The Impact of Implementing an "Incredible Years" Group Within a Family Living Unit in a Transitional Living Shelter: The Case of "Cathy"

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ABSTRACT

Young children who experience homelessness have a markedly increased risk of behavior disorders. This case study illustrates the impact of the "Incredible Years" (IY) program, an evidence-supported group psychotherapy intervention, on "Cathy," a 4-year-old Latina girl with externalizing behaviors who was living in a transitional program for homeless women and children. Adaptations of the model to address the child and family's trauma history and to allow for its implementation in a residential program are delineated. Qualitative and quantitative data support that the IY group had a positive impact on Cathy and her family and led to significant symptom decreases in externalizing behaviors and PTSD symptoms, as well as an improvement in the quality of child and parent interactions. Additionally, recommendations for future studies and treatment considerations and adaptations for this underserved population are addressed.

Key words: "Incredible Years" Program; children; Latina children; homelessness; externalizing behaviors; homeless residence; case study; clinical case study

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1. CASE CONTEXT AND METHOD

Aim of the Study and Rationale for Selecting the Clients

The aim of the current study was to test the application of the "Incredible Years" (IY) program, a manualized, group therapy intervention (Webster-Stratton & Reid, 2012), with a population of children and mothers recovering from homelessness Child externalizing behaviors, parental

stress, and a high rate of trauma exposure are all common among children who have experienced homelessness. The transitional living facility where the children and mothers resided long recognized the need for parenting intervention by including a required parenting class in their standard program, but prior to the current study such classes did not conform to evidence-based practice. The IY program has been implemented effectively with multi-stressed and traumatized families, including those referred to child protective services. For these reasons, IY offered an opportunity to provide the children and mothers in the residential facility with a best practice intervention to address their unique needs.

The Clinical Setting in which the Group Took Place

The Center for Homeless Women and Families is strategically located in the heart of a large, multi-ethnic inner city, in the area with the highest density of homeless women. The Center has four residences for homeless women, including the facility in the present case study, a transitional residence for women and their children, consisting of 21 individual apartments. The transitional residence program includes case management, employment services, counseling, dedicated children's programming and advocacy services. Residents are required to be employed, in school full-time, or actively engaged in seeking employment. In addition, women are required to participate in the residence's evening programs, which include completing a number of life skills and parenting classes.

Mental health services are provided by a local community mental health center (CHMC), both at the Center's residence and in the CMHC clinic. The CMHC is housed within a large tertiary care pediatric hospital and has a focus on the well-being of children and their families. Interdisciplinary care and training are provided by a diverse professional staff in a number of specialty areas, with an emphasis on evidence-supported clinical practice. The trauma psychology program at the CMHC has partnered with the Center for almost 10 years to provide trauma-informed services, including therapy groups, resident consultation, staff consultation and training and individual therapy for children residing in the facility. The CMHC assigns a staff psychologist to act as primary provider and liaison to the Center. Trauma-informed services are provided by that psychologist as well as other psychologists and psychology post-doctoral fellows specializing in trauma at the CMHC.

In the present study, the IY program was provided to residents in common areas at the Center. The parents' group was held in the communal dining room, with childcare for younger children provided in the childcare center next door. The children's group was held in a room initially dedicated as a children's library.

CMHC staff traveled to the Center each week for group, and transported all IY materials weekly. Holding the group therapy program at the participants' residence made it more easily accessible to them, but also brought some challenges. In addition to the need to bring materials each week, group leaders needed to arrive early to set up, as the furniture in both group spaces had to be rearranged to accommodate the group activities. Shelves and materials in the children's group room offered a distraction to the group members, and this was a factor that the leaders had to adapt to each week. Additionally, people would often be returning books to these

shelves during the group, which also served as a structural interruption and required flexibility of the group leaders and clients. The audiovisual equipment used by both groups (parent and child) each week was not always available or able to be located, and group leaders learned to bring a laptop computer in case they needed to improvise.

Methods

Procedures for Recruitment and Assessment Measures

Among the residents at the transitional residence, all women living with children under age 13 who were eligible for Medicaid were referred for the study. The intervention was provided by staff from the CMHC, and services were billed to the child's Medicaid. In order to introduce the program to the residents, the CMHC psychologist assigned to liaison with the shelter program held an informational meeting and family barbecue. The purpose and structure of the group program was explained verbally and with flyers. The same information was provided to residents by the Center staff during resident meetings and posted in the common area. No mother declined to be contacted regarding the group program. The CMHC intake coordinator contacted all the women to verify eligibility and arrange an initial appointment. Each child received an individual mental health assessment with a CMHC clinician. The purpose and structure of the group was reviewed individually with each caregiver, as well as the fact that participation in the program would meet the residential program requirement of a parenting class.

Initially, 11 women were referred to the program, with a total of 15 children under the age of 12. Based on the ages of the children referred, the IY Preschool Program was chosen for the children, and childcare arranged for those too young to participate. Of the initial 11 referred, 7 completed the initial assessment with one or more of their children for participation in the group. Of these families, four mothers were Latina, one African American, one Caucasian and one declined to indicate ethnicity. One family left before the group began and another family left 4 weeks into the program. Two of the mothers in the parents' group had children too young for the child program; childcare was provided for them to enable participation in the group.

One additional child, an older sibling of a participant in the group, was enrolled in the program 6 weeks after it had started. This is not common practice for the IY programs as its developer intends to keep closed groups. In this case, his mother was already in the parents group and the child was willing to participate and needs to participate were identified. In sum, of the original 11 women and 15 children referred to the program, 4 women and 5 children participated. See Table 1 for children's ages and weekly group attendance.

As listed in Table 2, the families were administered several standardized assessment measures before beginning and after completing the group. The Youth Outcome Questionnaire (YOQ), which is an omnibus measure of mental health functioning, and the Eyberg Child Behavior Inventory (ECBI), which measures externlizing behaviors, are used routinely at the CMHC to obtain pre and post outcome measures for IY groups. In addition, child and parent stress and trauma measures, specifically the Trauma Symptom Checklist for Young Children

(TSCYC) and the Parent Stress Index-Short Form (PSI-SF), were administered to obtain additional information about the children's and mothers' trauma exposure and current stress levels. Finally, mothers were administered the Detailed Assessment of Posttraumatic Stress (DAPS, Briere, 2001) at the second group session.

Following the initial intake and screening, the children and mothers were invited to complete the measures on a separate evening, so as to not disrupt the group process. The families were informed that the information from the standard IY measures would be used to help make the group effective for their children and that the additional measures of parental stress (PSI) and trauma (DAPS) were voluntary.

In order to maintain fidelity to the IY model while also addressing the unique needs of the group participants, several strategies were utilized. All group leaders participated in initial training and weekly group supervision of leaders with an IY expert.. All four group leaders consulted after each session to discuss progress, challenges and possible adaptations for the upcoming sessions. The child group leaders, also co-authors (MB and PH), maintained both therapeutic process and progress notes on a weekly basis. These were then reviewed and analyzed in order to bring up in supervision, to monitor progress and to discuss adaptations. The authors also referred to these notes in order to complete this manuscript. Based on a review of the literature on IY with trauma-exposed families, the therapists adapted the structure and format to meet the needs of this setting and specific population. Adaptations included conducting one or two home visits for each family, more generally utilizing a trauma-informed understanding of the children's and parents' participation and progress in treatment.

Confidentiality

As a partner to the Center for Homeless Women and Families, the CMHC clinic liaison was able to communicate with Center staff for the purposes of coordinating services. Center staff were kept informed of each woman's decision to participate, completion of the intake process and attendance at group. Diagnosis, individual history, family history and the individual content of the groups were not shared with Center staff. The initial individual appointment for each family included a review of confidentiality and the limits with regard to mandated reporting and coordination with Center staff. The clinic's standard HIPAA information was also provided, with the caregiver's receipt documented. At the initial caregivers' group session the leaders reviewed expectations for the group, including confidentiality. However, group members' sense of privacy in the group was impacted due to the group members all living at the same residence. The group leaders set clear expectations and modeled care and respect regarding group members' confidentiality.

2. THE CLIENT

At the time of the IY group, Cathy, a 4-year-old Latina girl with a history of homelessness, had never attended daycare or a school-type setting. The family consisted of her mother, Ms. Z., who was in her late twenties, and Cathy's 9-year-old sister, Yvette. Cathy was referred by the Center staff due to defiant behaviors as reported by Ms. Z. Cathy was described

as having externalizing and acting out behaviors. Her sister Yvette had a more anxious presentation, and she was described as "bossy" and "controlling," and hypersensitive to conflict, noise and negative affect. Ms. Z described Cathy and Yvette as opposites, with the Cathy being "the devil" and the elder sibling as "the angel." Their mother admitted to needing help with both of their behavioral presentations and stated it was impacting their home and school (for the eldest) functioning. Neither child had received mental health services prior to enrollment in this IY group. At other times, Ms. Z stated that she had the most "problems" with Cathy and that Yvette was "not a problem."

3. GUIDING CONCEPTION, WITH RESEARCH AND CLINICAL EXPERIENCE SUPPORT

Homelessness and Trauma

On any given day, an estimated 200,000 children in the United States are homeless. Homelessness can result from previous traumatic experiences and factors often associated with homelessness can be traumatizing for children and families. Homelessness represents a level of poverty that can greatly impact the well-being of children living in this environment, including but not limited to traumatic life experiences, parental psychopathology, lack of support systems, family problems, parental loss, violence, school/placement disruptions, and exposure to violence (Menke, 1998; Obradovic, 2010). By the age of 12, 83% of homeless children have experienced at least one violent event and 25% witnessed violence in their families. Unfortunately, research indicates there is a high level of unmet mental service needs among homeless families (Lee et al., 2010; Zima, Wells & Freeman, 1994).

Homelessness, Trauma and Children's Behavioral Issues

The impact of homelessness on children and families can have detrimental effects on a child's cognitive, emotional, physical and psychological development (Institute of Medicine, 1989; Menke, 1998; National Coalition for the Homeless; 2009, U.S. Department of Health and Human Services [USDHSS], 1990). Research indicates that children living in supportive housing have high rates of emotional and behavioral difficulties (Lee et al., 2010) and are as much as three times as more likely to exhibit behavioral or emotional problems compared to their non-homeless peers. For example, in Los Angeles County, more than three fourths of homeless children are reported to have at least one serious emotional, academic or behavioral problem with few receiving appropriate services (Zima, Wells, Benjamin and Duan, 1996). Studies suggest that children with documented abuse do not all suffer from PTSD but from a variety of other disorders such as oppositional defiant disorder, attention deficit hyperactive disorder and other disruptive behavioral disorders (Teicher et al., 2003).

Epidemiological studies have been conducted on child samples exposed to homelessness, but less focus has been given to the treatment interventions for the specific problems of this population. Similarly, the literature on the protective processes and interventions that contribute to symptom improvement in homeless children are limited (Obradovic, 2010).

Homelessness, Trauma and Impaired Parenting

Ninety-two percent of homeless mothers have experienced severe physical or sexual abuse during their lifetime, and 63% have experienced intimate partner violence (Bassuk et al., 1996). Homeless mothers have three times the rate of PTSD and two times the rate of substance abuse disorders as the general population (Weinreb et al., 2006); higher rates of depression (U.S. Department of Health and Social Services Administration on Children Youth and Families, 2006); and increased rates of chronic physical illness (Weinreb et al. 2006). However, their participation in mental health services is much lower leading to higher risk for continued homelessness, victimization and impaired parenting. Additionally, studies support that parental distress is associated with child behavior problems (Zima, Wells, Benjamin and Duan, 1996).

Evidence-Based Approaches to Youth Externalizing Behavior

Multisystemic Therapy (MST) is an individualized, family-based treatment developed to treat severe behavioral and emotional problems in youth. MST is highly influenced by systems theory and the work of Bertalanffy (1969), as well as Bronfenbrenner's (1979) social ecology theory. MST is an evidence-based treatment that has shown empirical success with treating children and adolescents with antisocial-like behaviors (Henggeler et al., 1998) and children and adolescents with severe emotional disturbance (Henggeler et al., 2002). Treatment studies have identified MST's success with more specific populations. For example, MST has shown significant and long-term progress with children and adolescents' overall mental health (Kazdin & Weisz, 1998), with adolescents' violent behaviors (Elliot, 1998), with adolescents' substance abuse (Stanton & Shadish, 1997), and with juvenile offenders (Henggeler, Melton, & Smith, 1992; Borduin, 1999; Borduin et al., 1995).

