Very satisfied	3: Mostly satisfied	2: Indifferent or mildly dissatisfied	1: Quite dissatisfied
19 responses	11	0	0
63.3%	36.7%	0.0%	0.0%

8. If you were to seek help again, would you come back to our program?

1: No, definitely not.	2: No, I don't think so.	3: Yes, I think so	4: Yes, definitely
0 responses	0	12	18
0.0%	0.0%	40.0%	60.0%

9. Since you started at the agency, has there been any change for better or worse in the way members of your family get along with each other (talk over problems, handle arguments, work out differences, help each other, feel toward each other, enjoy each other)? Would you say you now get along:

1: Much worse	2: Somewhat worse	3: Somewhat better	4: Much better
0 responses	1	16	13
0.0%	3.3%	53.3%	44.3%

TABLE 8. Rates and Percentages of Responses to the Consumer Satisfaction Survey, *continued.*

10. In general, how satisfied were you with the way you and your counselor got along with each other?

	1: Quite dissatisfied	2: Indifferent or Mildly dissatisfied	3: Mostly satisfied	4: Very satisfied
	0 responses	0	3	27
	0.0%	0.0%	10.0%	90.0%

11. How have you and your child changed for better or worse (in behavior, attitudes, feelings, or handling of problems) since service began?

	5: Much better	4: Somewhat better	3: Same	2: Somewhat worse	1: Much worse
Parent:	3 responses	16	3	0	0
	6.7%	53.3%	10.0%	0.0%	0.0%
Youth:	8 responses	16	6	0	0
	26.7%	53.3%	20.0%	0.0%	0.0%

12. Please tell us anything we could do to improve our program or staff.

a. Can't think of anything
b. Nothing
c. Make it longer. Problems are just getting reached at 3 - 4 weeks
d. The program is well enough how it is now.
e. Needs to be longer. Make it 12 weeks.
f. Involve the male figures of the families. They seem to be a major part of the family's problems.
g. Nancy's really nice.
h. Get more Nancys.
i. Have it closer to different areas where we live.
j. Order mushroom pizza.
k. The program is terrific.
l. None.
m. Have groups more often so that the chance of other problems happening would be minimized.

TABLE 8. Rates and Percentages of Responses to the Consumer Satisfaction Survey, *continued*

13. Please tell us anything you liked about our program or staff.

a. Nancy is terrific; she's doing a good job on helping us see how to deal with our problems.
b. I liked everything.
c. Everything.
d. It was with other people.
e. Nancy was a very helpful person. She is easy to talk to. She deserves a $10,000 raise.
f. Nancy talked to us on our own levels.
g. Nancy was very understanding and very giving of her time. She went out of her way to help my daughter and showed us she cared.
h. Nancy was extremely generous with herself, rather than taking a separate or superior attitude.
i. I liked the relaxation sessions. Nancy was very good.
j. Nancy was very helpful and down to earth.
k. Very informative about options to control anger.
l. Nancy is a great person to talk with - down to earth and to the point.
m. Nancy is a godsend. I feel lucky to have this program to help us.
n. Very understanding/informational.
o. Nancy R. was very direct, explained things well and had good concepts.
p. Very patient with the whole group, very fair, very informative, very helpful, very considerate.

APPENDIX A

Human Subjects Committee

THE UNIVERSITY OF
ARIZONA.
HEALTH SCIENCES CENTER

8 October 1996

Nancy Rybski, M.A.
c/o Carl Ridley, Ph.D.
Department of Family Studies
FCR 210
PO BOX 210033

RE: **HSC #96-166** AN EVALUATION OF COGNITIVE-BEHAVIORAL FAMILY THERAPY FOR DOMESTICALLY VIOLENT ADOLESCENTS

Dear Ms. Rybski:

We received your 7 October 1996 letter and accompanying revised consent form for the above referenced project. All of the conditions as set out in our 24 September 1996 letter to you have been met. Therefore, **full Committee approval** for this subjects-at-risk project is granted effective 8 October 1996 for a period of one year.

The Human Subjects Committee (Institutional Review Board) of the University of Arizona has a current assurance of compliance, number M-1233, which is on file with the Department of Health and Human Services and covers this activity.

Approval is granted with the understanding that no further changes or additions will be made either to the procedures followed or to the consent form(s) used (copies of which we have on file) without the knowledge and approval of the Human Subjects Committee and your College or Departmental Review Committee. Any research related physical or psychological harm to any subject must also be reported to each committee.

A university policy requires that all signed subject consent forms be kept in a permanent file in an area designated for that purpose by the Department Head or comparable authority. This will assure their accessibility in the event that university officials require the information and the principal investigator is unavailable for some reason.

Sincerely yours,

William F Denny, M.D.
Chairman
Human Subjects Committee

WFD:rs

cc: Departmental/College Review Committee

THE UNIVERSITY OF
ARIZONA.
HEALTH SCIENCES CENTER

21 February 1997

Nancy Rybski, M.A.
c/o Carl Ridley, Ph.D.
Department of Family Studies
FCR 210
PO BOX 210033

RE: **HSC #96-166** AN EVALUATION OF COGNITIVE-BEHAVIORAL FAMILY THERAPY FOR DOMESTICALLY VIOLENT ADOLESCENTS

Dear Ms. Rybski:

We received your 25 January 1997 letter and also 15 February 1997 letter and accompanying revised consent form for the above referenced project. Protocol changes involve decrease in total number of therapy hours from 12 to 11 and number of sessions from 8 to 6; and also study duration from 8 weeks to 6 weeks [consent form revised accordingly]. Approval for these changes is granted effective 21 February 1997.

