INFORMATION TO USERS

This manuscript has been reproduced from the microfilm master. UMI films the text directly from the original or copy submitted. Thus, some thesis and dissertation copies are in typewriter face, while others may be from any type of computer printer.

The quality of this reproduction is dependent upon the quality of the copy submitted. Broken or indistinct print, colored or poor quality illustrations and photographs, print bleedthrough, substandard margins, and improper alignment can adversely affect reproduction.

In the unlikely event that the author did not send UMI a complete manuscript and there are missing pages, these will be noted. Also, if unauthorized copyright material had to be removed, a note will indicate the deletion.

Oversize materials (e.g., maps, drawings, charts) are reproduced by sectioning the original, beginning at the upper left-hand corner and continuing from left to right in equal sections with small overlaps. Each original is also photographed in one exposure and is included in reduced form at the back of the book.

Photographs included in the original manuscript have been reproduced xerographically in this copy. Higher quality 6" x 9" black and white photographic prints are available for any photographs or illustrations appearing in this copy for an additional charge. Contact UMI directly to order.

UMI®

Bell & Howell Information and Learning
300 North Zeeb Road, Ann Arbor, MI 48106-1346 USA
800-521-0600

STRUCTURAL FAMILY THERAPY AND GROUP INTERVENTIONS WITH SINGLE-MOTHER FAMILIES

BY

ANNE SIPPELL

A Practicum Report

Submitted to the Faculty of Graduate Studies
In Partial Fulfillment of the Requirements
for the Degree of

MASTER OF SOCIAL WORK

Department of Social Work
University of Manitoba
Winnipeg, Manitoba

August, 1999

National Library of Canada
Acquisitions and Bibliographic Services
395 Wellington Street
Ottawa ON K1A 0N4
Canada

Bibliothèque nationale du Canada
Acquisitions et services bibliographiques
395, rue Wellington
Ottawa ON K1A 0N4
Canada

Your file Votre référence

Our file Notre référence

The author has granted a non-exclusive licence allowing the National Library of Canada to reproduce, loan, distribute or sell copies of this thesis in microform, paper or electronic formats.

The author retains ownership of the copyright in this thesis. Neither the thesis nor substantial extracts from it may be printed or otherwise reproduced without the author's permission.

L'auteur a accordé une licence non exclusive permettant à la Bibliothèque nationale du Canada de reproduire, prêter, distribuer ou vendre des copies de cette thèse sous la forme de microfiche/film, de reproduction sur papier ou sur format électronique.

L'auteur conserve la propriété du droit d'auteur qui protège cette thèse. Ni la thèse ni des extraits substantiels de celle-ci ne doivent être imprimés ou autrement reproduits sans son autorisation.

0-612-45153-4

Canada

THE UNIVERSITY OF MANITOBA

FACULTY OF GRADUATE STUDIES

*****

COPYRIGHT PERMISSION PAGE

Structural Family Therapy and Group Interventions With Single-Mother Families

BY

Anne Sippell

A Thesis/Practicum submitted to the Faculty of Graduate Studies of The University of Manitoba in partial fulfillment of the requirements of the degree of Master of Social Work

ANNE SIPPELL©1999

Permission has been granted to the Library of The University of Manitoba to lend or sell copies of this thesis/practicum, to the National Library of Canada to microfilm this thesis and to lend or sell copies of the film, and to Dissertations Abstracts International to publish an abstract of this thesis/practicum.

The author reserves other publication rights, and neither this thesis/practicum nor extensive extracts from it may be printed or otherwise reproduced without the author's written permission.

TABLE OF CONTENTS

FIGURES

TABLES

ABSTRACT

The members of single-mother families must adjust to the transitions related to normal development as well as additional stressors associated with the formation of the single-parent family. Adaptations to the demands exerted from inside and outside the family system enhance or hinder the growth of individual family members. The availability and utilization of resources, both personal and material, are significant factors in family adjustment. A lack of resources increases the vulnerability of children and adults in single-mother families to problems in adjustment.