Empirically Validated Parenting Programs

Positive Parenting Program (Triple P; Sanders, 2008; Sanders et al., 2004) is a parenting program with evidence for preventing social, emotional, and behavioral problems in childhood; for reducing child maltreatment; and to strengthening parenting and parental confidence.

Parents Under Pressure (PUP is an individualized parenting treatment approach for families who are facing adversities. Its overarching goal is for the family to develop positive and secure relationships with their children. Studies established success with improving family functioning in substance abuse recovering families (Dawe & Harnett, 2007; Dawe, Harnett, Rendalls, & Staiger, 2003) and with reducing child abuse potential in at-risk families (Harnett & Dawe, 2008).

Parent–Child Interaction Therapy (PCIT) is a treatment that includes child-parent dyads and was adapted to treat abusive parents and their children (Eyberg & Robinson, 1983). A controlled comparison study showed effectiveness at reducing recurrence of physical abuse compared to a standard parenting group (19% vs. 49%), while demonstrating reductions in negative parent-child interactions (Chaffin et al., 2004). Timmer, Urquiza, Zebell, and McGrath (2005) also found that PCIT increases compliance and reduces behavior problems with

physically abused children. Although PCIT addresses child-parent interactions, it does not target the child's emotional distress (Runyon & Urquiza, 2010).

Alternatives for Families: A Cognitive–Behavioral Therapy CBT (AF-CBT) has shown effectiveness in treating this population (Kolko, 1996). Composed of child-directed, parent-directed and family directed components, AF-CBT demonstrated greater improvement on measures of child externalizing behavior problems, parental distress, abuse risk and family conflict, in addition to reducing relative improvements in depression and anxiety. In AF-CBT, children learn coping strategies, affect regulation skills and cognitive processing skills to address coercive parenting experiences.

Combined Parent-Child CBT (CPC-CBT; Runyon, Deblinger, Ryan, & ThakkarKolar, 2004) addresses both the at-risk parent and the traumatized child by using child-parent dyad interventions in addition to addressing the PTSD symptoms directly. Major components of CPC-CBT include: systematic consequence review; motivational interviewing, gradual exposure and processing to reduce PTSD symptoms; and a child's abuse narrative to increase child-parent open communication about child-parent interactions. Two recent studies support CPC-CBT's effectiveness. A pilot study with 12 caregivers demonstrated significant pre- to post-treatment reductions in the use of physical punishments; in caregivers' depression and anger; and in the children's posttraumatic stress symptoms, depression and behavioral problems (Runyon, Deblinger, & Schroeder, 2009).

Consideration for Group Intervention to Address Parenting-Related Issues and a Child Externalizing Behaviors

The "Incredible Years" (IY) program, described in detail below, was chosen instead of the above programs because of the group component in IY. The benefits of group intervention were considered to be best suited to address parenting-related issues as well as to address child's externalizing behaviors. In terms of addressing parenting issues, the group format allowed the following:
• Reduces social isolation among caregivers
• Desensitizes participants to talking about their experience and homelessness
• Normalizes their experience as homeless.

In regard to addressing children's externalizing behavior, the group format allowed the following:
• Reduces social isolation among children
• Teaches content within developmental context
• Provides visual alternatives for all verbal materials
• Provides directive teaching approach
• Keeps a structured format
• Uses developmentally appropriate language
• Allows for slower pace/comprehension checks
• Keeps room for repetition, rehearsal and reminder phrases

- Social coaching and social learning provide opportunities for group leaders to model appropriate behaviors and for group participants to learn from other peers
- Uses Behavioral management/positive reinforcement system
- Uses of proximal praises (praising peers for desired behavior in order to change one group member's behavior)

Moreover, the group formats are cost effective interventions in comparison to individual interventions. Lastly, the homeless shelter requested the CHMC to provide a group intervention to their residents to address both mother's limited parenting skills and to target the children's externalizing behavioral issues. Of note, the requirements and scheduling of the shelter required mothers and children to be away from the shelter for most of the day as the shelter expected mothers to engage in job search and training and apartment hunting, in addition to the other groups that they had to attend at the shelter. Thus, a group intervention made it most feasible to reach a larger number of residents.

The "Incredible Years" Program

The "Incredible Years Child Dinosaur Treatment Program" is an evidence-based practice aimed at reducing children's aggression and behavior problems and increasing social competence at home and at school. It is comprised of both a parent group called the Preschool-Age BASIC Parent Training Program (Ages 3-5) and a child group called the Incredible Years School Age Basic Program. Both the Parent and Child group run concurrently (Webster-Stratton, 1980-2011). The groups include 18-20 sessions and each session runs for 2 hours.

The IY model is derived from several theories. Its major influence is cognitive social learning theory. More particularly, it is derived from Bandura's notion of modeling and self-efficacy; Piaget's developmental interactive learning methods; and Patterson's theory of coercion by negative reinforcement in the development and maintenance of deviant behaviors. The latter theory of Patterson is particularly important:

> The dyadic coercion process is built on the concept of negative reinforcement, where one family member's behaviors are maintained by the removal or avoidance of the aversive behavior of the other. The "classic form" of coercion begins with a conflict bout, when one member presents an aversive stimulus to some other member of the family. Example: A mother says to her two sons, "You two! Stop that fighting." They continue. When the younger one begins to cry, she shouts at the older boy, "Stop hitting your brother," and hits him with the flat of her hand until he begins to cry. He stops fighting with his younger sibling. As soon as the mother hits the older son, the fighting stops immediately. In this exchange, the mother has learned that her hitting behavior effectively removed the aversive stimulus, and thus she is more likely to resort to the same pattern of responding in the future. Hitting was negatively reinforced (Patterson, 2005, p. 1).

The IY programs also draw from cognitive strategies to challenge angry, negative and depressive self-talk among parents and to increase parenting self-esteem and confidence. Thus, the IY program relies on several group methods to model appropriate behaviors, teach alternative behaviors, and have the group participants rehearse the newly learned behaviors with live

feedback from the group leaders. For the children's group, these strategies include: Puppet Therapy; Role Plays; Video Vignettes; Social Interactions with Coaching; Creative Activities (Art, Games, Songs); Weekly Homework; and a Reward System.

Life-sized puppets include five year-old "Wally" and his four year-old sister "Molly," who both participate in the group along with the children. Additional puppet characters, "Tiny" the turtle, the school director "Dina," and the dinosaur and her newborn "Baby Dina" are also used. The puppets are operated by the child group leaders and act as active members of the group. They are used to model expected behaviors and to teach relational strategies.

The parent group also utilizes social modeling strategies including: Role Plays; Video Vignettes; Group Members Learning from One Another; Social Interactions with Coaching; Weekly Homework; and Frequent Verbal Praises and Tangible Rewards. This allows parents to learn new parenting strategies, observe it being implemented and practice it themselves.

Incredible Years Programs in a Homeless Shelter

To our knowledge, there is no current literature describing the applicability and effectiveness of the use of IY programs for families exposed to homelessness. Further, there are no published case studies documenting the progress of a group participant while considering its application from a trauma perspective.

The IY Parenting and Child programs are evidence-based treatments with a longstanding history of reducing child externalizing problems in community samples of disadvantaged families (Webster-Stratton, 1998; Gross, Fogg, Webster-Stratton, Garvey, Julion, & Grady, 2003; Miller Brotman, Klein, Kamboukos,Brown, Coard, & Sosinsky, 2003), including with families involved in the child welfare system (Webster-Stratton, 2009; Webster-Stratton & Reid, 2003).

In the research, risk factors including teen or single parenthood, very low income, and high initial levels of externalizing problem behavior showed no moderator effects, suggesting that the IY programs were as effective with the most disadvantaged families. Moreover, children of depressed mothers showed greater improvement of their externalizing behavior problems (Gardner, Hutchings, Bywater, & Whitaker, 2010). The IY model may be particularly relevant to families with a homelessness history as it addresses many of the complexities experienced by this population as described above. In addition, as mentioned above, because the IY model is group based, it allows families to build supportive networks while at the same time it reduces stigma, increases parental participation (Hurlburt, Nguyen, 2008), remains less costly than individual treatment, and considers the multiple stressors that families often endure and negatively impact their parenting (Webster-Stratton & Reid, 2012).

In order to address the unique needs of the mothers and children living at the shelter, adaptation and accommodations were made to the IY curriculum based on those proposed by the developer for use with families of maltreated children (Webster & Reid, 2012). Implementing the group therapy programs within a shelter facility also raised challenges to fidelity to the IY manual, and group leaders used consultation with other experienced IY leaders to address these

issues as they arose. Adaptations for this population are decribed below in the Treatment Plan description in the Case Formulation section below.

In the case of Cathy discussed in this manuscript, all four group leaders (2 in the child group and 2 in the parent group) received extensive training at the CMHC in both the child group and parent group programs from an IY certified trainer prior to starting the IY groups. This training is required by the IY program developer in order to be able to maintain fidelity to the model. Moreover, the group leaders participated in weekly supervision with an IY trained trainer at the CMHC. The level of experience with IY varied among group leaders, but this was the first time any of the group leaders had led an IY group in a transitional living shelter. The two group leaders for the child group are also authors of this manuscript (MB and PH). All four group leaders had prior experience working with children who had experienced various traumatic life experiences. All four group leaders were either first or second year psychology fellows completing their APA-accredited post-doctoral fellowship in clinical psychology.

4. ASSESSMENT OF THE CLIENT'S PRESENTING PROBLEMS, GOALS, STRENGTHS AND HISTORY

Demographic Information and Client's Family

For the length of the IY group, Cathy lived with her mother, Ms. Z, and her 9-year-old sister, Yvette, at the transitional living shelter. Mrs. Z identified both her daughters as Latina, as she did herself. She reported that both girls' fathers were also Latino. Mother was at this shelter due to the domestic violence she experienced in multiple relationships, including that with Cathy's father. The family was fluent in English and Spanish; however, Spanish was the predominant language spoken by mother.

At this shelter, the family received a private, furnished apartment and was expected to sign in and out daily. Ms. Z was involved in fulfilling the shelter requirements by looking for a job during the day and attending various classes on financial management, housing, case management and parenting. Attending the IY group fulfilled a parenting class requirement initiated by the shelter staff as part of her program. Ms. Z stated she did want to be part of the group due to Cathy and Yvette's fighting and other behavioral concerns. Ms. Z openly shared that she had post-partum depression after Cathy's birth, and that her clinical depression had continued to the day of the intake.

Additionally, Ms. Z shared that she had had a history of depression and anxiety prior to Cathy's birth. Ms. Z also stated she was in an emotionally and physically abusive relationship with Cathy's biological father. Thus, Cathy and her sister have a longstanding history of witnessing domestic violence. Yvette was exposed to verbal and physical violence from birth.

Ms. Z reported that she had conflicts with Yvette's father and her own extended family and moved in with Cathy's father prior to Cathy's birth (when mother was pregnant with Cathy), when Yvette was about 5 years old. Throughout her pregnancy with Cathy, Ms. Z reports high stress, verbal/loud fighting and physical assaults inflicted by her biological father. The intensity,

frequency and length of the domestic abuse and the relationship between Cathy's father and her mother are unknown; however, Ms. Z reported contact with Cathy's father stopped when Cathy was one year old and Yvette was six.

Ms. Z reported moving to a hotel when Cathy was one year old, then to an emergency shelter, followed by two other shelters and finally to her current placement. Per Ms. Z's report, Cathy had moved four times since she was 12 months old and Yvette was five years old, with their current shelter being Cathy's fifth residence. Ms. Z reported that Cathy and Yvette witnessed difficult situations (details not provided) and were exposed to mentally unstable people during these multiple transitions. However, details of the conditions and situations were not provided. All of these previous placements were located in different cities, and Ms. Z stated she had no support from friends or extended family.

Ms. Z reported that neither Cathy nor Yvette currently had any contact with their biological fathers. Ms. Z reported an extensive family history of drug use, incarceration and physical abuse. She stated that she has never used drugs in her life due to what it has done to her family members. Despite these stressors, Ms. Z reported that Cathy met her developmental milestones within normal limits.