The Human Subjects Committee (Institutional Review Board) of the University of Arizona has a current assurance of compliance, number M-1233, which is on file with the Department of Health and Human Services and covers this activity.

Approval is granted with the understanding that no further changes or additions will be made either to the procedures followed or to the consent form(s) used (copies of which we have on file) without the knowledge and approval of the Human Subjects Committee and your College or Departmental Review Committee. Any research related physical or psychological harm to any subject must also be reported to each committee.

A university policy requires that all signed subject consent forms be kept in a permanent file in an area designated for that purpose by the Department Head or comparable authority. This will assure their accessibility in the event that university officials require the information and the principal investigator is unavailable for some reason.

Sincerely yours,

William F Denny, M.D.
Chairman
Human Subjects Committee

WFD:rs

cc: Departmental/College Review Committee

APPENDIX B

UNIVERSITY OF MINNESOTA

Duluth Campus

Department of Social Work

College of Education and Human Service Professions

220 Bohannon Hall
10 University Drive
Duluth MN 55812-2496

218-726-7245

February 11, 1998

Nancy Rybski
2824 La Plumosa
Laguna Nigel, CA
92677-7049

Dear Ms. Rybski:

You have my permission to use the Abusive Behavior Inventory in your doctoral research. I would appreciate receiving copies of any research that you might publish using the ABI instrument

Sincerely,

Melanie Shepard, Ph.D

ARIZONA CHILDREN'S HOME ASSOCIATION

FAMILY VIOLENCE PROGRAM

Abusive Behaviors Index

Below is a list of behaviors that some people report that they have used against others when they get angry or upset. Please circle how often you have used these behaviors during the past ____ month(s) with your _____. Please estimate how often you have used these behaviors by circling either 0, 1, 2, 3-5, 6-10, 11-20, or 20+. The numbers mean the following:

0	= Never	6-10	= 6-10 times
1	= Once	11-20	= 11-20 times
2	= Twice	20+	= More than 20 times
3-5	= 3 - 5 times		

Section One:

1. Called him a name and/ or criticized him	0	1	2	3-5	6-10	11-20	20+
2. Gave him angry stares or looks	0	1	2	3-5	6-10	11-20	20+
3. Threatened to hit him or throw something at him	0	1	2	3-5	6-10	11-20	20+
4. Pushed, grabbed, shoved, or held him down	0	1	2	3-5	6-10	11-20	20+
5. Put down his family or friends	0	1	2	3-5	6-10	11-20	20+
6. Accused him of paying more attention to someone or something else	0	1	2	3-5	6-10	11-20	20+

Abusive Behaviors Index, *Continued*

7. Said things to scare him (told him something bad would happen, or threatened to commit suicide)	0	1	2	3-5	6-10	11-20	20+
8. Slapped, hit or bit him	0	1	2	3-5	6-10	11-20	20+
9. Threatened him with a knife, gun, or other weapon	0	1	2	3-5	6-10	11-20	20+
10. Threw, hit, kicked, or smashed something	0	1	2	3-5	6-10	11-20	20+
11. Kicked him	0	1	2	3-5	6-10	11-20	20+
12. Threw him around	0	1	2	3-5	6-10	11-20	20+
13. Physically attacked the sexual parts of his body	0	1	2	3-5	6-10	11-20	20+
14. Used a knife, gun or other weapon against him	0	1	2	3-5	6-10	11-20	20+
15. Threw something at him	0	1	2	3-5	6-10	11-20	20+
16. Punched him	0	1	2	2-5	6-10	11-20	20+
17. Scratched him, pulled his hair, spit at him, pinched him	0	1	2	3-5	6-10	11-20	20+

SECTION TWO:

Physical injuries sometimes occur as a result of the behaviors described above. Please put a number in each of the categories below, indicating how many times each of the following types of injuries occurred to your _____ during the last ____ month(s), as a result of the behaviors you used, above.

Abusive Behaviors Index, *Continued*

Minor bruises, scrapes, or scratches: These include bruises that are smaller than the top of a Coke can in size or go away within two weeks. They also include scrapes or scratches that don't bleed at all, or bleed just a little bit.

Number of times within the past ___ month(s): _____.

Minor cuts and bleeding: This includes any cuts, punctures, or gashes that bleed, such as a bloody nose or mouth, a cut on the head or arm, etc. These can be treated with pressure or Bandaids and don't require medical attention.

Number of times within the past ___ month(s): _____.

Sore muscles or sprains: This includes such things as sprained wrists or ankles, pulled muscles, etc.

Number of times within the past ___ month(s): _____.

Major bruises: This includes bruises that are bigger than the top of a Coke can in size and take more than two weeks to go away, such as a black eye, etc.

Number of times within the past ___ month(s): _____.

Broken bones: This includes any kind of broken bone, such as broken nose, wrist, arm, leg, etc.

Number of times within the past ___ month(s): _____.

Damage to internal organs: This includes internal bleeding as indicated by blood in the urine, blood in vomit, severe abdominal pain etc.

Number of times within the past ___ month(s): _____.

Became unconscious: This includes anything that might cause one to be knocked out or become unconscious, like falling and hitting his head against something, or choking him until he passed out.

Number of times within the past ___ month(s): _____.

