# Transitional Group Therapy to Promote Resiliency in First-time Foster Children: A Pilot Study

Patricia A. Craven[1]

Robert E. Lee[2]

Key Words

Foster Care, Attachment, Child Therapy, Group Therapy, "Best Practices"

[1] Patricia A. Craven PhD is the senior author on this paper, and is the Executive Director of Healing Transitions, 1725 Capital Circle NE, Suite 203, Tallahassee, Florida 32308. Email patriciacraven@healing-transitions.com.
[2] Robert E. Lee PhD is Norejane Hendrickson Research Professor at Florida State University, 240 Sandels, Tallahassee, FL 32306; Email relee@fsu.edu.

Abstract

Foster care places children at high risk for immediate and long term psycho-social-educational problems. A therapeutic "cocktail" – Transitional Group Therapy (TGT) – has been developed as an inoculation for first-time foster children in order to inhibit these undesirable effects. TGT combines best practices culled from diverse therapeutic approaches to foster children. Psycho-educational and play therapeutic interventions are included in a group therapy context. This combination focuses on the immediate experiences of these children while cultivating the bases of personal resiliency. In this pilot study 11 first-placement foster children, ages 6-11, demonstrated desirable changes in pro-social behavior and orientation toward peers, family, and schools. TGT is worth further exploration as a "shot in the arm" to boost resiliency in first-placement foster children.

Transitional Group Therapy, Attachment, and Resilience in Foster Children:

A Pilot Study

Foster care has been empirically associated with negative influences on development, including acute and chronic emotional and social problems (see reviews in Lee & Whiting, 2008a). This is ironic -- foster care is intended to rescue children from adverse circumstances. There consistently have been over 500,000 children a year in foster care in the United States (US Department of Health & Human Services, National Center on Child Abuse & Neglect, 1996; US Department of Health and Human Services, National Clearinghouse on Child Abuse and Neglect Information, 2001).

Foster placement is difficult for children because it consists of multiple abrupt breakups and transitions: family, neighborhood, and friends (e. g., Clausen, Landsverk, Ganger, Chadwick, & Litronwnik, 1998). Moreover, many of these losses are ambiguous (Lee & Whiting, 2007; 2008b). Feelings of stigmatization are common and destructive (e.g., Blower, Addo, Lamington, & Towlson, 2004; Lee & Whiting, 2008c). Presumably, the first time foster placement occurs must be especially difficult. However, not all inhabitants of foster care fare the same. There are individual differences ranging from success stories to tragedy. Nevertheless, little has been written, and less empirically tested (see Craven & Lee, 2006; Lewis, Dozier, Knights, & Maier, 2008) about how these predictable deleterious influences could be moderated when children are initially placed in foster care. Transitional Group Therapy (TGT) is an attempt to develop a prophylactic tool by combining practices hitherto found beneficial in the treatment of foster children with emotional and behavioral problems. It combines psycho-education and play therapy in a group format to promote immediate increase in personal resiliency. This therapeutic "cocktail" is expected to prevent the short-term behavioral problems in these children that

disrupt their initial placements and lead to an escalation of losses and their concomitant insecurity.

This was a pilot study and, as such, it had two important parts, feasibility and promise. Attempts to implement TGT in an agency setting uncovered some facilitating factors and many barriers. An ecosystemic explication of this may be found in Craven (2008a). This article addresses the issue of efficacy, namely, evidence that – once installed – the potential of TGT to accomplish its aims.

### *Theoretical Basis of TGT*

In our professional experience, the amount of the amount of negative influence experienced by children in foster care is a function of how *resilient* they are, that is, the extent to which they can endure and even grow from stressful experiences (see review in Walsh, 1996). Resiliency is an outcome produced by the following constellation of personal traits: social competency, problem-solving skills, autonomy, optimism, and the ability to recruit social support (e.g., Cicchetti & Garmezy, 1993). However, the acquisition and application of all but autonomy presuppose social trust (see Ambert, 1997) and social trust is an ingredient likely to be minimized when children have been maltreated and then are removed from their homes. (See Crittenden, 1988, Crittenden & Farnfield, 2008, Davies, 2004, and Jager, 2008, for discussions of interpersonal trust, first with foster children, and then with those who are now adults and parents.) Therefore, if resiliency in foster children is to be promoted, concurrently something must be done about their more superficial trust issues and how they regulate their anger (see Crittenden, 2006). We do not know the extent to which attachment styles are malleable. However, we are told that the expression of deep-rooted negative attachment styles can be influenced by psychoeducation and corrective emotional experiences (Crittenden, 2002, 2008).