Ms. Z did not provide specific information about her educational background, but her writing ability in response to the group evaluations show solid skills.

Standardized Measures Employed in the Case

Ms. Z completed the following standardized measures, which are described in more detail in Table 2 (the first four measures were completed pre- and post-therapy, and the DAPS, only at pre-therapy.)

• The Youth Outcome Questionnaire (Y-OQ; Burlingame, Wells, & Lambert, 1995), a measure of a parent's perception of her child's overall progress in therapy (see results in Table 3).

• The Eyberg Child Behavior Inventory (ECBI; Eyberg & Pincus, 1999), a measure of a parent's perceptin of her child's externalizing, acting out behaviors (see results in Table 4).

• The Trauma Symptom Checklist for Young Children (TSCYC; Briere, 2005), a measure of a parent's perception of her child's trauma-related and abuse-related symptoms (see results in Table 5).

• The Parent Stress Index Short Form (PSI/SF; Briere, 2001), a self-report measure of a parent's experienced stress in relating to and managing her child (see results in Table 6).

• The Detailed Assessment of Posttraumatic Stress (DAPS; Briere, 2001), a self-report measure of an adult's peritraumatic, posttraumatic, and related symptoms (see results in Table 7).

The Parent's View of Client's Problems

Upon intake Ms. Z described Cathy as demonstrating frequent tantrums (three times a week of yelling, screaming and crying fits); physically aggressive behaviors towards her older sister (pinching, pushing and hitting her); and extreme "moodiness." These behaviors reportedly began after their last move to the current shelter. Ms. Z strongly agreed with the following items on the pre-group PSI/SF measure: "My child gets upset easily over the smallest thing," and "I feel that my child is very moody and easily upset." Pre- and post-test scores on the parent report measures of Cathy's behavior can be found in Tables 3-5, which indicate a number a scales on which Cathy was above the cutting point of clinical-level problems, such as the Total Score on the Y-OQ (Table 3); the Intensity and Problem scales on the ECBI (Table 4); and the Anger/Aggression Scale on the TSCYC (Table 5), with the latter representing Ms. Z's particular complaint about Cathy's externalizing behaviors.

Ms. Z was invested in helping Cathy and Yvette to overcome the past trauma (witnessing domestic violence and unstable living environments) they had experienced. She showed insight as she made a connection between these past situations and the family's current functioning. However, Ms. Z had a difficult time seeing the connection of Cathy's day-to-day problem behaviors in light of her previous difficult life experiences and instead would frequently interpret Cathy's acting out behaviors as components of Cathy's personality. Cathy's behavioral challenges were especially striking to Ms. Z in light of Cathy's older sister's compliant personality and age-related abilities.

Ms. Z's perspective on Cathy's behavior problems caused daily conflict in the family. Several times during the group interactions, Ms. Z was heard describing Cathy as the "devil" and her sister as the "angel." It is unclear how Ms. Z saw and experienced her relationships with Yvette's father and with Cathy's father, as this could also have impacted her view of each child. Based on information provided by Ms. Z, each girl's father was physically abusive. Cathy's older sister demonstrated internalizing behaviors (i.e., keep feelings inside, limited range of feelings, quiet, anxious, sadness, hypervigilent, low self-esteem, self-critical) and had a very different symptom manifestation than Cathy. This dynamic was addressed in the treatment plan for the family as well as individually for the Cathy.

Parent Self-Reported Symptoms

Ms. Z's self-report of her own parenting stress on the PSI/SF can be found in Table 6. The scores show that she endorsed a high stress profile with clinically significant stress levels on pre-group measures of parental stress. For example, she strongly agreed with the following statement on the PSI on the pre-group measures, "Having a child has caused me more problems than I expected in my relationship with my spouse (or male/female friend)." Additionally, examples of some items she agreed to are:

> I often have the feeling that I cannot handle things well.
> I feel trapped by my responsibilities as a parent.
> There are quite a few things that bother me about my life.

Ms. Z admitted to having a history of depression and anxiety as mentioned in the intake above prior to the start of this group intervention. She often made negative statements about herself and her parenting skills throughout the group.

Pre-treatment Ms. Z was administered the DAPS questionnaire for the purpose of gathering information about her trauma experiences, in conjunction with family-centered care planning in order to refine trauma-informed adaptations to the group therapy program. As seen in Table 7, Ms. Z endorsed several traumatic events in the past and scored in the clinically significant range for post-traumatic symptoms; however, because the treatment focus was on Cathy and on Ms. Z's parenting skills, a formal diagnosis was not given to Ms. Z. On the other hand, it was clear through Ms. Z's history and self-reporting that she had experienced multiple traumas in the past that continued to impact her daily functioning and parenting. Referrals to individual mental health services in the community were offered to Mrs. Z. (as they were to other group participants), but Ms. Z declined.

Diagnosis

Due to Cathy's history of interpersonal and living disruptions across her development, her exposure to domestic violence (emotional and physical), and her symptoms beginning at the transition into a new living environment, she was given a DSM-IV diagnosis of Adjustment Disorder with Disturbance of Conduct, 309.3.

Strengths

As described below in section 6 on the course of the group therapy, from the beginning of the group, Cathy demonstrated a number of individual strengths, particularly a desire to participate, a willingness to follow adult directions and an eagerness to follow the lead of other children in the group. Cathy had a difficult time adjusting to the group setting due to no history of daycare or preschool. Though Cathy was shy and did not speak during the first session, she continued to stay in the group and followed some instructions given by the leaders, such as sitting at the table for snack time, coming back to the group after wandering away (after multiple prompts) and occasionally raising her hand to speak (per group rules). As she grew in her comfort with the group leaders and other children in the group, she was able to open up more and each week became more cooperative with the structure. She was helpful towards others and eager to help pass out the group snack.

Cathy also benefited from strengths in her mother and the parent-child relationship. Ms. Z was dedicated to attending the sessions and diligently worked with Cathy to complete the homework each week, ensuring Cathy's attendance and completion of assignments, allowing her to maximize her benefit from the group. Both Cathy and Ms. Z demonstrated a hardworking and dedicated approach to the group.

Although Cathy had relational conflicts with her mother and sister, she presented with a strong bond and sense of comfort with them. She was able to communicate her needs to her mother and sister during play and often asked her sister for the toy the sister was playing with before taking it from her. Cathy presented with high resiliency, as evidenced by meeting her

goals throughout the group while still being in a transitional living environment. Ms. Z was supportive of her daughters' participation in the program and receptive to the therapist's comments and suggestions in her parenting practices.

5. CASE FORMULATION AND TREATMENT PLAN

Case Formation

Cathy is a four-year old Hispanic female with a history of multiple stressors that caused trauma and disruptive behavior symptoms and threatened to impair her healthy developmental trajectory. From birth until the age of 12 months old, Cathy was exposed to her father's physical and emotional violence towards her mother. Cathy had resided in five different living environments since her first birthday, with each move triggered by either conflict in the home or by shelter transitions. Ms. Z stated that she had struggled with anxiety and depression, both prior to Cathy's birth and continuing after, increasing Cathy's risk for behavior problems. In addition, based on Ms. Z's self-reported score on the DAPS assessment (see Table 7), she is likely experiencing posttraumatic stress, which could be impacting Cathy's perspective and development.

Social learning theory posits that individuals learn from one another through observation, imitation, and modeling (Bandura, 1972), and Cathy had seen a good deal of anger and violence between her mother and father. In line with this, research has shown that school-aged children exposed to homelessness, with its various challenges, are at risk of developing mental health problems (Menke, 1998). Ms. Z's symptoms (high stress, anxiety, depression, and unstable living situations); Cathy's trauma exposure (witnessing domestic violence, living in emergency shelters); and Cathy's multiple transitions at a young age could have functioned as precipitating factors triggering the onset of Cathy's disruptive, externalizing behavior problems.

Cathy's externalizing behaviors appeared to have been maintained through a number of personal and contextual factors. Cathy's family structure and routine had changed multiple times leading Cathy to not know what to expect due to multiple living situations. In addition, Ms. Z was experiencing a high level of parental stress, as measured from the PSI/SF (see Table 6).

According to Ms. Z's own statements, Ms. Z experienced anxiety and depressive symptoms on a daily basis as she thought about trying to take care of her children without employment, stable housing, or supportive family or friends. Cathy's symptoms appeared to be maintained and reinforced by family system factors, such as inadvertent maternal modeling of fear, anxiety, hopelessness and instability. Ms. Z had a limited awareness of healthy parental boundaries and impacts of parental modeling as she shared her financial concerns and stressful thoughts freely while Cathy was present. Ms. Z frequently stated she had to get things done or they (Cathy and family) would have nowhere to live.

In addition, Ms. Z herself identified that she had few models of effective parenting and had difficulty knowing how to respond to Cathy's negative behaviors. During the group, she sometimes wondered how her own lack of parenting models might impact her children. In line

with Patterson's above-mentioned theory of coercion by negative reinforcement in the development and maintenance of deviant behaviors, Ms. Z tended to provide Cathy with negative attention for misbehavior, and was less likely to attend to her when she was not a "problem." In addition, Ms. Z's view of Cathy as "the devil" likely increased her attention to and thus reinforcement of behaviors that confirmed this point of view. This parent-child dynamic likely impacted Cathy's externalizing behaviors.

The family had many strengths that were seen as personal protective factors for Cathy and could lead to a positive prognosis. These strengths included Ms. Z's dedication and investment in the group progress and desire to help her children and herself to recover from the trauma and stress they had experienced. Ms. Z demonstrated protectiveness in moving from environments that were unsafe for Cathy and the family. Ms. Z clearly had set Cathy and her sister as a priority and was motivated to do what was needed to secure housing and help them succeed as a family in spite of feeling tired, overwhelmed, anxious, and depressed.

Treatment Plan

Cathy was seen as a good fit for the IY group due to her externalizing behaviors and Ms. Z's elevated levels or parental stress. The IY group was created with the goal of decreasing disruptive behaviors in children by increasing their coping skills. Parental knowledge and parenting skills were addressed in the parent group. Due to Cathy's symptoms stemming in part from family systemic problems (including witnessing domestic violence and subsequent homelessness) and lack of early intervention (Cathy had not attended any form of daycare or schooling prior to her intake), she presented as a child who could benefit from participating in the IY program. In addition to the specific skills taught in the group, it was believed that the IY group's structure and format would provide a sense of predictability, consistency, and safety, all of which had been lacking in Cathy's life, which exacerbated her acting out behaviors.

Cathy's Motivation

During the first session Cathy did not speak to either child group leader and was minimally responsive to instruction, engagement or structured activities. It was clear from the first session that Cathy would need additional engagement strategies and efforts to become part of the group due to her limited response and anxiety in the beginning of the group. Both group leaders discussed Cathy's history and conceptualized that Cathy was exposed to many different people over the course of her five living arrangements and appeared to be suspicious and fearful of others.

The child group leaders therefore made specific adaptations to the IY group structure to engage Cathy and help her to engage in the group process. Adaptations included, but were not limited to: an extended transition period at the beginning of the group; the addition of visual cues, allowing for more physical engagement (e.g., having children holding the physical cues, moving from one area to other, and engaging in interactive learning such as in an egg hunt); using an individualized behavior checklist; using individualized goals; having lower expectations

in terms of learning and attentional capacity; and employing thoughtful/intentional incorporation of food due to limited resources of the families and conducting home visits.

Developmental Considerations

The child group leaders considered Cathy's history and lack of schooling or daycare in helping Cathy to adjust to the structure of the group. The group leaders helped Cathy's mother to understand Cathy's quiet and anxious presentation in light of this being her first experience in a structured setting. In light of Cathy's unpredictable past living situations, group leaders made a point to encourage and highlight the importance of structure and predictability for Cathy in the home setting and in the group setting. Examples of this encouragement included decreasing the mother's verbalizations about stressors to her children; having the mother use behavior charts to encourage positive target behaviors in her children; and priming both siblings for changes/transitions with warnings and some age-appropriate explanations.

Targeting Maintaining Factors in the Family

Based on an understanding of her mother's inadvertent reinforcement of problem behavior through negative attention, a parenting intervention was essential to reduce factors that maintained Cathy's negative behaviors. All parents participated in the parenting program. Multiple randomized clinical trials have demonstrated that parents who have participated in the IY parenting program display more positive parent interactions with children and reduced criticism and harsh discipline (Webster-Stratton, 2001).