APPENDIX C

FAX TRANSMISSION

Functional Assessment Systems, L.L.C.
Kay Hodges, Ph.D.
2140 Old Earhart Road
Ann Arbor, MI 48105
(313) 769-9725
Fax: (313) 769-1434
E-mail: hodges@provide.net

To:	Nancy Rybski	**Date:**	February 25, 1998
Fax #:	714-282-2801	**Pages:**	1, including this cover sheet
From:	Kay Hodges, Ph D.		
Subject:	Refusal of permission to publish CAFAS		

COMMENTS:

Nancy,

I received your request to include the CAFAS in your dissertation Unfortunately, I must decline this request. Because the CAFAS is a marketable instrument, I cannot allow it to be published. I thank you for your request and hope that submission of your dissertation proceeds well without inclusion of the CAFAS.

Truly,

Kay Hodges

APPENDIX D

UNIVERSITY OF CALIFORNIA. LOS ANGELES

UCLA

BERKELEY • DAVIS • IRVINE • LOS ANGELES • RIVERSIDE • SAN DIEGO • SAN FRANCISCO

SANTA BARBARA • SANTA CRUZ

SCHOOL OF PUBLIC HEALTH
10833 LE CONTE AVENUE
LOS ANGELES, CALIFORNIA 90024-1772

-1.11 /G3

Dear Colleague:

Thank you for your interest in the Multidimensional Anger Inventory (MAI). I have sent you: a copy of the MAI; scoring instructions; and a reprint of an article describing the development of the inventory.

You are welcome to use the inventory in your research. When you have the data, I would appreciate receiving descriptive statistics for the MAI in your sample and a summary of the findings relevant to the MAI.

Good luck with your research.

Sincerely,

Judith M. Siegel

Judith M. Siegel, Ph.D., M.S. Hyg.
Professor

JMS:rk

ARIZONA CHILDREN'S HOME ASSOCIATION
FAMILY VIOLENCE PROGRAM

Multidimensional Anger Inventory

Everyone gets angry from time to time. A number of statements that people have used to describe the times that they get angry are included below. Read each statement and write the letter that best describes your reaction.

Write in:

A if "completely undescriptive of me"
B if "not very descriptive of me"
C if "neither descriptive nor undescriptive of me"
D if "somewhat descriptive of me"
E if "completely descriptive of me"

__ 1. I get angry more often than most other people.
__ 2. Other people seem to get angrier than I do in the same type of situation.
__ 3. I hold grudges against other people, but I don't tell anyone about them.
__ 4. I try to get even with the person who's gotten me angry.
__ 5. I think nasty thoughts about the person who's gotten me angry.
__ 6. It is easy to make me angry.
__ 7. When I am angry at someone, I let that person know.
__ 8. Something makes me angry almost every day.
__ 9. I often feel angrier than others would in the same situation.
__ 10. I feel guilty when I show that I'm angry.
__ 11. When I'm angry with someone, I take it out on whomever is around me.
__ 12. I'm surprised at how often I get really angry.
__ 13. Once I let people know I'm angry, I can get over it.
__ 14. Sometimes, I get angry for no specific reason.
__ 15. I can make myself angry about something that's happened in the past just by thinking about it.
__ 16. Even after I express my anger, I have a hard time getting over it.
__ 17. When I don't express my anger, I think about it a long time.
__ 18. People can really bug me by just being around me.
__ 19. When I get mad, I stay mad for a long time.
__ 20. When I hide my anger from others, I get over it quickly.
__ 21. I try to talk over problems I have with people without letting them know how really angry I am.
__ 22. When I get angry, I calm down faster than most people.

Multidimensional Anger Inventory, *Continued*

___ 23. I get so angry sometimes, I think I'm going to lose it.
___ 24. It's hard for me to let people know I'm angry.
___ 25. I get angry when someone disappoints me.
___ 26. I get angry when someone's unfair to me.
___ 27. I get angry when someone blocks my plans.
___ 28. I get angry when I'm held up by someone or something.
___ 29. I get angry when someone embarrasses me.
___ 30. I get angry when I have to be with people I don't respect.
___ 31. I get angry when I do something stupid.
___ 32. I get angry when I'm not given credit for something I've done.

APPENDIX E

Cognitive-Behavioral Family Group Therapy
For Domestically Violent Adolescents

Subject's Consent Form

I AM BEING ASKED TO READ THE FOLLOWING MATERIAL TO ENSURE THAT I AM INFORMED OF THE NATURE OF THIS RESEARCH STUDY AND OF HOW I WILL PARTICIPATE IN IT, IF I CONSENT TO DO SO. SIGNING THIS FORM WILL INDICATE THAT I HAVE BEEN SO INFORMED AND THAT I GIVE MY CONSENT. FEDERAL REGULATIONS REQUIRE WRITTEN INFORMED CONSENT PRIOR TO PARTICIPATION IN THIS RESEARCH STUDY SO THAT I CAN KNOW THE NATURE AND RISKS OF MY PARTICIPATION AND CAN DECIDE TO PARTICIPATE OR NOT PARTICIPATE IN A FREE AND INFORMED MANNER.

PURPOSE

I am being invited to participate voluntarily in the above-titled research project. The purpose of this project is to evaluate the effectiveness of family group therapy in treating and reducing family violence.

SELECTION CRITERIA

I am being invited to participate because I have been arrested for domestic violence in Pima County, Arizona, and have been referred to the Family Violence Prevention Program of the Pima County Juvenile Court. I am between the ages of 13 and 18 and live with my biological mother. My mother, who does not reside with my biological father, is invited to participate in this family group therapy with me.

STANDARD TREATMENT(S)

If I do not choose to participate in this treatment, I may seek other alternative treatments available to me through Juvenile Court. These include up to 10 sessions of in-home family counseling, or a Saturday domestic violence education program.