*Description of Transitional Group Therapy (TGT)*

Transitional Group Therapy is a short-term intensive group experience. It is informed by empirically determined best practices with regard to the support of traumatized children (e. g., Brohl, 2007; Craven & Lee, 2006; Crittenden, 1997) and interventions with families at risk for child maltreatment (Crittenden, 2002; McWey, 2007). In general, those interventions considered well-supported and efficacious have been characterized by:

- High structure, informed by accepted family, interpersonal, and mental health lore and theory
- Creation of a safe environment for experience and learning
- Abreaction and mastery, often facilitated by play and art therapies
- Use of group process
- No clinical indication that the treatment constitutes a substantial risk of harm to those receiving it, compared to its likely benefits

Although many experts advocate play therapy as the primary approach to traumatized children (see www.a4pt.org), others (e.g., Gil, 2006) now highlight the value of interventions that incorporate the strengths of multiple treatment modalities. Group processes, including self-support groups (see Sumner-Mayer, 2008), are an important part of multi-modality treatments. Beyond being a venue for venting feelings and obtaining relief from that, a group therapeutic milieu offers curative factors that possibly may exceed those of other formats (Yalom, 1996). Groups allow their members to discover that others experience similar pains and struggles and, from that, to experience relatedness, diminution of shame, and instillation of hope. Groups also allow peers to help each other, providing a sense of competency and the experience of being in a supportive environment. Also, the group process develops positive socializing techniques while

raising awareness of extra-familial social resources. Finally, the group therapeutic milieu may be especially well-suited for young people who may not trust the adults in their lives and who, as adolescents, are inclined to look to their peer culture for models of coping and identity (Wood, 2008). These generic properties of support groups can be heightened for children in distress if trained adult facilitators focus the groups on topics that can help the children better understand their current life situations, develop and use effective coping strategies, and learn how to make responsible life choices in responding to their dilemmas (O'Rourke & Worzbyt, 1996).

Following these dictates, TGT is an experiential approach that employs play therapy (e.g. sand tray, drawings, puppet play, and role-play) and psycho-educational techniques in a strengths-based group format in order to:

- Teach and cultivate characteristics of personal and relational resiliency (Walsh, 1994) to ease the abrupt and often traumatic transition into foster placement
- Reverse feelings of loss, abandonment and betrayal through safe expression of emotions and other forms of social outreach, e.g., anger is displayed, but regulated, in a milieu wherein the children are validated and valued
- Cultivate an inner sense of psychological permanence though increasing self esteem and group identification
- Educate the children about foster care
- Decrease feelings of stigmatization

These inchoate traits and education are expected to interact with the environments in which the children are living parts and make the children's developmental prognoses more favorable. It will take longitudinal treatment fidelity and appropriate data acquisition to ascertain these growth curves. The present study marks the first step.

Treatment fidelity requires a manual. The TGT *Manual* (Craven, 2008b) sets forth 12 group sessions, two each week. Each session has a treatment objective supported by psycho-educational and therapeutic activities developmentally appropriate for children aged 6 to 12. Group sessions are 90 minutes in length and are facilitated by a lead therapist and a technician. At the beginning and at the end of each session, free play time is permitted. However, each session has an objective, activity, and homework. The homework is related to the next session's activities, for example, *"What do you want to be when you grow up?"* All group sessions are videotaped so that they might be audited for clinical supervision and assessment of treatment fidelity.