In addition, group leaders from the child and parent groups worked together with the families to engage them at a relatable and hands-on level by conducting one home visit during the group cycle. One group leader from the parent group and one from the child group visited Cathy and her family in their transitional living apartment.

The group leaders focused on providing feedback and support for the home to help Cathy and family become more successful in the implementation of the home interventions. For example, group leaders provided comments and feedback for placement of the rewards chart and homework placement. Cathy's mother had Cathy's and Yvette's papers stacked in a large pile of "important papers," making it difficult to find specific worksheets or homework. The group therapists provided a simple suggestion of keeping the rewards charts and papers of importance for the whole family in an easily accessible place, such as on the refrigerator as a reminder to Cathy and the family. The group leaders also offered praise and modeled the IY specific praise interventions with Cathy's mother to encourage further motivation and use of the technique.

Treatment Goals

Cathy's individual goals were developed to address her relational acting out with Yvette, her mother, and her peers in order to help prepare her for attending school for the first time. Due to Yvette being in the same group, the group leaders were able to make individual goals for Cathy and Yvette to help decrease conflict between the siblings. Cathy's group therapy goals focused on:

- increasing Cathy's appropriate interpersonal interactions with her peers and sister,
- decreasing Cathy's moodiness and aggressive physical and acting out behaviors, and
- increasing Cathy's school readiness, including age-appropriate independent action and following the rules (to encourage compliance in the home and future school setting and to help decrease symptoms of noncompliance and ignoring others).

Yvette's individual therapy goals focused on:
- increasing age-appropriate social interactions (e.g., sharing with others, not "bossing around" her sister, decreasing controlling behaviors toward her sister and peers, which had limiting friendships and conflict in the home),

- increasing appropriate sharing of thoughts and feelings (Yvette had a limited range of expressing feeling, which appeared to stem from her desire to be seen as the "good" daughter), in order to reduce her depressive symptoms, and
- decreasing verbal and physical fighting with Cathy.

6. COURSE OF TREATMENT

Weekly group participation is outlined in Table 1. As shown, Cathy attended all sessions but two of the 22-session program. The same was true of her mother's participation in the Incredible Years Pre-school Age Basic Program. The parent groups and child groups were conducted concurrently at the women's shelter on consecutive Tuesdays in the early evenings.

Cathy participated in the Incredible Years Child Dinosaur Treatment Program along with her sister and other child residents from the shelter. Due to the temporary nature of the family's residence, a transitional homeless shelter, the group remained open for the first few weeks to allow children to join after its start date. Other families left the Center and ended the group before its completion. Thus, as shown in Table 1, not all members who started the group completed the group, and new group members joined the group at session 4 (Yvette, Cathy's sister) and at session 7 ("Michael," a 9 year old boy). Other than Yvette, all the children in the group presented with externalizing behavioral issues.

Ms. Z participated in the Incredible Years Preschool Age Basic Program along with other mothers living at the homeless shelter. The parents' group always took place at the same time as the children's group. As also shown in Table 1, the parents' group size varied every week also due to the nature of being in a transitional living shelter. Some of the reasons group members reported for missing the group were due to having to go grocery shopping, having a job interview, gaining employment or attending appointments for section opportunities to secure housing—all requirements that were put forth by the Center's residential program.

Structure of the Children's Group

A predictable routine is important for children with externalized behavioral issues and with histories of living in unpredictable environments in order to assist them with knowing what to expect, focusing their attention to the task at hand and gaining control over their behavior.

This was especially important for Cathy and her peers as their previous experience was comprised of unpredictable and chaotic environments and unsafe relationships. Consistency and predictability allowed Cathy to learn the routine, engage in the activities, reduce her hypervigilance, trust the group leaders, and learn the material. The IY model takes this in consideration and provides group leaders with the structure as described below. Small adjustments made by the group leaders are also included in this discussion and will be noted in the description of the group process below.

The children's group utilized the following structure:

1. Cathy and the other participants were welcomed to the group during an unstructured play/transition time in which they were allowed to choose their own activity. This assisted Cathy's transition to the group while reducing her anxiety. It also fostered her sense of independence. Cathy often gravitated toward hand puppets (not puppets used by IY group leaders) or books. The child group leaders often extended this transition period to accommodate the needs of Cathy and also to accommodate other group members' late arrival. In our group at the shelter, this transition period ranged from 5-10 minutes (as recommended by the IY protocol) to 30 minutes (which extends beyond the protocol) for a few sessions.

2. To signal the structured part of the group, the group leaders (and the life-sized puppet Wally) initiated the "Welcome Song." Cathy at times joined the song while she chose to not participate other times. After the group members greeted each other during the song, the participants then sat in their assigned seats on the floor forming a half circle.

3. Next, the group usually followed this format:
   – Review Homework/ Check in
   – Review Previously Learned Material
   – Teaching new material using visual cue cards
   – Role Modeling performed by the puppets Wally and/or Molly
   – Role Playing with children
   – Snack/Dinner
   – Video Vignettes with active participation
   – Art activity to reinforce learning and/or social coaching
   – Close circle
   – Counting of earned chips and reward
   – Informing parents group of learning and assigned homework

4. Behavioral management/positive reinforcement system
   Clear cups were set up in the front of the room. Each group member had an individual cup well-marked with their name which was clearly visible to group members. Throughout the session, group leaders placed chips into the cups for desired behaviors. Every time this was done, the group leader verbally described the desired behavior which resulted in earning a chip for the child. For example, when Cathy laid down in her designated area, a group leader would say: "Oh, I see Cathy in her own space area...here is a chip for being in your space!"

In the first few sessions, chips were easily earned and given often by group leaders. This tool was used to increase group members' interest in the group and as a way to indirectly describe group rules and expectations. By using proximal praises (praising peers when trying to shape one child who is not following directions), the child who is not displaying the desired behavior will often realize that his peers are earning chips for a certain behavior which may lead to the child to then display the desired behavior. Thus, rather than placing attention to the negative or undesired behavior, group leaders place their focus on other peers who are displaying the desired behavior. In later sessions, chips become a bit more difficult to earn and may be linked to specific behaviors. For example, Cathy may no longer earn chip for "laying down in her designated area." Now, she is expected to be sitting down in order to earn a chip.

Two reward programs were simultaneously used:

- An individual program in which each group member's chips were counted at the end of each session. Each group member had a reward sheet. With a group leader, group members exchanged their chips for stickers on their reward sheet. Four chips were traded for 1 sticker. Four stickers were needed to trade in for a trip to the "prize box." The prize box was stocked with small, developmentally appropriate rewards.
- A group program in which all group members' chips were collectively counted in order to earn a collective reward (e.g., pizza party) over the course of several sessions. At the end of each session, the total number of chips was counted and placed on a poster for each child to see how many more chips were needed to earn the collective reward. Group leaders reviewed the number of chips earned at the beginning of each sessions.

Structure of the Parents' Group

Before describing the course of treatment for Cathy in the IY Child Dinosaur Treatment Program, the objectives for the Incredible Years preschool-Age BASIC Parent Training Program are summarized below. The program is divided in three main units.

Promoting Positive Behaviors in School-Age Children

The objectives of this unit are the following:
- Understanding how to build a positive relationship with children;
- Building children's self-esteem and self-confidence through supportive parental attention;
- Understanding the importance of adult attention for promoting positive child behaviors and how lack of attention and interest can lead to child misbehaviors;
- Understanding how to use coaching to encourage children's persistence and focus, build emotional literacy, and to encourage social skills;
- Understanding the effects of social rewards on children;
- Building children's self-esteem and self-concept; and
- Understanding how to set up star and point systems to motivate children in an age-appropriate way to address problematic behaviors.

Reducing Inappropriate Behaviors in School-Age Children

The objectives of this unit were the following:
- Creating clear and predictable routines;
- Giving effective commands;
- Implementing Time Out for noncompliance, hitting and destructive behaviors;
- Recognizing how to help children be more compliant;
- Avoiding power struggles;
- Teaching children how to calm down; and
- Recognizing when to use logical consequences, privilege removal or start up commands.

How to Support Your Child's Education

The objectives of this unit are the following:
- Providing positive support for children's reading;
- Understanding how to motivate children through praise and encouragement;
- Setting up a predictable daily learning routine for academic activities; and
- Understanding the importance of working with your child's teacher and advocating for your child.

Course of Treatment in the Children's Group

The Incredible Years Child Dinosaur Treatment Program consists of 18-20 sessions divided across 8 units. In this case, 2 sessions were added by the group leaders to cover all the material. Each unit is named after a dinosaur, as Dina, a dinosaur puppet, serves as the director of Dina School. Dina School is what the group members and leaders will call the group throughout over the course of all sessions. Other puppets, Wally and Molly, both life-size puppets mirroring a 5 and 4 year old sibling set, were present in most of the sessions. Dina's baby, known as "Baby Dina," makes an appearance later in the group and provides and opportunity to review skills learned. Of note, both leaders of the child group are also authors (M.B. and P.H.) of this manuscript.

Sessions 1-2. Apatosaurus: Making New Friends & Learning School Rules

The objectives of this unit are the following:
- Understanding the importance of rules;
- Participating in the process of rule making;
- Understanding what will happen if rules are broken;
- Learning how to earn rewards for good behaviors; and
- Learning to build friendships.

Ms. Z dropped off Cathy and Yvette and introduced her family to the two leaders, one male and one female. Due to her age, Yvette was not an original member of the group. Thus, after meeting everyone, she was brought across the hall where she participated in child care as provided by the residential shelter. In the group, besides Cathy, there were two other children in

this session, Allyson and Jade, both 4 plus year-old girls (see Table 1). Cathy had previously met the female group leader during the intake session. The two other participants had previous experience in groups through preschool. Thus, given their familiarity with group settings, they greeted the group leaders and introduced themselves when approached by Wally. However, Cathy, with her own doll in hand, did not respond nor interact with the group leaders, made minimal eye contact, and remained silent in an almost paralyzed fashion.

Wally, as played by the male group leader, opted to mirror Cathy's behavior in an attempt to normalize her anxiety with the transition and new interactions. Wally made statements such as, "These are new people," and "I'm going to play over here on my own until I'm ready," to verbalize what Cathy may have been feeling at the time. At the same time, Wally made reassuring comments about the group leaders such as "Patrick and Michelle are my friends," and "They are nice people!"

The unstructured play/transition time, typically 5-10 minutes, was extended to allow Cathy to join her peers and Wally at the table. Cathy joined but remained silent with flat affect. The group leaders alternated between using direct and proximal praises to reinforce her participatory behavior and to encourage her to maintain her participation.

Once the group leaders announced the transition to the welcome song, Cathy continued to play on her own rather than joining. She exhibited the same response once the group sat down for the instructions despite encouragement from other group members and the use of prompts and proximal praises by both group leaders. Cathy then joined the group for a bit before getting up and going back and forth with no noticeable response to the reward system of verbal and non-verbal praises. This back and forth continued for several sessions to follow. In the first group session, Cathy went to the corner of the room and fell asleep. Given's Cathy's age, the group leaders agreed on continuing with the group structure for the other group members.

Cathy ended up joining again when dinner was provided. She also participated in the IY game activity at the end of group. With minimal participation from Cathy, the group leaders were left with several questions after the group. The minimal participation, short attention span, and of lack of response to any structure quickly challenged the decision to include Cathy in the group as she was the only participant who never had had classroom experience in the past.

Following the first session, during the debriefing period, the group leaders of the child and the parent group agreed to give Cathy both time and support to adjust to the IY group. Strategies to assist her included speaking with mother about having Cathy nap prior to the group, including more age appropriate and engaging activities, providing shorter instructions, allowing opportunities for Cathy to move around often, using a designated sitting area that was appropriate and enjoyable for her, and using more visual cues and prompts while remaining flexible and understanding of Cathy's capacity. At the same time, it was important to consider how these strategies might have impacted the other group members as they were all a bit older than Cathy. These strategies and adaptations were observed to also be helpful to the other group members, who also engaged actively with the additional visual cues and prompts. The other members frequently received positive reinforcement (such as praise) for their engagement in

following the rules and appeared to experience positive benefits from being identified as models in the group.