PROCEDURES

If I agree to participate, I will be asked to consent to the following: Two videotaped interview/family therapy sessions at Arizona Children's Home Association; and four in-

office family group therapy sessions. In the two videotaped family therapy sessions, my mother and I will be asked to discuss four questions about conflict and violence. The treatment program of the two family sessions and the four group sessions will take place over a six-week period. Each of the two family interviews will last about 1.5 hours, and the family group sessions will take about 2.0 hours. In total, I will receive about eleven (11) hours of therapy.

I will be asked to complete the following questionnaires: A life stress checklist; an anger reaction rating scale; and a violent behavior rating scale.

If I agree to participate, I understand that I will be randomly assigned to either one of two groups, as if by the flip of a coin. One group will begin treatment immediately; the other group will begin treatment as soon as the first group completes treatment. The "waiting list" group will begin treatment six weeks after the initial assessment.

RISKS

The greatest risk in this treatment is that, rather than being reduced, the conflict within my family actually increases with members of my family becoming angrier. A second risk is that, while this treatment may not be harmful to my family, it may not be helpful in reducing domestic violence, either.

If my family is assigned to wait for treatment, but we require treatment before the program actually begins, the Principal Investigator, Nancy Rybski, will meet with us to assess our need for immediate treatment. If we cannot wait for the program to begin, Ms. Rybski will refer us to another program or agency which can provide us with treatment immediately.

If at any time during the program we feel that we need crisis services, any member of my family is free to page Nancy Rybski at (520) 410-9841. Ms. Rybski has agreed to be available to meet with my family and I at any time if our problems warrant quick professional response.

BENEFITS

A benefit is a valued or desired outcome. The desired outcomes of this program include: Improved communication skills for each member of my family; improved stress and

anger management skills for my family; and improved social skills for my family. If I develop and use better conflict resolution skills, my risk of future conflict, domestic violence, and arrest may be reduced.

CONFIDENTIALITY

All paperwork I complete, which includes questionnaires, homework, and intake forms will be kept in a confidential clinical chart in a locked file cabinet. Likewise, any videotape of my family and I will be kept in a locked file drawer. The file drawer and cabinet are maintained in the locked clinical chart room (#17) at Arizona Children's Home Association. Only privileged staff at Arizona Children's Home Association (such as the file clerk, the Principal Investigator, or state licensing auditors) will have access to my clinical file.

Ms. Rybski will maintain a computer data entry program, on which I will be identified only by a code number (such as "M001" or "F040"). I will never be personally identified as a subject in this study outside of the documents in my clinical file.

PARTICIPATION COSTS AND SUBJECT COMPENSATION

I understand that this program is being provided free of charge to Pima County Juvenile Court--neither the Court nor my family will ever receive a bill for any services we receive while in this program. I understand that there are no costs to me or my family, other than the cost of transportation for our family and group sessions at Arizona Children's Home Association, and our time.

I also understand that I will not be paid for my participation in this study.

LIABILITY

I understand that side effects or harm are possible in any research program despite the use of high standards of care and could occur through no fault of mine or the investigator involved. Known side effects have been described in this consent form. However, unforeseeable harm may also occur and require care. I understand that money for research-related side effects or harm, or for wages or time lost, is not available. I do not give up any of my legal rights by signing this form. Necessary emergency medical care

will be provided without cost. I can obtain further information from Nancy Rybski, M.A., CMFT at (520) 622-7611, ext. 1413. If I have questions concerning my rights as a research subject, I may call the Human Subjects Committee office at 626-6721. Additional information/questions concerning liability (other than covered above) must be discussed with the Principal Investigator, or institution.

AUTHORIZATION

BEFORE GIVING MY CONSENT BY SIGNING THIS FORM, THE METHODS, INCONVENIENCES, RISKS, AND BENEFITS HAVE BEEN EXPLAINED TO ME AND MY QUESTIONS HAVE BEEN ANSWERED. I UNDERSTAND THAT I MAY ASK QUESTIONS AT ANY TIME AND THAT I AM FREE TO WITHDRAW FROM THE PROJECT AT ANY TIME WITHOUT CAUSING BAD FEELINGS OR AFFECTING MY MEDICAL CARE. MY PARTICIPATION IN THIS PROJECT MAY BE ENDED BY THE INVESTIGATOR OR BY THE SPONSOR FOR REASONS THAT WOULD BE EXPLAINED. NEW INFORMATION DEVELOPED DURING THE COURSE OF THIS STUDY WHICH MAY AFFECT MY WILLINGNESS TO CONTINUE IN THIS RESEARCH PROJECT WILL BE GIVEN TO ME AS IT BECOMES AVAILABLE. I UNDERSTAND THAT THIS CONSENT FORM WILL BE FILED IN AN AREA DESIGNATED BY THE HUMAN SUBJECTS COMMITTEE WITH ACCESS RESTRICTED TO THE PRINCIPAL INVESTIGATOR, NANCY RYBSKI, M.A., CMFT, OR AUTHORIZED REPRESENTATIVE OF THE FAMILY STUDIES DEPARTMENT OF THE UNIVERSITY OF ARIZONA, OR SUPERIOR COURT AUDITING PERSONNEL. I UNDERSTAND THAT I DO NOT GIVE UP

THE REST OF THIS PAGE IS INTENTIONALLY LEFT BLANK.

Subject's Consent Form
Page 5

ANY OF MY LEGAL RIGHTS BY SIGNING THIS FORM. A COPY OF THIS SIGNED CONSENT FORM WILL BE GIVEN TO ME.

Subject's Signature	Date
Parent	Date
Witness (if necessary)	Date

INVESTIGATOR'S AFFIDAVIT

I have carefully explained to the subject the nature of the above project. I hereby certify that to the best of my knowledge the person who is signing this consent form understands clearly the nature, demands, benefits, and risks involved in his/her participation and his/her signature is legally valid. A medical problem or language or educational barrier has not precluded this understanding.