This practicum describes the application of structural family therapy and a group intervention in work with single-mother families where the presenting concern was behavioural problems of a latency aged child. Common themes of economic instability, multiple stresses, social isolation and family violence are discussed.

ACKNOWLEDGEMENTS

This practicum could not have been completed without the help of many people. I would like to thank my advisor, Diane Hiebert-Murphy, for her encouragement, suggestions and thoughtful guidance of my learning. I also thank David Charabin and Linda Perry for serving on my committee and for reviewing the practicum report.

I appreciated the spirit of cooperation at the Elizabeth Hill Counseling Centre and I thank the staff at the centre and my fellow students for their collegial support. I would also like to thank the families who allowed me to be a part of their lives and agreed to be part of my practicum. Their persistence and resilience in the face of difficult life challenges taught me much.

Thanks also go to my mother who taught me much about adapting. Most importantly I thank my life partner, Dave, for his encouragement and support and my sons Drew and Kenn for their capable computer assistance and for their humor and understanding.

INTRODUCTION AND OVERVIEW

The objective of this practicum was to work with single-mother families as they attempted to find solutions to the problems they encountered. The number of women raising children without substantial financial or emotional support from the fathers of their children is increasing (McKie, 1989) placing many families at risk for a variety of problems (Furstenberg, Brooks-Gunn, & Philip Morgan, 1987; Gelles, 1992; Hetherington, 1989; McLanahan, 1983; Richards, 1993). Strong relationships, particularly mother-child relationships, are seen as potential mediators between a child and factors in the environment that impact on their development (Belsky, 1984; Dubow & Luster, 1990; Furstenburg et al., 1987; Hetherington, 1989). Interventions that strengthen relationships within families and with supports in the community may benefit single-mother families (Kaplan & Girard, 1994; Kissman, 1991; Webster-Stratton, 1997).

A psycho-educational parent support group for single mothers and structural family therapy were the chosen interventions. These modalities have been reported as useful in work with single parent families and are often used in combination with other interventions and often include participants living in other family forms (Aponte, Zarski, Bixenstine, & Cibik, 1991; First & Way, 1995; Kaplan & Girard, 1994; Kissman, 1991; Wayne, 1979; Whipple & Wilson, 1996).

My learning goals were to increase my knowledge and understanding of the issues facing single-mother families and to develop my skills as an agent of change using the chosen modalities.

The practicum report is divided into Three Parts. Part One includes a

profile of single-mother families in Canada and some of the contextual issues and problems they may encounter. The theoretical frameworks that guided the interventions and a critique and discussion of their applicability to work with single parent families follows. Part Two describes the practicum and provides an analysis of the two interventions. Part Three draws out the common themes that arose during the practicum and reflections on my learning.

PART ONE: LITERATURE REVIEW

CHAPTER ONE

Section One: Profile of Single Mother Families

Statistical Information

There are more than one million Canadian single parent families, representing 14% of families nationally (McKie, 1993). This number has tripled in the past thirty years with the rate of growth of single parent families four times that of two parent families. Rates for Aboriginal single parent families living off of reserves have been reported as two times the national average (McKie, 1993).

Canadian female-headed families outnumber male-headed single parent family by a factor of four. The vast majority of the almost two million children in single parent families live with their mother. Over half of these families (60%) are comprised of two people (McKie, 1993). Although some parents share custody of their children, the norm is for paternal contact and financial support to decrease after divorce or separation (Richards, 1993; Sidel, 1992). Because single parenthood is a transient state, many single parent families may experience the transitions associated with moving in and out of a single-parent form more than once (Carter & McGoldrick, 1989; McKie, 1993).

Formation of Single-Mother Families

More than half of all single parent families are formed after the dissolution of a marriage or common-law relationship. The second most frequent route to single parenthood is the birth of a child to a never married woman. Although widowhood was the most frequent route to single parenthood until the 1960's, it is now the least frequent (McKie, 1993). These statistics do not include the uncounted number of families in

which women are raising children alone due to the absence of their partners for work responsibilities, incarceration or illness (Carter & McGoldrick, 1989; Morawetz, 1984).