There are three stages of treatment:

*Stage 1-establishing rapport (sessions 1-3).* It is important to build a working alliance, namely shared goals and enough of a relationship to support work on those goals (see Bordin, 1994). The first three sessions are instrumental in building rapport and introducing the group process. Therefore, the first group session is attended by both the birth and foster families and each child learned that other children also not living with their parents and that their situations are similar. In the second session, the children begin by introducing themselves using positive traits. They also establish group rules and decorate personal folders in which to keep handouts and pictures. For homework they are to try and remember at least one group member's name. Finally, in the third session the children discuss characteristics that make people stronger and prepare them for the future. Super heroes are discussed and group members create a cape that represents desired strengths and powers for example, invisibility, flying, speed, *chakra* power, and controlling the wind. They discuss what a hero is, using examples such as a policeman,

fireman, and scuba divers. They do the *safety hand* activity (Hobday & Ollier, 1999) in order to identify important personal contacts if they ever feel unsafe.

*Stage 2- introducing resiliency (sessions 4-7).* Session four begins with the process of introducing resiliency traits such as social competence, creativity, self-assurance, support, and expression of feelings and emotions. Calming music plays during discussion of anger and impulsive behavior, good days and bad days, and handling anger. The next session consists of recognizing strengths and talents. Session six focuses on problem-solving wherein the children discuss scenarios, their needs and feelings, and the merits of various responses. The final session of this stage consists of explorations of the group members' families, and the roles of the members, using sand trays and discussion.

*Stage 3- integration of knowledge (sessions 8-12).* In the last four sessions the children are to identify and make personal sense out of what they have learned from their experiences in TGT thus far. Session eight focuses on their future, namely, what is it they want to be when they grow up. The objective of the ninth session is to promote teamwork, sharing, and taking care of ones health by making good choices. Discussion on physical health includes exercise, eating, sleeping, and dental care. Also friendship is discussed: How to make friends and why someone is your best friend. (Many children will name others in the group as their best friends.) In the tenth session the group activities focus on establishing appropriate boundaries, trust in others, social skills, and group cohesiveness. Experiential activities illustrate and reinforce these goals.

The goal of the twelfth, final, session is to debrief the children and caregivers on former sessions, meet with caregivers, and discuss any reactions or concerns about what has transpired over the past several weeks. Music and food are provided and a diploma is given to each group member. Group members are invited to say good bye to each other while playing and interacting.

Experience suggests that may be a sad time for many of the children. They probably will not want TGT to end and many will exchange phone numbers.

## *Method*

In this pilot study, TGT was evaluated through both quantitative and qualitative methods. Pre- and post measurements administered to the foster parents or relatives of group members were compared. Qualitative analysis of the senior author's field notes, progress notes by the TGT therapists, and video transcripts of TGT sessions added depth.

Qualitative methods are encouraged for use during preliminary cycles of research when there is an emphasis on exploration (Yin, 1989 & Corbin & Strauss, 1994). It is understood that the tentative model of the intervention consists of the potential of numerous revisions based on recursive iteration with qualitative and quantitative data. The diverse findings help shape progressive versions of the intervention with an eye toward improved implementation and, ultimately, validity for the population.

### *Participants*

Although 28 local children between the ages of 6 and 12, in their first foster care placement were eligible for TGT, only 11 were enrolled. The foster parents of the others would not commit to six weeks of twice-weekly sessions. They cited busy schedules and additional responsibilities. All of the 11 children had experienced either neglect or abandonment and the parents of eight of them currently were incarcerated on various charges, including child physical and sexual abuse and substance abuse. The majority of the children who participated in TGT had an Axis I mental health diagnosis (American Psychiatric Association, 2000). Two had an adjustment disorder, five had anxiety disorders, and one had been diagnosed as a posttraumatic stress disorder. Seven out of the 11 children were diagnosed with attention deficit, hyperactive

disorder, but this was not their primary diagnosis. Eight of the participants were male; 3 were female. Seven were White; 4 were Black.