Signature of Investigator	Date

APPENDIX F

ARIZONA CHILDREN'S HOME ASSOCIATION
FAMILY VIOLENCE PROGRAM

Family Descriptors

Questions for Mom:
Have you ever been married?
Are you in a relationship now?

Is there a history of physical abuse in your family?
Has there been abuse in any of your relationships?
Did the kids see it?
Did you seek help (a shelter,counseling, whatever) for the abuse?

Is there any history of alcohol or drug abuse in your family?
With any of your partners?

How many kids do you have?
How far apart in age are they?

What is your annual income: < $10K; $10K - $20K; > $20K
How far did you get in school:
Do you practice a religion? If so, which one?

Questions for Kid:
What grade are you in school:
Have you ever been: Suspended; expelled; in detention:
Have you ever been in either gifted & talented or special ed classes?
What type of school do you attend: Regular; alternative; none (expelled)

Do you or have you used alcohol?
Do you or have you used drugs, including marijuana or huffing?
Do you smoke?

Have you ever received mental health services before?

Have you ever been arrested before?

Do you claim a gang? If so, which one?
If you claim, how old were you when you were jumped in?

APPENDIX G

March 3, 1998

Nancy Rybsky
Canyon Acres Children's Services
233 S. Quintana Dr.
Anaheim Hills, CA 92817

Dear Ms. Rybsky:

I hereby grant you limited permission to use the Domestic Conflict Containment Program as a part of your doctoral program only.

Sincerely,

Gwen Harrison Neidig

Gwen Harrison Neidig
as Administrator, Estate of
Peter H. Neidig, and as
President, Behavioral Science Associates, Inc.

P.O. Box 87
Stony Brook, NY 11790
(516) 689-6114 • Fax (516) 689-0224

APPENDIX H

ARIZONA CHILDREN'S HOME ASSOCIATION
FAMILY VIOLENCE PROGRAM

Program Principles

1. The primary goal of this program is to stop violence in the home.

2. Although anger and conflict are part of family life, violence has no place in the family and is never okay.

3. Abusiveness is a learned behavior.

4. Abusive behavior happens when people are in a relationship, but it is the responsibility of the violent person to control his/her violent behavior.

5. Abusiveness is a desperate but unhealthy way to make things change in a family.

6. Abusiveness tends to get worse, both in terms of violence and how often it occurs, if it is not stopped.

7. Children who are abusive to their family members very often grow up and continue to be abusive to their spouses and children.

APPENDIX I

ARIZONA CHILDREN'S HOME ASSOCIATION
FAMILY VIOLENCE PROGRAM

Anger Lessons Worksheet

1. How did your father act when he was angry?

2. How did your mother act when she was angry?

3. How did they handle conflicts?

4. Was anybody afraid at home?

5. What did you learn at home about:

   (a) How men are angry?

   (b) How women are angry?

   (c) Resolving conflicts?

6. How did you express anger when you were younger?

7. What did you learn here about your family or yourself that you would like to change?

APPENDIX J

ARIZONA CHILDREN'S HOME ASSOCIATION
FAMILY VIOLENCE PROGRAM

Violence Cycle Worksheet

Phase One: Tension Building

Stressors:

Cues:

Phase Two: Violent Episode

Triggers:

Phase Three: Remorse

Evidence of Remorse:

APPENDIX K

ARIZONA CHILDREN'S HOME ASSOCIATION
FAMILY VIOLENCE PROGRAM

Time-Out Contract

1. The cues that _____ is getting angry are:

   The cues that _____ is getting angry are:

2. The triggers that we need to avoid are:

3. The neutral, non-blaming time-out signal that we will use is:

4. When either of us gives this signal,

   _____ will go :
   _____ will go :

5. The time-out period will last:
   At the end of this period, we will:

6. During the time-out we will observe the following rules:

_____	_____
Client	Date
_____	_____
Client's parent	Date
_____	_____
Nancy Rybski, M. A., CMFT Center for Family Therapist Senior Therapist	Date

APPENDIX L

ARIZONA CHILDREN'S HOME ASSOCIATION
FAMILY VIOLENCE PROGRAM

Anger Log I

Date/ Time	Incident	Anger Level (0-100)	Thoughts during and after the incident	Outcome

APPENDIX M

ARIZONA CHILDREN'S HOME ASSOCIATION
FAMILY VIOLENCE PROGRAM

Anger Log II

Date/ Time	Incident	Anger Level (0-100)	Automatic Thoughts (Hot)	Rational Thoughts (Cool)	Outcome	Anger Level (0-100)

APPENDIX N

ARIZONA CHILDREN'S HOME ASSOCIATION
FAMILY VIOLENCE PROGRAM

Anger Self-Analysis Worksheet

In order to gain experience in applying the A-B-C model of anger control, complete the following worksheet.

STEP 1 - ACTIVATING EVENT OR INCIDENT

Write a brief, objective description of a recent incident in which you experienced anger. Write just the facts as they would have been recorded by a TV camera. List who, what, where, and when, without elaboration or interpretation.

STEP 2 - ANGER LEVEL

Assign a number to your anger level, 0 (none) to 100 (maximum).

STEP 3 - BEHAVIOR

Record what you did (the behavior engaged in) in response to the activating event (Swore, left the room, clenched fist and jaws, etc.).

STEP 4 - AUTOMATIC THOUGHTS AND BELIEFS

Write down the internal sentences you were saying during and after the activating events. The more of these thoughts you can become aware of, the better, so write down several (Examples: "I can't stand it," "It's not fair," "I'd like to ...")