In addition, due to the extended transition period needed, the group leaders discussed adaptations in order to prioritize the material, increase engagement strategies, and add games/visuals. One of the usual components of the first group session, demonstrating and practicing time-outs, was not covered as planned due to the extra engagement time needed. The group leaders therefore agreed to spend another session in this unit to review the rules and practice the time-out sequence. This allowed Cathy to adapt to the structure, feel more comfortable with the group leaders, and know what to expect for undesired behavior such as hitting, before moving on to other material. Interestingly, the group leaders never had to use timeouts during the entire 20 sessions. A discussion of potential reasons will follow in the discussion section.

Sessions 3-4. Triceratops: Detecting and Understanding Feelings

The objectives of this unit are the following:
- Learning words for different feelings;
- Learning how to tell how someone is feeling from verbal and nonverbal expressions;
- Increasing awareness of nonverbal facial communication used to portray feelings;
- Learning different ways to relax;
- Understanding why different feelings occur;
- Understanding feelings from different perspectives; and
- Practicing talking about feelings.

The group leaders introduced feelings to the group through reading a book focused on identifying and expressing feelings. The mix of colors and images offered an important starting point to assist Cathy with identifying basic feelings and learning a vocabulary to express her emotions. Moreover, Cathy was comfortable with this activity as it proved developmentally appropriate and enjoyable for her. When the lesson moved on to slightly more complicated material Cathy lost interest.

Cathy did not participate in the role plays as she wandered off around the room. On a positive note, Cathy left the group by saying "Bye Michelle," "Bye Patrick," and "Bye Wally," indicating that she may have been feeling more comfortable and increasing her trust with the group leaders.

Given the small size of the group, the group leaders decided to invite Cathy's sister to the group as a group participant. She was approached by the end of session 3 and her mother and Yvette quickly agreed to have Yvette join the group. Being outgoing and typically wanting to please adults, Yvette enthusiastically greeted the group leaders and Wally. She also quickly adapted to the structure and rules of the group.

By the 4th session, Cathy's participation level had increased, but Cathy's involvement continued to be unpredictable and sparse. Consequently, it was important for the group leaders to

seize any opportunity for teaching and learning. Prior to moving into teaching new learning in the structured part of the group, the group leaders used the beginning unstructured play/transition period to provide Cathy with opportunities to rehearse some of the previously learned skills. During the transition time, Cathy was typically alert and engaged. She gravitated toward hand held puppets and books that were kept in the room. While Cathy sat down and looked at books or asked group leaders to read to her, the group leaders and Wally used this unstructured time to enhance Cathy's affective identification skills by having her recognize different feelings and also discussing her own feelings with different puppets. As always, Wally's presence reinforced the learning by modeling appropriate affective verbalization by using "I" statements, naming feelings and asking about others' feelings.

Later on in that same session, Cathy actively engaged in one of the structured activities for the first time. The purpose of this activity was to match different feelings to a situation that may provoke certain feelings. Cathy successfully matched several of Wally's feeling faces to corresponding social situations. Cathy showed enthusiasm by smiling.

Cathy's engagement in the activity appeared to have been influenced by the strategies employed by the group leaders. This included using visuals, focusing on basic skills and choosing activities that Cathy was familiar with andthat allowed her to be physically active. Rather than sitting in a group format and raising their hand to answer a question, Cathy and other group members were asked to physically get up and match cut up faces to social situations that were drawn on the board before returning to their seat. Older group members, including Yvette, also appeared to enjoy the moving around and showed respect for the rules by coming back to their seats to wait their turn. They also displayed patience by waiting during Cathy's turn. This was especially important for Yvette, who had the tendency to jump in and answer for Cathy. Praises and reminders were provided to Yvette by group leaders during Cathy's turn. Reviewing the skills in a developmentally appropriate way by the group leaders increased Cathy's and other group members' sense of mastery over the material and enabled Cathy to be successful joining the structured group activity.

Sessions 5-6. Iguanodon: How to be Successful in School (Listening, Quiet Hands Up, Concentrating, Checking and Cooperating)

The objectives of this unit are the following:
- Learning how to listen, wait, avoid interruptions, and put up a quiet hand to ask questions in class;
- Learning how to handle other children who poke fun and interfere with the child's ability to work at school;
- Learning how to stop, think, and check work first;
- Learning the importance of cooperation with the teacher and other children; and
- Practicing concentrating and good classroom skills.

In Session 5 Cathy appeared excited to join the group upon her arrival. She was also much more verbal during the transition period. It was unclear to the group leaders at the time what may have facilitated a smoother transition. Perhaps it was the presence of Cathy's sister

and/or the fact that Cathy's familiarity and comfort level with the group leaders and members had increased. Moreover, as we found out after the group, Cathy's mother shared with us that prior to the group, as taught in the Parent group, she had spent "extra time" with Cathy "playing" while Cathy's sister was at a play date with a peer. This "special play time" is one of the major components of the parents' group. By Session 5, members in the parents' group had learned how to play with their children, practiced this with live coaching during the child and parent group sessions, and were instructed to play at home with their children.

At one point during the group session, Patrick exited the room for a brief time. Cathy asked Michelle, "Where's Patrick?" Upon his return, she greeted him and greeted Wally with a high five. After the welcome song, Cathy transitioned well to the sitting activity as she was intrigued by the new sitting area. The group leaders provided each group participant with his or her own "blanky" to sit on with their name on it. Following the principle of reinforcing behaviors that approximate behavioral goals, both group leaders had agreed to praise Cathy for any instance of her being on her blanket no matter if she was lying down or sitting.

During both Session 5 and 6, Cathy would often speak out of turn and often off topic. While discussing school rules, Cathy would initiate an off-topic conversation with the female group leader. The group leaders were thus faced with a new dilemma. In this unit, the group leaders teach the children to raise a "quiet hand" before speaking, a skill that would serve Cathy well in school and that would promote Cathy's success in this group. On the other hand, given Cathy's quietness and reluctance in participating, the group leaders wanted to increase any vocalization and involvement.

Meanwhile, it became clear that Cathy's sister Yvette was quick to exhibit parentified behavior, intervening at any opportunity she had to either encourage Cathy to participate or to interrupt Cathy's behavior. This needed to be addressed both to have Yvette focus on her own learning and also to allow Cathy to have her own developmental trajectory and to increase Cathy's level of independence. Yvette's individualized goals were then revised to include "focusing on yourself" and "being patient with your sister."

Cathy continued to speak without raising her hand. Cathy did not respond to modeling performed by the group leaders or Wally, and Cathy was also oblivious to proximal praises, that is, modeling praises granted to Cathy's peers. Thus, the group leaders opted for the use of a slight physical prompt (the female group leader would offer a soft rising of Cathy's elbow when she began to speak). This was quickly matched with verbal praise, a high five from Wally, and/or earning of a chip token (see behavioral management system above), all of which which helped Cathy in maintaining her participation.

In regard to keeping Cathy on topic, the use of visual cues and active instructions were necessary. For example, when learning the *Stop, Look, Think and Check* sequence to improve attentional capacity, the group leaders designed an egg hunt activity. In each egg was a visual component of the sequence. In addition to using the cue cards as provided by the IY program, smaller versions were replicated by group leaders and placed in each egg. Cathy appeared eager to participate in this activity as she rapidly joined the activity and opened each egg with

excitement. Cathy was given her own set of eggs to search for to provide her the opportunity to gather her own eggs at her own pace. She also enjoyed putting the sequence in order (1-4), a task that she was familiar with and felt competent in completing. Again, the older peers appeared to enjoy this activity.

Sessions 7-9. Stegosaurus: Wally Teaches Problem Solving Steps (Identifying Problems and Solutions, Finding More Solutions, Thinking of Consequences)

         The objectives of this unit are the following:
- Learning how to identify a problem;
- Thinking of solutions to hypothetical problems;
- Learning verbal assertive skills;
- Learning how to inhibit impulsive reactions; Understanding what apology means;
- Thinking of alternative solutions to problem situations such as being teased and hit;
- Learning to understand that solutions have different consequences; and
- Learning how to critically evaluate solutions (one's own and others).

         Molly the puppet introduced herself during the transition/play time. (In the previous session, Wally had kindly announced her long awaited presence). Cathy appeared to take a liking to Molly. Molly is friendly and well-mannered yet assertive when needed. She is also 4 years old and about to start school next year, just like Cathy. Also, a new group member, Michael, joined this session (see Table 1). This 9 year old male, son of a resident and parent group member, was introduced to the group.

         Once homework was reviewed, Wally and Molly engaged in a conflict in front of the group. They argued about a typical brother-sister dispute over who was going to read a book at the beginning of the session. This led to them pulling the book back and forth and raising their voices. This scripted conflict was short-lived and its purpose served to include the group participants in identifying the problem and generating potential solutions. During this activity, Cathy's attention and participation levels fluctuated. She was unable to describe the problematic situation or volunteer solutions as her older group members did. On the other hand, she identified Wally and Molly's feelings of anger and sadness, demonstrating that her learning from the previous sessions was maintained and that she was aware of the activity. Group leaders hypothesized that her apparent wandering attention may have been related to past exposure to domestic violence and a discomfort with the conflict being modeled.

         Molly sat next to Cathy during the activity, which helped Cathy to sustain her involvement in the activity and permitted the group leader to quickly use Molly as needed at times to model, praise, encourage, prompt, or distract Cathy in regulating her attention. Molly is a well-mannered rule-follower. She sits quietly and raises her hand before speaking. She was also quick to notice and comment when Cathy was displaying desired behaviors: "Hey Michelle, my friend Cathy is doing a great job at sitting down in her space, she needs a chip for that!" The group leader also used Molly to reassure Cathy that the group is safe. Wally also apologized to Molly and to the group for losing his cool. This strategy enabled the group leaders to support Cathy to re-regulate following the earlier conflict between Wally and Molly.

Given the success of the matching game in the previous week, the group leaders designed a similar activity. This time, Wally or Molly described a solution using a visual cue card and provided brief example to illustrate the solution. Solutions include but were not limited to "asking for help," "using my words," and "taking a deep breath." After a new solution was presented, the participants were asked to quickly search a matching card from another pile of solution cue cards. This kept the activity engaging and active and also reinforced learning with repetition. The group leaders found that Cathy's attention level and learning capacity were greater when she was provided with the opportunity to use recognition versus free recall. Moreover, Cathy felt successful, which preserved her excitement and engagement in the activity. Again, Cathy was not expected to learn as many solutions as the other children.

The group leaders faced an unexpected challenge in week 9. They realized during preparation time that the DVD player provided by the Center did not properly function. Therefore, the group leaders chose to perform role plays in order to substitute for the video vignettes. This also created a challenge for Cathy as she had responded more positively to the DVD vignettes than role plays in the past. The solution generated for the subsequent sessions was bringing a portable laptop computer as a backup upon which to play the DVD.

Sessions 10-13. Tyrannosaurus Rex: Wally Teaches Problem Solving Steps (Controlling Anger and Problem Solving)

The objectives of this unit are the following:
- Recognizing that anger can interfere with good problem solving;
- Understanding Tiny Turtle's story about managing anger and getting help;
- Understanding when apologies are helpful;
- Recognizing anger in themselves and others;
- Understanding anger is okay to feel "inside" but not to act out by hitting or hurting someone else;
- Learning how to control anger reactions;
- Understanding that things that happen to you are not necessarily hostile or deliberate attempts to hurt you;
- Practicing alternative responses to being teased, bullied, or yelled at by an angry adult; and
- Learning skills to cope with another person's anger.

The group leaders introduced the unit with a role play in which Wally shared being upset with the group about being teased at school by a peer. Wally displayed a moderate level of anger by expressing his feelings, stomping his feet, breathing hard, and raising his voice. This appeared to startle Cathy (and Yvette). Cathy responded with a freeze-like reaction. Once some of her peers provided some solutions for Wally to calm down, Cathy also seemed to be more present in the group.

Wally quickly apologized for his anger outburst and thanked his peers for helping him calm down. The group leaders again contemplated that given Cathy's exposure to domestic violence, anger and yelling may serve as a trauma reminder and/or trigger for Cathy. It was then important to reassure Cathy that Wally had no potential for violence and had the capacity to calm

down. Meanwhile, it was also imperative for Cathy herself to learn adaptive anger management techniques, given her tendencies to get easily angry and throw temper tantrums at home.