*Quantitative Procedures*

The children were pre- and post-tested for the presence of mental health symptoms (Child's Behavior Checklist) and traits of personal resiliency (Behavior and Emotional Rating Scale - Second Edition, CBCL). The CBCL is designed for children ages 4 to18, and is the most commonly used measurement in published studies of child pathology (Vignoe & Achenbach, 1998). It contains 118 behavioral items. The results of the questionnaire give a profile composed of nine problem scales (withdrawn, somatic complaints, anxious/depressed, social problems, thought problems, attention problems, delinquent behavior, aggressive behavior, and sex problems (Kroes, Kalff & Steyart, 2002). It has been well standardized and has excellent reliability: test-retest correlation = 0.93, inter-parent correlation = 0.76, Cronbach's coefficient alpha = .96 (Wamboldt, Wamboldt, & Gavin, 2001). The BERS-2 is a 52-item rating scale for youth ages 5 to18 years (Epstein & Sharma, 1998). The items involve five standard subscales: interpersonal strengths, affective strength, family involvement, school functioning, and intrapersonal strengths. Cronbach's coefficient alpha for the five BERS-2 subscales are strong, ranging from .91 (school functioning) to .98 (interpersonal strengths). The Wilcoxon Signed Ranks Test was used to determine whether any differences between pre- TGT and post-TGT were statistically significant.

## *Results*

*Quantitative Analyses*

As indicated in Table 1, upon completion of TGT the children demonstrated changes in the desirable direction on both the CBCL and the BERS-2. Of all of the negative attitudes and

behaviors assessed by the CBCL, decreases in three of them – *Anxious/Depressed*, *Rule-Breaking Behavior*, and *Aggressive Behavior* – were statistically significant. Similarly, increases in strengths-oriented attitudes and behaviors increased on the BERS-2 . The positive changes in three of the five BERS-2 subscales were statistically significant: *Interpersonal Strength*, *Family Involvement*, and *School Functioning*.

*Qualitative Analysis of Work Products*

Repetitive words, phrases, and distinctive interactions emerged as the TGT group sessions and transcripts were coded. The principle ones were:

- *Group camaraderie*. Children who participated in group sessions were able to identify with other children in the group. Group participants developed friendships and demonstrated concern for and trust with other group members.
- *Dealing with uncomfortable emotions*. Many discussions and the processing of activities displayed the children's difficulty when dealing with anger and frustration. They were reluctant to talk about such matters, described events when their emotions exacerbated their problems, and said that they frankly did not know what to do with their anger beyond venting it verbally or physically upon the offending people, objects, and events.
- *Insecurities and lack of empowerment related to self, home, and others*. The children appeared to lack empowerment and struggled with activities that focused on recognizing their own strengths and identifying future goals. They commonly described themselves as physically unattractive and generally undesirable. They exhibited shame about themselves, their parents, and the fact that they were in foster care. Pervasive sadness and/or anger were common.
- *The importance of free time and play in group therapy*. Free play was the most enjoyed

activity in the group. It was not the content per se but the process of play that appeared to decrease anxiety and promote group cohesion. The children learned about others in the group through this valuable time before and after structured activities. Group members also appeared to verbally respond more freely during free play than during structured planned activities. Although structured activities had defined purposes and objectives, free play allowed for personal expression without the control of an adult who directed their actions.

### *Discussion*

It is well documented that many foster children have a tendency to be overly compliant (Crittenden, 2002) or to act up antisocially (Fisher, Gunnar, Chamberlain, & Reid, 2000). Both stances can be seen as a reaction to the anxiety engendered by their situation: Fear, frustration, and anger may be too massive to be capped; Antisocial behavior may test the safety of a new relationship or push that relationship away (Crittenden 1988, 1997, 2002; Lewis, Dozier, Knights, & Maier, 2008). Although this behavior can threaten the foster care system and result in successive unsuccessful placements at great emotional cost to the children, it is important that negative emotions not be suppressed. Instead, foster children must find good enough ways to regulate and to integrate their emotional states. There is some indication that TGT may provide a milieu in which these adaptive behaviors are cultivated and nurtured.

However, any implications of these data must be done with extreme caution. There was no comparison group. Therefore, desirable changes in the participants' behavior could be all or partially a product of our intervention. They also may be all or partially the result of things happening over time *outside the intervention*, for example, the participants getting used to or having good experiences within their foster homes, new neighborhoods, and attendant

institutions. Even if observed changes are all or partly driven by the intervention, we cannot know whether or not this unique intervention made a difference. Changes can be caused by the children being focused upon and/or being made self conscious in positive ways. So, in the absence of a comparison group, we do not really know if we are measuring what we think we are measuring. We also do not know if we can generalize from these findings to other children in foster care. Our sample is small and opportunistic. It does not represent the diversity of "all young children in foster care": The individual circumstances made up of age, gender, region, ethnic subculture, circumstances of maltreatment, and so on. The next studies need to extend TGT -- with high treatment fidelity -- to larger, carefully-selected samples, the selection done on the basis of theory. For example, some of our participants did well; others did not. There also needs to be, not just a control group of non-participating individuals, but systematically created groups receiving alternative treatments that contrast with what is offered by TGT.