Anger Self-Analysis Worksheet, Continued

STEP 5 - SELF-ANALYSIS QUESTIONS

Answer each of the following questions either yes or no to analyze whether or not your automatic thoughts increase your level of anger and discomfort.

	YES	NO
- Are my automatic thoughts based on an objective, rational interpretation of the event?	___	___
- Does my anger help me achieve my long-term goals or is it simply disruptive?	___	___
- AM I angry at someone who truly meant to hurt me?	___	___
- Do my automatic thoughts contribute to a positive attitude and sense of well-being?	___	___

If you answered yes to all four questions, your anger is probably adaptive and within acceptable limits. Congratulations, you can stop at this point.

If you answered no to any of the four questions, your anger is probably maladaptive and excessive, and you will find it helpful to complete the rest of the exercise.

STEP 6 - RATIONAL THOUGHTS

Substitute rational thoughts for any automatic thoughts listed for Step 3 that increase your anger and discomfort.

STEP 7 - FINAL ANGER LEVEL

Assign a number (0-100) to your anger after substituting rational thoughts for automatic thoughts. The greater the difference between the values listed in Step 2 and Step 7, the more successful you have been in refuting your irrational, anger-producing thoughts.

STEP 8 - RATIONAL BEHAVIOR

List the rational behavior you intend to engage in now or for similar activating events in the future.

APPENDIX O

ARIZONA CHILDREN'S HOME ASSOCIATION
FAMILY VIOLENCE PROGRAM

Stress Symptoms

Physical
Increased heart rate
Tightness of chest
Difficulty breathing
Sweaty palms
Trembling, tics, and twitching
Headache
Urinary frequency, diarrhea
Nausea and/or vomiting
Constant state of fatigue
Muscular contractions (jaws, forehead, neck, shoulders)
Susceptibility to minor illness
Slumped posture

Psychological
Feelings of worthlessness
Depression
Suspiciousness, jealousy
Anxiousness
Cynicism
Lack of capacity for enjoyment
Decreased initiative
Tendency to blame others
Self-deprecating, self-critical
Forgetfulness, preoccupation
Decreased or increased fantasy life
Lack of attention to details
Past-oriented, not present
Decreased creativity
Decreased sexual interest
Irritability, angary outbursts
Boredom
Apathy

Behavioral
Procrastination, inability to complete projects
Sleep disturbance (increased or decreased)
Appetite disturbance (increased or decreased)
Increase in smoking or drinking
Accident proneness
Avoidance of physical exercise
Restlessness, disturbed concentration
Tendency to cry
Decreased involvement with others
Math and grammatical errors
Blocking (not hearing)
Decrease in productivity

APPENDIX P

ARIZONA CHILDREN'S HOME ASSOCIATION
FAMILY VIOLENCE PROGRAM

Anger Management Self-Statements

PREPARING FOR A PROVOCATION

This may be upsetting, but I know how to cope.
Remember, lose your cool and you lose control.
Stick to the issue; don't take it personally.
Nobody can make me mad; it's up to me.
Take that deep breath, hold it, exhale, and relax.

IMPACT AND CONFRONTATION

I'm cool and in control.
Stay calm. Continue to relax.
control my thinking and control my anger.
It would be nice if he/she didn't act like that.
There's no reason to get angry.

COPING WITH AROUSAL

Tight muscles? Stay loose and relax.
Time to take a deep breath.
There's no payoff in getting angry.
Stick to the issue and see it through.
Anger is a signal that I need to take control of myself.
Cool thoughts instead of hot.

SUBSEQUENT REFLECTION

I kept my cool and I kept control.
I made it! Now stick with the cool thoughts.
I'm getting better and better.
Write it down. Another success.
It could have been a lot worse.

APPENDIX Q

ARIZONA CHILDREN'S HOME ASSOCIATION
FAMILY VIOLENCE PROGRAM

	Nonaggressive Behavior	Assertive Behavior	Aggressive Behavior
Characteristics of the Behavior	Ignores, does not express own rights needs or desires. Permits others to infringe on rights.	Expresses and asserts own rights and needs. Stands up for legitimate rights.	Expresses own rights at expense of others. Inappropriate outburst or hostile overreaction.
Your feelings when you engage in this behavior	Weak, hurt, anxious. Disappointed in self and possibly angry later.	Confident, self-respecting. Feels good about self at the time and later.	Angry, self righteous, indignant. Feels superior, possibly guilty later.
Nonverbal behavior	Avoidant, slumped body. Nervous gestures and mannerisms. Weak voice	Open, direct. Good eye contact does not appear nervous. Clear, steady tone of voice.	Glaring, narrowed eyes. Rigid posture. Clenched fists. Raised voice.
Verbal Behavior	Rambling statements. Qualifiers (maybe/only). Negatives (Don't bother/It's not important).	Concise "I" statements, cooperative words; empathic statements of interest.	Clipped, interrupting statements. Threats. Name calling, putdowns, accusations.
Outcome	Does not achieve desired goals.	May achieve desired goals.	Achieves desired goals by hurting others.