The group leaders had to find ways to increase Cathy's participation in the learning of the anger management steps. The anger management skills are part of the problem-solving skills and are numerous and confusing for a young child. Thus, during the structured teaching period of the group, the group leaders asked Cathy to hold visual cue cards and respond to questions by pointing at some of the cards and visual information as a means to check for comprehension. For example, when holding the visual cue card displaying deep breathing (a skill that was previously learned), she was able to show the card to her peers and demonstrate the behavior to group leaders and members.

Similarly to previous sessions, Cathy became more involved in the learning in the following sessions when puppets were used as a teaching method in the activity and when she was able to engage in a more active role. Tiny Turtle, another IY puppet, paid a visit to review and rehearse the anger management steps. Tiny speaks about using his own turtle shell to take a break from difficult situations and to think of an appropriate solution. Tiny also led a visualization exercise. Cathy seemed to admire Tiny and paid close attention to his teaching. Cathy also rehearsed the anger management strategies by using her own puppet. In the last session of this unit, Cathy made her own turtle shell and rehearsed going in and out of her shell when upset just as Tiny had instructed her. This concept appeared to generalize to other situations as the group leaders and mother observed Cathy using an "imaginary" turtle shell when feeling angry in the subsequent weeks.

Sessions 14-17. Allosaurus: "Molly Manners" Teaches How to be Friendly
(Helping, Sharing, Teamwork at School and at Home)

The objectives of this unit are the following:
- Learning what friendship means and how to be friendly;
- Understanding ways to help others;
- Learning the concept of sharing and the relationship between sharing and helping;
- Learning what teamwork means;
- Understanding the benefits of sharing, helping, and teamwork; and
- Practicing friendship skills.

The group leaders faced another unexpected event. Cathy and her sister missed the second and third sessions of this unit due to a lice infestation. Ms. Z approached the group leaders before the groups and asked if Cathy and her sister could complete their homework despite their absence. The group leaders were pleased with mother's dedication to her children's learning and her understanding of the importance of consistency. The group leaders also sent Cathy and Yvette the dinner that was going to be served during group to their residence. The group leaders agreed to add an extra session in order for Cathy and Yvette to learn the teamwork material before moving on to the next unit.

The friendship skills were taught, as usual, using various methods ranging from teaching with visual cues (e.g., cue cards as provided by the IY program), modeling, having the children observe friendly behaviors on multiple video vignettes, and having the children participate in role plays. Cathy's participation in the learning of the skills appeared more elevated than in the previous sessions, which seemed associated with the fact that the puppet Molly started to take an active role in teaching the group.

Cathy engaged quite well in a teamwork activity in which she and Molly cooperated in drawing a larger poster of Dina, the Dina School principal, while the older participants collaborated on another project. In this activity, Cathy engaged with Molly, displaying various friendship skills, such as asking permission before drawing, taking turns, allowing Molly to make some of the decisions, and sharing materials. This activity appeared developmentally appropriate for Cathy and prepared Cathy well for entering school, which was coming up at the end of the summer.

Sessions 18-19. Brachiosaurus: Molly Explains How to Talk with Friends (Tell, Listen, Ask)

The objectives of this unit are the following:
- Learning how to ask questions and tell something to a friend;
- Learning how to listen carefully to what a friend is saying;
- Understanding why it is important to speak up about something that is bothering you;
- Understanding how and when to give an apology or compliment;
- Learning how to enter into a group of children who are already playing;
- Learning how to make a suggestion rather than give commands; and
- Practicing friendship skills.

Due to more difficulties with technological equipment experienced by the group leaders, the children's group joined the parent's group for some of the session. The children's group watched the DVD vignettes with their mothers. Then, the group leaders facilitated an activity in which the children practiced introducing themselves (including the *Tell, Listen* and *Ask* skills) to one another as well as with one parent from the parent group. It is important to note that although this was the first time that the child and parent group were combined, the children were familiar with the parents as they share the same residence. Cathy was at first reluctant to participate. However, she responded well to Wally's lead and her mother's encouragement. This also provided parents with an opportunity to use the skills they had learned "live" with their own children, with some social coaching and praises by both parent and child group leaders. This combined group was not planned and is not part of the IY protocol. However, as discussed in the debriefing session, it appeared to be a success in reinforcing both children and parents' previously learned skills.

In the next session, most of the learning occurred during structured teamwork activities. In order to encourage and prompt Cathy to utilize her friendship skills during these activities, the group leaders developed a new activity in addition to using social coaching and the reward system. *Friendship Cookies*, a slight adaptation created by one of our colleagues who was a previous group leader at the CMHC, were introduced. In order to bake a friendship cookie, group

participants were required to collect a list of ingredients (aka friendship skills). The group leaders created a list of ingredients that included 2 compliments, 3 instances of sharing, 2 instances of helping behavior, 3 polite questions, and 2 instances of taking turns.

Cathy was provided with her own individualized list, which included pictures of the required ingredients with empty spaces for the number of requirements for each ingredient. As soon as Cathy performed a friendly act, one of the group leaders would put a sticker on the blank space while offering verbal praises and high fives. Cathy responded well to the praises and visual reward system. She was proud to turn in her list of completed tasks. The ingredients were then placed in a pretend oven and then magically re-emerged as fresh baked cookies, which Cathy very much enjoyed. Using the slight adaptation allowed the group leaders to teach all the Friendship skills as designated by the IY program in a way that both Cathy and older group members appeared to enjoy and benefit from.

Session. Graduation

The objectives of this unit are the following:
- Review problem solving skills and friendship skills: and
- Celebrate the graduation from the IY programs.

The puppet Baby Dina was born! In the previous session, Dina had shared that she was expecting a baby and was hoping to introduce her baby to the group. Baby Dina, a small puppet, came out of her egg at the beginning of the structured part of the group. As a newly hatched baby dinosaur, Baby Dina needed to learn all the skills the children had covered during the group. This provided an opportunity to review previously learned skills before moving on to the graduation. Cathy explained to Baby Dina a few anger management skills she had learned from Tiny Turtle.

The IY group typically ends with a graduation ceremony. Accordingly, a combined group was planned for the graduation festivities. Both Cathy and Yvette sat with their mother. Cathy interacted with her peers and the parents' group leaders as well. The festivities included food provided by the CMHC as well as food prepared by most of the families who participated in the group. Dinner was followed by a graduation ceremony. The group leaders invited each family to the stage, one at a time. When Mrs. Z's turn came, the parent group leaders then shared about Ms. Z's commitment to her girls and how impressed they were with Ms. Z's participation in the group and her ability to use positive and consistent parenting skills. The group leaders also provided Ms. Z with a certificate to signify her completion of the IY parent program.

Next, the children's group leaders also shared how pleased they were with the children's participation, including Cathy's participation and her progress along with presenting her with a certificate for her completion of the Dina school. Lastly, Ms. Z shared positive compliments about her two daughters, a speech she had prepared in advance. She highlighted Cathy's improved ability to share her feelings verbally, interact positively with her sister, and comply with her directions. Cathy stood quiet yet proud. She was dressed in a black cap and gown, both

way too big for her. Her mother smiled, cried, and smiled again. Cathy smiled broadly, the same smile group leaders saw when Cathy said she felt comfortable in group.

Unfortunately, an unanticipated event occurred toward the end of the graduation party. Two mothers (not Ms. Z) engaged in a loud verbal argument in front of their peers and children. Yvette, and Cathy both reacted strongly yet differently as the argument escalated. Yvette attempted to distract one of the group leaders by initiating a conversation and posing a series of questions. Conversely, Cathy responded by shutting down just as she did when Wally displayed anger a few weeks prior. Cathy appeared startled for a few minutes even after the two mothers de-escalated. Ms. Z stayed with Cathy and provided calm reassurance. Cathy was able to re-regulate and rejoin her peers with support from her mother, both displaying new skills learned through participation in the IY program.

7. THERAPY MONITORING AND USE
OF FEEDBACK INFORMATION

The use of feedback information, consultation, and quantitative data were used to inform the treatment as the group progressed. Due to the setting and population, this monitoring was key to maintaining fidelity while increasing flexibility and responding to the participants within an appropriate and helpful context. Fidelity to the IY model was maintained through several strategies. Group leaders used video vignettes and scripts contained in the IY leaders' manual (Webster-Stratton, 2001) for each session. Activities were planned for both the child and caregiver groups that were based on examples within the manual. In addition, group leaders met weekly with other experienced IY leaders and a nationally certified IY Trainer for weekly consultation.

Because of the unique needs of the traumatized families participating in the group, the uncertain living context of all of them, and the unusual residential setting of the group, monitoring and feedback was also important in continuing to ensure that the group interventions were tailored to the specific children and families involved.

Quantitative data was gathered after the first session for pre-measures, and in the last week, for post-measures. For a description of the measures collected see Table 2, and for outcomes, see Tables 3-8. This data was gathered at the Center and was scheduled for a day other than the group day so as to not interfere with the group format or take longer than two hours of the participant's time within one session. In addition, due to the full schedules of the parents and many requirements of the transitional living home, dinner was provided for both sessions where they were invited to come and complete the measures.

Information gathered from the pre-treatment data aided in planning appropriately for each individual participant in the parent and child groups as well as providing valuable information about the presence of trauma in the parent group. The participants completed all of the pre-test measures provided, but later several group members shared that the DAPS had been a painful reminder of past trauma for them. Following a discussion in the caregivers' group about their response to the assessment, and their recognition of the impact of trauma exposure on their daily

functioning as well as parenting, the group leaders withdrew the planned post-measure of the DAPS. This was addressed to the group with sensitivity and accommodations were made to provide additional support for the members of the group who had strong emotional reactions to the questionnaire. The group members verbalized that they felt "heard" by the group leaders and stated they didn't feel listened to or respected by many others in the community and in their lives.

This was one example of trauma-informed care, taking the reactions and feedback of the clients into consideration with their best interest at the forefront of the treatment planning. The group leaders provided the parents with additional resources for seeking mental health services that provided either sliding scale fees or were supported by their medical insurance. These resources could provide continuing care resources that were beyond the scope and purpose of this group intervention. Due to the strong reaction the parents had to the DAPS measure, the group leaders took extra caution to provide a safe, validating, and trauma-informed environment throughout the group to aid in successful learning and treatment.

Another tool to enhance both fidelity and flexibility in the program was an arrangement in which the parent and child group leaders met all together weekly after the group therapy sessions to discuss adaptations and to focus on treatment planning. The group leaders also met within their individual group teams to consult and plan for each week.

Also, the child group leaders made additional efforts each week to consult with each parent briefly after or before the group and model appropriate praise and other techniques to encourage positive parent-child interactions.

Additionally, the group leaders offered a home-visit consisting of 30 to 60 minutes. This visit promoted the use of visuals like a behavior chart, deep breathing/coping skills sheets, and cue cards, all from the IY materials presented in IY group. The home visit promoted the use of a positive family living structure, with rule reminders for chores and homework, including the placement of visual reminder sheets on the refrigerator, otherwise separated from the mail, bills and other piles of unorganized papers in the home. The home visit was also an opportunity to observe the child and parents in their daily environment in order to provide hands-on feedback and inform treatment planning. The parents were receptive to this intervention, which included one parent group leader and one child group leader who were able to address the individual learning needs of each family and to encourage each individual's treatment goals.

8. CONCLUDING EVALUATION OF THE GROUP THERAPY PROCESS AND OUTCOME

Quantitative Evaluation by Parent Self-Report

The results on the parent-report measures completed by Ms. Z about her own experiences and attitudes are presented in Tables 3-8. The results from each table are presented below.

The Youth Outcome Questionnaire (Y-OQ; see Table 3)

The Y-OQ (Burlingame, Wells, & Lambert, 1995) tracks change in functioning and includes six sub-scales which yield a total score that indicates whether the symptoms are clinically significant or within normal limits. Cathy's scores on the pre-measures yielded a total score of 65, which indicated clinically significant impairments in overall functioning. Post-measures demonstrate a decline of symptoms on all of the sub-scales, yielding a total score of 35, which indicates a within-normal level of symptoms. The mother's post-score ratings of Cathy indicate that symptoms related to behavioral dysfunction, distress and relational problems substantially decreased, which is consistent with the verbal reports of Cathy's mother, observed behaviors of Cathy in the group setting, and other post-data to be described below.