Moreover, it is reasonable to expect that TGT may not be enough. Foster children spend vastly more time in their larger social system than in the therapeutic intervention. That is why Dozier and her associates (Lewis, et al. 2008) emphasize the importance of secure and therapeutic foster care placements. They offer foster families an empirically-validated psycho-educational intervention – "Attachment and Biobehavioral Catch-up – with the goal of making foster homes therapeutic milieu. Whereas TGT addresses peer relatedness with an eye to developing personal resiliency, Attachment and Biobehavioral Catch-up cultivates the foundation of relational resiliency (see Walsh, 1996).

Finally, although standardized treatment programs with very narrow aims may be attractive to family scientists and their funding sources, families in the foster care system have complex problems and our programs may need to be attuned to these families (Barrett &

Crittenden, 2008). Many experts advise so-called "ecosystemic" approaches, that is, developmentally-appropriate interventions that address the many environments in which a foster child is simultaneously embedded (e. g., Lee & Stacks, 2004; McWey & Donovan, 2008).

### *Conclusions*

This paper describes a pilot study with the grave limitations typical of such exploratory work. Its initial data are promising. Most children who participated in TGT demonstrated a statistically significant decline in anxious/depressed, rule-breaking, and aggressive behavior. Those are the kinds of behavior most disruptive to placements. Concurrently, there were positive changes in the children's orientation to the people around them, including each other, their families, and schools. It remains to demonstrate, using appropriate methodology, the extent to which these kinds of changes can be replicated with larger groups of young foster children of diverse description, and the extent to which these changes actually result from TGT (a best practices "cocktail") as opposed to more covert influences. We must also determine the extent to which TGT is efficacious relative to other therapeutic interventions and for what participants.

*References*

Ambert, A. (1997). *Parents, children, and adolescence.* New York: Hawthorn Press, Inc.

American Psychiatric Association. (2000). *Diagnostic and Statistics Manual, IV-TR*. Washington, DC. Author.

Barrett, H., & Crittenden, P. (2008). When a baby is thrown out with the bath water, does anyone hear it scream? *DMM News*, May, 3.

Blower, A., Addo, A., Hodgson, J., Lamington, L., & Towlson, K. (2004). Mental health treatment of "looked after" children: A needs assessment. *Clinical Child Psychology and Psychiatry, 9*, 117-129.

Bordin, E. S. (1994). The working alliance: Theory, research and practice. In A. O. Horvath & L. Greenberg (Eds.), *The working alliance: Theory, research, and practice* (pp. 13-37). Oxford, England: John Wiley & Sons.

Brohl, K. (2007). Working with traumatized children: A handbook for healing, Revised edition. Washington, DC: Child Welfare League of America.

Cicchetti, D., & Garmezy, N. (1993). Prospects and promises in the study of resilience. *Development and Psychopathology, 5,* 497-502.

Clausen, J., Landsverk, J., Ganger, W., Chadwick, D., & Litronwnik, A. (1998). Mental health problems of children in foster care. *Journal of Child and Family Studies, 7,* 283-296.

Corbin, J. & Strauss, A. (1990). Grounded theory research: Procedures, canons, and evaluative criteria. *Qualitative Sociology, 13*, 3-21.

Craven. P. A. (2008a). The effectiveness of Transitional Group Therapy: Promoting resiliency in foster children. Retrieved 9.20/2008 from http://etd.lib.fsu.edu/theses/available/etd-07112008-110736/unrestricted/CravenPDissertation.pdf.

Craven (2008b). *Manual for Transitional Group Therapy*. Unpublished document, available from senior author.

Craven, P. A., & Lee, R. L. (2006). Therapeutic Interventions for foster children: A systematic research synthesis. *Research in Social Work Practice, 16*, 287-304.