APPENDIX R

ARIZONA CHILDREN'S HOME ASSOCIATION
FAMILY VIOLENCE PROGRAM

Feelings List

Accepted
Affectionate
Afraid
Angry
Appreciated
Attractive
Awkward
Beautiful
Brace
Calm
Comfortable
Competent
Concerned
Confident
Confused
Defeated
Dejected
Dependent
Depressed
Desperate
Disappointed
Eager
Easygoing
Embarrassed
Envious
Excited
Feminine
Flirtatious
Friendly
Frustrated
Generous
Grateful
Guilty
Happy
Hateful
Hopeful
Hopeless
Hostile
Humorous
Hurt
Ignored
Impatient
Inadequate
Incompetent
Indecisive
Independent
Inferior
Inhibited
Insecure
Involved
Isolated
Jealous
Lonely
Lovable
Loving
Loyal
Manipulated
Masculine
Misunderstood
Needy
Old
Optimistic
Passionate
Peaceful
Persecuted
Phony
Playful
Pleased
Possessive
Prejudiced
Preoccupied
Pressured
Protective
Proud
Quiet
Rejected
remorseful
Sad
Secure
Seductive
Self-reliant
Sexy
Shy
Silly
Sinful
Soft
Sorry
Stubborn
Stupid
Superior
Supportive
Suspicious
Sympathetic
Tender
Terrified
Threatened
Touchy
Unappreciated
Uncertain
Understanding
Uptight
Used
Useless
Victimized
Violent
Weary
Wishy-washy
Youthful

APPENDIX S

ARIZONA CHILDREN'S HOME ASSOCIATION
FAMILY VIOLENCE PROGRAM

Feeling-Talk

Once you have acquired the ability to detect and label feelings, you are ready to practice feeling-talk. Your feeling-talk should:

1. Be phrased as "I" statements.

2. Use statements rather than questions.

3. Be present-oriented and promptly stated. In other words, focus on what's going on now, and talk about what's going on as it happens.

4. Follow the "say-ask" principle. That is, check to make sure that you're understanding the other person correctly. For example, "I heard you say such-and-so; is that right?"

Practice feeling-talk with your family member at least once per day during the next week. You can tell us your results at the next meeting.

APPENDIX T

ARIZONA CHILDREN'S HOME ASSOCIATION
FAMILY VIOLENCE PROGRAM

Making Positive Requests

We tend to get in conflict with others when we're "inconvenienced;" when something we want or expect doesn't happen. In order to make sure that your wants and expectations are fully understood by the people who need to understand them, you can practice making positive requests.

1. Be prompt. Make requests when they become an issue,m rather than silently holding them inside. Otherwise, there is the possibility that holding them inside can build up irritation and resentment, since the other person hasn't somehow "magically" understood that you need something.

2. Be positive. Requests should be made positively, expressing what is wanted of the listener, not just what is wanted. For example, rather than "Stop making all that noise," "Please be quiet" is more respectful and positive.

3. Be specific. The more detailed your request, the more information you give the other person to process. Rather than "Do your work," expectations are clearer with "I would like you to wash the dishes and sweep the floor, please." The latter is also more positive and specific.

4. Use "I" language. Requests that start with "you" almost always sound like accusations, and are likely to get defensive responses. "I would like you to be home by 12:00, please" is a lot less accusatory than "You always come in late."

5. Use "how" or "what," not "why" questions. If you need to ask questions for clarification, "how" or "what" will focus on the process, but "why" tends to lead to defensiveness. "Why didn't you finish clearing the table?" will probably get a defensive response, whereas "How will you get it done?" or "What can I do to help?" will help the listener stage out a plan of action.

6. Look for and reward positive compliance. Looking for and rewarding positive compliance is probably the most important step in the process. Rewarding positive behavior is much more likely to lead to repetition of the behavior in the future than any amount of threat or punishment. People always perform better for the carrot than for the stick.

APPENDIX U

ARIZONA CHILDREN'S HOME ASSOCIATION
FAMILY VIOLENCE PROGRAM

Positive Expressions Handout

We have a tendency to take things--and people--for granted. Remember, the person you're with is one of the most important people in the world to you, but when was the last time you told him/her so? Your assignment for the next week is to say something of affection and caring, praise and compliment, or appreciation, to your family member, once each day.

AFFECTION AND CARING

"I like you."
"I enjoy being with you."
"I was really concerned about you."
"I love you."
"I'm glad you're my mom/kid."

PRAISE AND COMPLIMENTS

"That's great!"
"You look very nice."
"You're doing a good job."
"Good idea."
"I really enjoy spending time with you."

APPRECIATION

"Thanks."
"I really appreciated that."
"I can see that you really put a lot of effort into that."
"You did a great job. Thanks."
"I couldn't have done it without you."

APPENDIX V

ARIZONA CHILDREN'S HOME ASSOCIATION
FAMILY VIOLENCE PROGRAM
Consumer Satisfaction Survey

1. How would you rate the quality of the service you received?

   4: Excellent 3: Good 2: Fair 1: Poor

2. Did you get the kind of service you wanted?

   1: No, definitely not. 2: No, not really. 3: Yes, generally. 4: Yes, definitely

3. To what extent has our program met your needs?

   4: Almost all have have been met. 3: Most of them have been met. 2: Only a few have been met. 1: None have.

4. If a friend were in need of similar help, would you recommend our program?

   1: No, definitely not. 2: No, don't think so. 3: Yes, I think so. 4: Yes, definitely

5. How satisfied are you with the amount of help you have received?

   1: Quite dissatisfied. 2: Indifferent or mildly dissatisfied 3: Mostly satisfied 4: Very satisfied

6. Have the services you received helped you to deal more effectively with your problems?

   4: Yes, they helped a great deal. 2: Yes, they helped somewhat. 3: No, they really didn't help. 4: No, they got worse.