The Eyberg Child Behavior Inventory (ECBI; see Table 4)

The ECBI measures a parent's perception of a child's externalizing behaviors. Cathy's pre- and post-scores on the ECBI yielded similar results as the Y-OQ in that Cathy scored at the clinically significant level on pre-measures and her post-measures yielded a within-normal score.

The Trauma Symptom Checklist for Young Children (TSCYC; see Table 5)

At pre-therapy, Ms. Z's ratings showed Cathy with scores of 70 and above—that is, above the clinical cut-off point—on the following clinical scales: Depression, Anger/Aggression, Post-Traumatic Stress Avoidance, Post-Traumatic Stress Arousal, and Post-Traumatic Stress-Total. At post-therapy, all of these scores decreased substantially, with all but Anger/Aggression being below the clinical cut-off.

The Parent Stress Index Short Form (PSI/SF; see Table 6)

The PSI/SF yields a Total Stress score from three scales: Parental Distress, Parent-Child Dysfunctional Interaction, and Difficult Child. Ms. Z's Total Stress score was at the 98th percentile pre-treatment, and at the 94 percentile post-treatment. Both scores were above the clinical cut-off point and were not statistically different from each other (see Table 6).

Analysis by the Reliable Change Index (see Table 8)

Jacobson and Truax's Reliable Change Index (RCI) determines whether a pre-therapy to post-therapy change within an individual case on a standardized measure (which meets certain psychometric characteristics) is significant in two ways. It assesses whether the amount of change of a client on a particular measure is *statistically* significant (i.e., more than the unreliability of the measure would suggest might happen for 95% of subjects); and it assesses whether a client's change is *clinically* significant, that is, whether the client moved from being above the "cutting point" defining the psychopathological range of the scale to below that cutting point.

Table 8 indicates the results of the RCI analysis of those measures in Tables 3-6 that met the psychometric characteristics required by the RCI model. As shown there was both clinically

and statistically significant change on four of the measures: the Total Score on the Youth Outcome Questionnaire; the Intensity and Problem scores on the Eyberg Child Behavior Inventory; and the Post-Traumatic Stress Total score on the Trauma Symptoms Checklist for Young Children. The data thus represent a significant decrease of Cathy's post-traumatic, aggressive, relational and externalizing problems at post-treatment. The decrease in Cathy's symptoms were also observed by the group leaders and by Ms. Z. Cathy's participation and relationships within the group setting at the end of the group demonstrated increases in skill level for following structure, for appropriate identification and expression of her feelings, for increased adaptive coping skills, for increased compliance, and for increased ability to regulate emotions.

Quantitative Evaluation of Parent Self-Reports

The results on the standardized parent-self report measures completed by Ms. Z are presented in Tables 6 and 7, including the Parent Stress Index Short Form (PSI/SF) and the Detailed Assessment of Posttraumatic Stress (DAPS).

The DAPS results indicate that Ms. Z is experiencing post-traumatic-stress-related symptoms at a clinically significant level. In a parallel way, the PSI/SF results indicate that Ms. Z was experiencing clinically elevated stress in her parenting role, both at pre- and post-treatment, with no statistically significant change on total stress (see Table 8). This lack of overall change on the PSI/SF seems explained by the fact that, even though Cathy's behavior improved substantially, Ms. Z's family continued to reside in the shelter. Following from this, she was faced with ongoing parenting stress related to meeting the expectations of the residential program and progressing towards greater independence for herself and her family. In the last few months of her time-limited stay, she was in the process of looking for employment and housing (waiting for the approval of her Section 8 housing support) and continued to have limited to no support from family or friends.

On the other hand, it should be noted that Ms. Z's score that directly related to her interactions with Cathy—on the Parent-Child Dysfunctional Interaction scale (see Table 5)—demonstrated a positive decrease, going from a score of 36, above the clinical cut-off point, to a score of 22, below the clinical cut-off point. Due to the nature of the IY group and the goals described throughout, this measure reflects a positive impact on the child and parent interactions.

Qualitative Indicators of Change

The quantitative data described above suggests that the IY programs were effective at reducing Cathy's externalizing behaviors, post-traumatic symptoms (avoidance, arousal), and anger and aggression. Additionally, qualitative data suggest other positive outcome, both in terms of Cathy's own functioning and her relationships with her sister and her mother.

First, group leaders noticed a change in the participation of Ms. Z, Cathy's mother, in the group. At first, she was quiet, reserved and reluctant to participate. As she became more comfortable, she became more active. For example, she showed up early to each group, dropping off Cathy and Yvette to the children's group early and chatting with the children's group leaders

before going to check in with the parent group leaders. In the parent group, she took a more active role in sharing her concerns with group leaders, actively participating in role-playing activities, and having the confidence to share advice and solutions with other group members.

Second, this observed positive attitude and confidence appeared to generalize to her relationship with her daughters. For example, as observed by both the parents and children group leaders, Ms. Z became more equipped in setting firm and appropriate limits with her daughters while being more active and comfortable when interacting and playing with them. This change was noticed not only through Ms. Z's actions. During the initial intake, she described her daughters as "the angel and the devil." At the end of the group, her attitude toward her daughters became much more balanced as she was able to recognize and praise desired and positive behavior while she spoke about undesired behaviors that need to be addressed.

Third, the relationship between Cathy and Yvette also appears to have been positively impacted by their participation in the group. Between the two, group leaders witnessed more age-appropriate behavior. For example, Yvette slowly relinquished her tendency to jump in and "parent" her sister, allowing for group leaders to intervene and for Cathy to become somewhat more independent. Over the course of treatment, this led to Cathy's greater participation in the group activities (e.g., more frequent, longer in duration, and more verbal) and increased confidence for Cathy as observed by group leaders and Ms. Z.

Lastly, the group led to changes in Ms. Z's attitude toward the future and receiving help. She appeared more hopeful about her immediate future (i.e., transitioning into independent living and getting a job), and her more distant future (e.g., Yvette and Cathy doing well in school). Ms. Z also reported being open to receiving ongoing therapy for herself and her daughters.

Outcome Discussion and Conclusion

Adaptations and Accommodations in Implementing the IY Program

As this was our first time carrying out the IY programs in a homeless shelter and given the challenges that the setting and population brought up throughout the group, a discussion about the adaptations and accommodations that were used is as follows. We believe that several adaptations and accommodations were necessary in order to conduct the IY group in the transitional homeless shelter, and that these adaptations were directly and indirectly responsible for the positive outcomes attained.

The IY parent program is not a trauma-focused intervention. It targets improving parenting skills and aims at reducing children's conduct and behavior problems. This was our primary goal in providing the IY programs in the transitional homeless shelter, given that the children exhibited behavioral problems and that the shelter expected parents to participate in a parenting class. However, understanding homelessness from a trauma-informed lens, we recognized the children's externalized behavioral problems and the parents' lack of parenting skills as directly linked to previous traumatic experiences and/or the stressors associated with previous and current homelessness.

Early in the parent group, participants verbalized their needs associated with their past trauma history and current stressors, and how these negatively impacted their parenting, social interactions, and self-regulations skills. In regard to Cathy's case, Ms. Z, even though one of the most quiet parent in the group, often mentioned having the tendency to isolate herself from other relationships and always feeling stressed and "on edge," leading to feelings of depression and inadequacy as a parent. Parents wanted to speak about their own needs with improving their self-regulation, social skills, and problem-solving abilities, all skills similar to what their children were learning in the Dina School. Parents (and co-leaders) understood that past traumas and current stressors got in their way of parenting and functioning.

Moreover, the parents often arrived late to group and/or appeared distracted during the group. Tardiness and unfocused participation may have easily been understood as resistance or transference (e.g., distrust of authority generalized from past experience), as the parents may have just been completing the group as another requirement imposed by the shelter. Many of these families, including Cathy's mother, having been exposed to multiple traumatic events and having experienced ongoing disappointment and maltreatment from other individuals and systems, presented with a generalized distrust of other individuals and systems. Thus, receiving help and believing in changes could at times have been difficult and may have played into some of the behavior demonstrated by the parents.

On the other hand, the group leaders quickly understood that the group participants were under constant pressures from ongoing life stressors and previous negative experiences. The shelter residents faced a state of constant instability. Although they were living in a safe and newly built home-like setting with beautiful amenities, this transitional shelter did not provide long-term stability for the families. Consistent with its mission to support independence, the shelter required parents to be persistently looking for more permanent housing and seeking employment immediately from their move-in date. In addition, their current living arrangement was dependent on the staff's positive views of them as meeting program expectations. This meant increased pressure to comply with the expectations and to remain in good status. This led to high anxiety and worry due to the perceived high demands of the program.

At the same time, the parents verbalized wanting to learn parenting skills and actively participated in role plays. Past trauma reminders, current stressors, and high demands from the shelter proved to be a better explanation for parents' tardiness and unfocused participation than was their resistance and distrust. At times, they seemed preoccupied by thoughts of past traumas. Topics presented in the group, conflict existing between group participants, and responses from other participants were sometimes experienced as trauma triggers by the caregivers.

As a structured, social learning-informed intervention, IY for parents included the presentation and practice of many concepts and skills that were new to them. This did not allow the group leaders to spend time in the group processing issues brought up by the parents or straying from prescribed topics to address trauma. However, accommodations and adaptations were necessary.

The most fundamental modification was for group leaders to continuously understand the parents' and the children's behavior, participation, and stress level from a trauma-informed perspective. Although the parents' past traumas were never the direct focus of treatment, they were directly acknowledged to the mothers throughout the group. Moreover, group leaders remained aware of the direct impact of the parents' past traumas and current stressors and how they manifested themselves in the group and in regard to their ability to learn and apply the presented information.

Group leaders had to display flexibility in adapting the curriculum and teaching the content, while remaining true to the IY model and addressing this population's unique needs. Some examples of the use of flexibility were observed in the group leaders agreeing to allow an atypical age gap in the children's group, which led to Cathy and Cathy's sister Yvette both participating in the children's group. In addition, group leaders conducted home visits with each family in addition to the weekly phone calls that are standard in IY. Having a parent and child group leader meet the family in their own homes led to a better understanding of the barriers and challenges in the family's living situation, while providing opportunities to review previously learned skills and to apply them directly in their environmental context. Providing food prior to the group is an engagement strategy proposed by IY and often used when the IY programs are implemented at the CMHC. The group leaders opted to provide a full dinner in the middle of each group. In order to allow enough time to complete all activities in the children's group, the group leaders served food while the children watched the video vignettes.

Lastly, the impact of engagement skills and therapeutic competence cannot be underestimated. Group leaders continuously validated, empathized with, and empowered families in addition to advocating for their needs with the shelter's staff. Concerns were brought up to the staff to sensitize them to the need for more trauma-informed care and trauma-focused interventions.

Adaptations and flexibility were also imperative for a successful delivery of IY in the children's group. As previously mentioned, conducting this group off site presented many challenges such as additional preparation, transportation of materials, adapting to an environment with unmovable distractions, coordination and communication with the shelter staff, and increased awareness and respect for being in the families' living quarters. The structure and consistency of the group environment is important, and if conducted at the CMHC facilities, this lies mostly within the control of the group leaders. At the shelter, there were times when the rooms were changed or materials were moved or broken that the leaders expected to have available.

For example, upon arrival one week there was a large piano in the room that was not present the week before and was not able to be relocated to another room. The child group leaders were able to format the session away from the piano and provided instructions prior to the group about the room restrictions to promote safety and focus during the group. This is just one example of being flexible in an environment that made it possible for the participants to attend and was largely out of the control of the group leaders.

The Impact of Implementing an "Incredible Years" Group Within a Family
   Living Unit in a Transitional Living Shelter: The Case of "Cathy"
K.C. Rogers, M. Bobich, & P. Heppell
Pragmatic Case Studies in Psychotherapy, http://pcsp.libraries.rutgers.edu
Volume 12, Module 2, Article 1, pp. 65-112, 06-29-16 [copyright by authors]

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These adaptations led to positive attendance, positive attitude, and active participation (despite conflict among group participants and occasional anger with shelter's staff). Parents and children left the group feeling heard, acknowledged, and respected. The group also installed hope for the families as they saw themselves, many of them for the first time, complete an entire program from start to finish.