Crittenden, P. (1988). Relationships at risk. In J. Belsky & T. Nezworski (Eds.), *Clinical implications of attachment* (pp. 136-174). Hillsdale, NJ: Erlbaum.

Crittenden, P.M. (1997). Toward an integrative theory of trauma: A dynamic-maturational approach. In D. Cicchetti & S. Toth (Eds.), *The Rochester Symposium on Developmental Psychopathology, Vol. 10. Risk, Trauma, and Mental Processes* (pp. 34-84). Rochester, NY: University of Rochester Press.

Crittenden, P.M. (2002). If I knew then what I know now: Integrity and fragmentation in the treatment of child abuse and neglect. In K. Browne, H. Hanks, P. Stratton, & C. Hamilton (Eds.). *Prediction and prevention of child abuse: A handbook* (pp.111-126). John Wiley and Sons: London.

Crittenden, P.M. (2006). A dynamic-maturational model of attachment. *Australian and New Zealand Journal of Family Therapy, 27*, 105-115.

Crittenden, P. M. (2008). *Raising parents: Attachment, parenting, and child safety*. Devon, UK: Willan Publishing.

Crittenden, P., & Farnfield, S. (2008). Kinship placements: An integrative approach. In R. E. Lee & J. B. Whiting (Eds.). *Foster care therapist handbook: Relational approaches to the children and their families* (pp.227-250). Washington, DC: Child Welfare League of America.

Davies, D. (2004). *Child development, second edition: A practitioner's guide.* New York:

Guilford.

Epstein, M. H., & Sharma, J. (1998). *Behavioral and Emotional Rating Scale: A strength- based approach to assessment.* Austin, TX: PRO-ED.

Gil, E. (2006). *Helping Abused and Traumatized Children: Integrating Directive and Nondirective Approaches.* New York: Guilford.

Fisher, P. A., Gunnar, M. R., Chamberlain, P., & Reid, J. B. (2000). Preventive intervention for maltreated preschool children: Impact on children's behavior, neuroendocrine activity, and foster parent functioning. *Journal of the American Academy of Child and Adolescent Psychiatry, 39,* 1356-1364.

Hobday, A., & Ollier, K. (1999). Creative therapy with children and adolescents. Atascadero, CA: Impact Publishers, Inc.

Jager, K. (2008). *"But I Don't Trust You."* Recognizing and dealing with parents' history of trauma: The story of Amy. In R. E. Lee & J. B. Whiting (Eds.). *Foster care therapist handbook: Relational approaches to the children and their families* (pp.451-467). Washington, DC: Child Welfare League of America.

Kroes, M., Kalff, A.C., & Steyart, J. (2002). A longitudinal community study: Do psychological risk factors and child behavior checklist scores at 5 years of age predict psychiatric diagnosis at a later age? *Journal of the American Academy of Child and Adolescent Psychiatry, 41,* 955-1008.

Lee, R. E., & Stacks, A. M. (2004). In whose arms? The case for relational therapy in supervised visitation in foster care. *Journal of Family Psychotherapy, 15*(4), 1-14.

Lee, R. E., & Whiting, J. B. (2007). Foster children's expressions of ambiguous loss. *The American Journal of Family Therapy, 35,* 417-428.

Lee, R. E., & Whiting, J. B. (Eds.). (2008a). *Foster care therapist handbook: Relational Approaches to the children and their families*. Washington, DC: Child Welfare League of America.

Lee, R. E., & Whiting, J. B. (2008b). Ambiguous loss: A key component of foster care. In R. E. Lee & J. B. Whiting (Eds.), *Foster care therapist handbook: Relational approaches to the children and their families* (pp.83-101). Washington, DC: Child Welfare League of America.

Lee, R. E., & Whiting, J. B. (2008c, in press). Young children's voices: Narratives about the relationship of a puppy to its mother. *Child and Youth Care Forum.*

Lewis, E., Dozier, M., Knights, M., & Maier, M. (2008). Intervening with foster infants' foster parents: Attachment and biobehavioral catch-up. In R. E. Lee & J. B. Whiting (Eds.), *Foster care therapist handbook: Relational approaches to the children and their families* (pp.269-292). Washington, DC: Child Welfare League of America.