7. In an overall, general sense, how satisfied are you with the services you have received?

   4: Very satisfied 3: Mostly satisfied 2: Indifferent or mildly dissatisfied 1: Quite dissatisfied

Consumer Satisfaction Survey, *Continued*

8. If you were to seek help again, would you come back to our program?

1: No, definitely not.	2: No, I don't think so.	3: Yes, I think so	4: Yes, definitely

9. Since you started at the agency, has there been any change for better or worse in the way members of your family get along with each other (talk over problems, handle arguments, work out differences, help each other, feel toward each other, enjoy each other)? Would you say you now get along:

1: Much worse	2: Somewhat worse	3: Somewhat better	4: Much better
0 responses	1	16	13

10. In general, how satisfied were you with the way you and your counselor got along with each other?

1: Quite dissatisfied	2: Indifferent or Mildly dissatisfied	3: Mostly satisfied	4: Very satisfied

11. How have you and your child changed for better or worse (in behavior, attitudes, feelings, or handling of problems) since service began?

5: Much better	4: Somewhat better	3: Same	2: Somewhat worse	1: Much worse

12. Please tell us anything we could do to improve our program or staff.

13. Please tell us anything you liked about our program or staff.

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IMAGE EVALUATION
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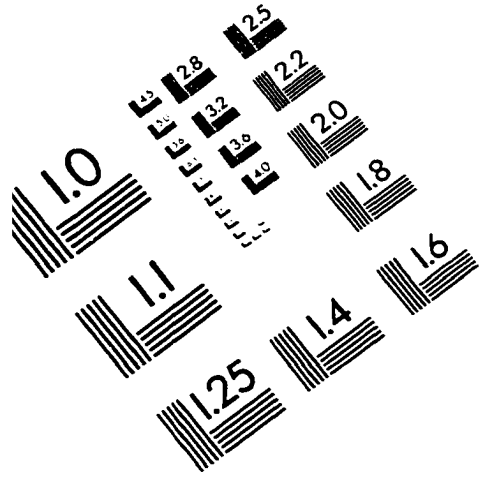

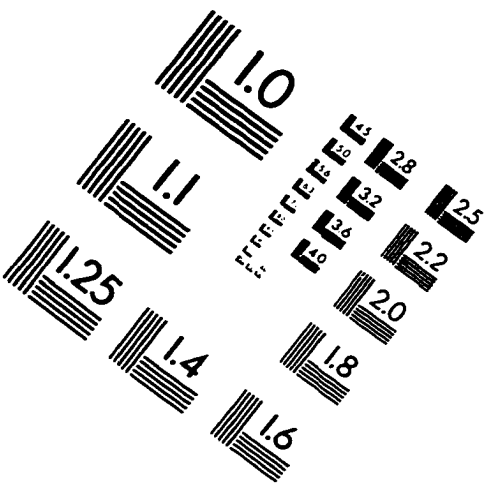

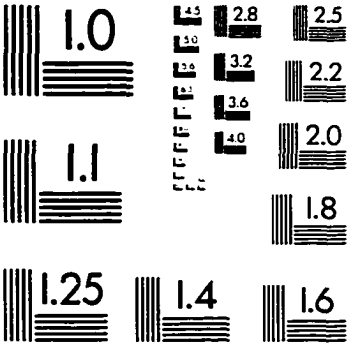

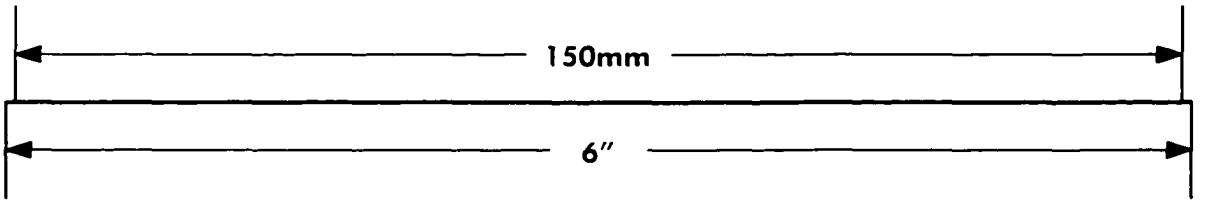

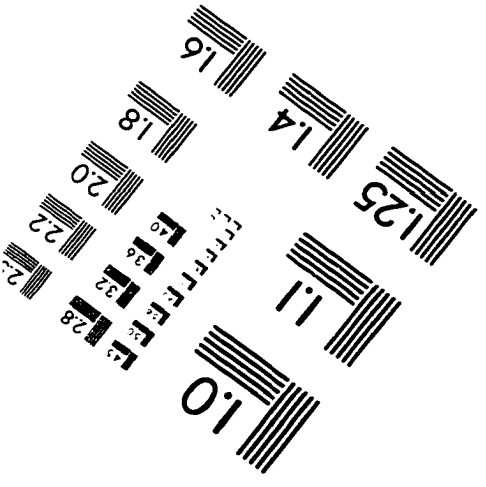

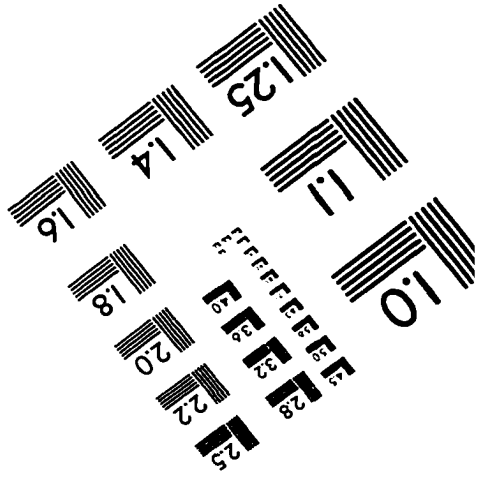

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