The Positive Meanings of the Program's "Graduation" Ceremony

Overall, the graduation served several additional purposes not mentioned in the IY objectives. For this population, given their histories of past traumatic experiences, long-standing histories of separations and abrupt terminations, this graduation also served a number of positive functions. Specifically, it functioned as a celebration of the progress made by Ms. Z, Yvette and Cathy; as a way to say goodbye that included normalizing feelings associated with goodbyes; as a way to provide an experience of a healthy goodbye; as a way to prepare Cathy and her family for future predictable goodbyes; and as one more opportunity to highlight the strengths and skills of the family so as to empower them and reinforce the hope and possibility that the new skills they used in the group could generalize to future situations and experiences.

More importantly, the graduation for the families who participated in the IY group, including Cathy's family, signified an accomplishment of completing the entire program from start to finish. For many of these families, constant instability, danger, threats, and financial stressors resulted in multiple transitions, abrupt terminations, premature endings and broken relationships. For example, none of the children had completed a full academic year in the same school. In addition, many of the participating mothers, including Ms. Z, missed the opportunity to graduate from high school. Negative thinking and hopelessness often experienced by individuals who have experienced complex trauma and constant stressors led the mothers to have the belief that their children might also fail to graduate from any organized learning experience.

Thus, for most of the participating families it was a powerful experience to complete the entire 20 weeks of the Dina school, to reflect on their progress, to hear positive compliments, and to see their children wearing a cap and gown with a graduation certificate in hand. One participant shared the following with her son in front of the group:

> Given my situation, I didn't think I would be able to provide for you the opportunity to achieve much. Today, thinking about all that we have been through and with the support of others, I see you now and believe you will be able to graduate many more things in your future.

Ms. Z attentively listened and nodded her head. Her face revealed a sense of accomplishment matched with hope.

Moreover, the outcome revealed that Cathy had made gains in the areas of social skills, effective communication, complying with structure, adaptive coping skills, and positive parent and child interactions. In a complementary way, Ms. Z had made gains in providing structure, praising, enacting positive child and parent interactions, and responding to Cathy's needs—all suggesting that the IY programs were a good fit for this family in this setting.

Finally, Mrs. Z also opted to have her daughters continue with therapy through the CMHC. Prior to participating in the group, she refused to enroll them in mental health treatment. This suggests that her personal experience and observations of the impact of the group program on Cathy changed her understanding of therapy as something that could be helpful for Cathy.

Participating in this group and study was rewarding for all the staff members who conducted or helped with this group due to the high need that is represented by this population. Though it was challenging at times to implement a group in a transitional living shelter, it was also rewarding to see the positive impact it made on Ms. Z and her children and on the other families who participated and would likely not have otherwise received this intervention. The experience of Ms. Z's family demonstrates the effect that an adapted, trauma-informed approach in conducting an IY group within a transitional living shelter can have on this population. With this in mind we would like to provide some discussion for future directions and notes to clinicians who may work with this population in a group setting.

Implications for Future Research

As detailed throughout, having a trauma-informed approach and providing trauma-informed care was essential to the success of the IY groups and the cohesion of the group between members and leaders. Though the focus of the group was to help decrease disruptive externalizing behaviors, many of these behaviors stemmed from the lack of parental consistency and symptoms of post-traumatic stress due to a history of trauma in all the parents (as reflected in the parental results on the Detailed Assessment of Posttraumatic Stress [DAPS] measure and in the children's results on the Trauma Symptoms Checklist for Young Children [TSCYC] measure.)

The group leaders spent additional time each week planning how to proceed with treatment while keeping to the structure of the group and also providing adaptations for trauma-informed care. When working with this population it is recommended that each behavior and comment made by the child and parent be conceptualized through a trauma-informed perspective so that the mental health professional can respond to the families with sensitivity and respect to their histories.

To further investigate and clarify the impact of an IY group with this population, we believe it is necessary to conduct the group in a similar fashion as the one represented in this study. We thus suggest that the adaptations perceived to have impacted the families in this case study be included in follow-up treatment, either within this particular shelter or within another similar shelter to further assess the impact of the IY group and its adaptations. Further research comparing outcomes from shelter-based IY with care-as-usual would provide important information about the effectiveness of specific IY intervention strategies for this very disadvantaged and needy population.

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Table 1. Weekly Group Participation

Name	Age at start of group	Session Number																						
		1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23
Cathy Z.	4y, 2m	X	X	X	X	X	X	X	X	X	X	X	X	X	X			X	X	X	X	X	X	X
Yvette Z.	9y, 10m				C	C	C	C	C	C	C	C	C	C	C			C	C	C	C	C	C	C
Michael K.	9y, 4m	P	P	P	P	P	P	X	X	X		X	X	X	X	C	C	C	C		X	X	X	X
Jade D.	4y, 2m	X	X	X	X	P	X	X	X	X				X	X	X	X							
Alyson P.	4y, 5m	X	X	X																				
Mari F.	2y, 0m	P	P		P	P	P	P	P	P	P	P	P	P		P	P	P	P	P	P		P	
Taylor R.	2y, 7m	P	P	P	P	P	P	P	P	P	P	P	P	P	P	P	P	P			P	P	P	P
Ryan M.	1y, 3m		P		P				P	P	P	P	P					P	P		P			

X=Child and Parent group
C=Child group only
P=Parent group only.

Table 2. Measures

Youth Outcome Questionnaire (Y-OQ; Burlingame, Wells, & Lambert, 1995): The Y-OQ is a brief 64-item parent report measure of treatment progress for children and adolescents (ages 4 – 17) receiving mental health intervention. The Y-OQ is meant to track change in functioning and includes six subscales: Interpersonal Distress (ID), Somatic (S), Interpersonal Relationships (IR), Critical Items (CI), Social Problems (SP) and Behavioral Dysfunction (BD). Pre-to-post-therapy results for Ms. Z on the Y-OQ are shown in Table 3.

Eyberg Child Behavior Inventory (ECBI; Eyberg & Pincus, 1999): The ECBI is a parent report of externalizing, aggressive, acting out behaviors. The ECBI was originally constructed from case record data compiled to provide a list of 36 of the most typical problem behaviors reported by parents of conduct problem children. The response format is designed to assess each of the 36 items on two dimensions: the frequency of its occurrence and its identification as a problem. The frequency ratings range from (1) never occurs, to (7) always occurs, and are summed to yield an overall problem behavior Intensity Score with a potential range of 217 points (36 to 262). The problem identification measure requires the parent to circle "yes" or "no" when asked, "Is this behavior a problem for you?" The total Problem Score (between 0-36) is calculated by summing the number of problems circled. Two clinical cutting scores have been derived from normative data: 127 on the Intensity scale and 11 on Problem scale, with higher scores suggesting the need for treatment. Pre-to-post-therapy results for Ms. Z on the ECBI are shown in Table 4.

Trauma Symptom Checklist for Young Children (TSCYC; Briere, 2005): The TSCYC is a 90-item caretaker-report measure of children's trauma-related and abuse-related symptomatology. It was developed for the assessment of trauma-related symptoms in children ages 3-12. It contains two reporter validity scales and eight clinical scales, as shown in Table 5, which also shows the pre-to-post-therapy results for Ms. Z.

Parent Stress Index Short Form (PSI/SF; Abidin, 1995): The PSI/SF is a direct derivative of the Parenting Stress Index (PSI) full-length test. All 36 items on the Short Form are contained on the Long Form with identical wording and are written at a 5th-grade reading level, for parents of children 12 years and younger. The PSI/SF yields a Total Stress score from three scales: Parental Distress, Parent-Child Dysfunctional Interaction, and Difficult Child. Pre-to-post-therapy results for Ms. Z on the PSI/SF are shown in Table 6.

Detailed Assessment of Posttraumatic Stress (DAPS; Briere, 2001): The DAPS is a self-report instrument that assesses peritraumatic and posttraumatic symptoms and associated features related to a specific traumatic event. The measure includes two validity scales, three Trauma Specification Scales, and eight Clinical scales. Table 7 lists the various scales and presents the pre-therapy results for Ms. Z. As explained in the text, the DAPS was not administered post-therapy because the experience of taking it pre-therapy was very upsetting to the mothers in the study.

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Table 3. Ms. Z's Ratings of Cathy at Pre-Therapy and Post-Therapy:
Youth Outcome Questionnaire (Y-OQ)

Scale	Pre-Therapy Measures	Post-Therapy Measures
Interpersonal Distress (ID)	27	14
Somatic (S)	6	3
Interpersonal Relationships (IR)	7	3
Critical Items (CI)	5	3
Social Problems (SP)	12	9
Behavioral Dysfunction (BD)	8	3
Total Score	**65***	**35**

*Total Score is above clinical cut-off of 46.

Table 4. Ms. Z's Ratings of Cathy at Pre-Therapy and Post-Therapy:
Eyberg Child Behavior Inventory (ECBI)

Scores	Pre-Measure Raw score/ T-Score	Exceeds Cutoff?	Post-Measure Raw score/ T-Score	Exceeds Cutoff?
Intensity	151/T65	Yes	94/T49	No
Problem	22/T69	Yes	9/T52	No

Note: There are two clinical cutting scores: 127 on Intensity and 11 on Problem, with higher
scores suggesting the need for treatment.

Table 5. Ms. Z's Ratings of Cathy at Pre-Therapy and Post-Therapy:
Trauma Symptoms Checklist for Young Children - TSCYC

Scale	Pre-Measure T-Score	Post-Measure T-Score
Response Scales		
Response Level (RL)	>110	88
Atypical Response (ATR)	84	49
Clinical Scales		
Anxiety (ANX)	44	40
Depression (DEP)	81*	55
Anger/Aggression (ANG)	110*	78*
Post-Traumatic Stress-Intrusion (PTS-I)	58	44
Post-Traumatic Stress-Avoidance (PTS-AV)	85*	55
Post-Traumatic Stress-Arousal (PTS-AR)	75*	54
Post-Traumatic Stress Total (PTS-TOT)	77*	51
Dissociation (DIS)	59	44
Sexual Concerns (SC)	49	49

*Above clinical cut-off

Table 6. Ms. Z's Ratings of Herself at Pre-Therapy and Post-Therapy:
Parent Stress Index Short Form (PSI/SF)

Scale	Pre-Measure Data		Post-Measure Data	
	Raw Score	**Percentile**	**Raw Score**	**Percentile**
Defensive Responding	26	#	25	#
Parental Distress (PD)	44*	97th %	40*	96th %
Parent-Child Dysfunctional Interaction (P-CDI)	36*	>99th %	22	65th %
Difficult Child (DC)	30	75th %	35*	87th %
Total Stress	110*	98th %	97*	94th %

Defensive responding raises questions of validity when the raw score is 10 or less.

* Above clinical cut-off

Table 7. Ms. Z's Ratings of Herself at Pre-Therapy:
Detailed Assessment of Posttraumatic Stress (DAPS)

Scale	T-Score
Validity Scales	
Negative Bias *(NB)*	47
Positive Bias *(PB)*	54

Trauma Specification Scales	
Relative Trauma Exposure *(RTE)*	45
Peritraumatic Distress *(PDST)*	68*
Peritraumatic Dissociation *(PDIS)*	59

Clinical Scales	
Reexperiencing *(RE)*	80*
Avoidance *(AV)*	82*
Hyperarousal *(AR)*	74*
Posttraumatic Stress - Total *(PTS-T)*	81*
Posttraumatic Impairment *(IMP)*	85*
Trauma-Specific Dissociation *(T-DIS)*	47
Substance Abuse *(SUB*	47
Suicidality *(SUI)*	60

*Exceeds clinical cut-off

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Table 8. Reliable Change Index (RCI)

Scale	See Table	Pre-Therapy Score	Post-Therapy Score	RCI Analysis Shows That the Change is Statistically Significant
Youth Outcome Questionnaire: Total Score	3	65*	35	Yes
Eyeberg Child Behavior Inventory: Intensity	4	151*/T65	94/T49	Yes
Eyeberg Child Behavior Inventory: Problem	4	22*/T69	9/T52	Yes
Trauma Symptoms Checklist for Young Children: Post-Traumatic Stress Total	5	80*	59	Yes
Parent Stress Index Short Form: Total Stress	6	110*	97*	No

* Above the clinical cut-off