McWey, L. M. (2007). Predictors of attachment styles of children in foster care: An attachment theory model for working with families. *Journal of Marital and Family Therapy, 30,* 439-452.

McWey, L. M., & Donovan, P. (2008). Providing developmentally appropriate family therapy. In R. E. Lee & J. B. Whiting (Eds.), *Foster care therapist handbook: Relational approaches to the children and their families* (pp.153-180). Washington, DC: Child Welfare League of America.

O'Rourke, K., & Worzbyt, J. C. (1996). *Support groups for children*. Washington, DC: Accelerated Development.

Saunders, B.E., Berliner, L., & Hanson, R.F. (Eds.). (2004). *Child Physical and Sexual Abuse: Guidelines for Treatment (Revised Report: April 26, 2004)*. Charleston, SC: National Crime Victims Research and Treatment Center.

Sumner-Mayer, K. (2008). An integrative approach involving the biological and foster family systems. In R. E. Lee & J. B. Whiting (Eds.), *Foster care therapist handbook: Relational approaches to the children and their families* (pp.181-225). Washington, DC: Child Welfare League of America.

US Department of Health and Human Services, National Clearinghouse on Child Abuse and Neglect Information. (2001). *Child Maltreatment 1999: Reports from the States to the National Clearinghouse on Child Abuse and Neglect.* Washington, DC: United States Government Printing Office.

US Department of Health & Human Services, National Center on Child Abuse & Neglect. (1996). *Child maltreatment 1994: Reports from the states to the National Center on Child Abuse and Neglect.* Washington, DC: United States Government Printing Office.

Vignow, D., & Achenbach, T. (1998). *Bibliography of published studies using the Child Behavior Checklist and related materials.* Burlington: University of Vermont, Department of Psychiatry.

Wamboldt, Z., Wamboldt, F. S., & Gavin, L. (2001). A Parent-Child Relationship Scale derived from the Child and Adolescent Psychiatric Assessment (CAPA). *Journal of the American Academy of Child and Adolescent Psychiatry*, *40,* 945-953.

Walsh, F. (1996). The concept of family resilience: Crisis and challenge. *Family Process, 35*, 261-281.

Wood, D. (2008). Group therapy for adolescents: Clinical paper. Retrieved August 1, 2008, from

http://www.mental-health-matters.com/articles/article.php?artID=251.

Yalom, I. D. (1996). *The theory and practice of group psychotherapy* (4th ed.). New York: Basic Books.

Yin, R. K. (1989). *Case study research* (2nd Ed.). Newbury Park, CA: Sage.

Table 1

*Pre- and Post-Intervention Mean Scores on the Child Behavior Check List (CBCL) and the Behavioral and Emotional Rating Scale – Second Edition (BERS-2), Wilcox Signed Ranks Test*[a] *(N = 11*[b]*)*

| Variables | Pre-TGT | Post-TGT | *T* | |
|---|---|---|---|---|
| CBCL | | | | |
| Anxious/depressed | 7.70 | 4.60 | -2.499 | * |
| Withdrawn/depressed | 3.40 | 2.10 | -1.023 | |
| Somatic complaints | 3.50 | 2.50 | -1.065 | |
| Social problems | 6.30 | 5.10 | -1.205 | |
| Thought problems | 5.80 | 4.90 | -.655 | |
| Attention problems | 8.60 | 7.00 | -1.612 | |
| Rule-breaking behavior | 7.30 | 4.70 | -1.904 | * |
| Aggressive behavior | 16.20 | 11.80 | -1.955 | * |
| BERS-2 | | | | |
| Interpersonal strengths | 19.00 | 25.50 | -1.960 | * |
| Family involvement | 16.80 | 20.70 | -1.684 | |
| Intrapersonal strengths | 20.10 | 25.10 | -1.482 | |
| School functioning | 12.50 | 17.50 | -2.102 | * |
| Affective strengths | 13.50 | 16.30 | -1.483 | |

[a] Decrease in CBCL scores and increase in BERS-2 scores indicate positive change; Probability: * = < .05;

[b]Youth gender: 8 = *male*, 3 = *female*. Youth age: 7-11.