Problems of Single-mother Families

As with other families, problems in single-mother families tend to be linked to income, social supports and stresses with specific concerns about children (Carter & McGoldrick, 1989; McKie, 1993). The challenge for single-mother families is to meet members' needs and accommodate to change with fewer resources and more significant life stresses than the majority of those living in other family forms (Evans, 1998; McKie, 1993; Vosler & Proctor, 1991). Children from single parent families are at greater risk of experiencing behavioural problems and negative outcomes than children raised in two parent families, particularly if they are exposed to a number of risk factors at the same time (Dubow & Luster, 1990; Hetherington, 1989; Lindner, Hagan, & Brown, 1992; Luster & Mittelstaedt, 1993; Richards, 1993).

Multiple stresses

Single mothers in clinical and non-clinical populations have been found to experience more acute and chronic stress than other heads of households (Green & Crooks, 1988; McLanahan, 1983; Vosler & Proctor, 1991). Concerns about childcare, custody, child safety, immediate financial demands, unemployment, job changes, loss of income, lack of child support, movement of household, the arrival and departure of household members and a lack of time are reported as contributing to feelings of stress (Hanson, 1986; Sidel, 1992; Vosler & Proctor, 1991). The dehumanizing effects of poverty can also increase stress (Gelles, 1992; Halpern, 1990; Rutter, 1981). Societal expectations for women to preserve families and to prevent problems in their children

without regard to contextual factors may contribute to a single mother feeling isolated and stigmatized (Baines, Evans, & Neysmith, 1997; Canetto, 1996; Swift, 1995; Walters, Carter, Papp, & Silverstein, 1988). Single mothers who also experience oppression due to racial, historical, religious or cultural discrimination may feel additional stress and stigma (Stack, 1974; Swift, 1995).

In addition to the anticipated emotional and behavioral disturbance in children associated with family disruption and new family formation (Hetherington, 1989; Wallerstein, 1991), custody disputes and some custody arrangements can contribute to behavioral and emotional problems in children (Johnston & Campbell, 1993; Macoby, Depner, & Mnookin, 1990; Portes, Howell, Brown, Eichenberger, & Mas, 1992). Children exposed to chronic marital discord or who witness overt violence are likely to experience emotional and behavioral problems (Emery & Tuer, 1993; Portes et al., 1991; Smith, Berthelsen, & O'Connor, 1997).

Cumulative and excessive stress is associated with poor mental and physical health, and an increased risk of problem parenting (Gaudin, Polansky, Allie, Kilpatrick, & Shilton, 1993; Luster & Okakgaki, 1993). Single mothers whether divorced, separated or never married have significantly higher rates of depression than married mothers (Davies, Avison, & McAlpine, 1997). Mothers of children with behavioral problems have been found to have lower levels of self esteem, less confidence in their parenting abilities and higher levels of anxiety and depression compared to mothers of children without such problems, particularly when the mothers have limited social supports (Sheeber & Johnson, 1992).

Low earning potential, lack of child support and inadequate social assistance contribute to the economic instability and high risk of poverty for single-mother families (Evans, 1998; McKie, 1993). Economic constraints may help to explain the tendency for single-mother families to make frequent moves, rent or share accommodation, live in lower standard housing and be concentrated in less desirable neighborhoods (McKie, 1993). The availability and affordability of quality childcare has a direct impact on a single mother's income (Ferguson, 1998; Sidell, 1992).

Social Support

The presence of a supportive network of friends, family members and professionals is associated with high levels of physical and mental health and feelings of efficacy and empowerment in single mothers (Barratt, Roach, Morgan, & Colbert, 1996; Furstenburg et al., 1987; Hanson, 1986; Stack, 1974; Stevens, 1988). Support may be instrumental or emotional.

Accessing available support varies and is affected by a mother's age, religious, cultural and racial background, developmental history and the availability of supports in the community and in personal networks (Barratt et al., 1996; Belsky, 1984; Brown, 1989a, 1989b; Emery & Tuer, 1993; Furstenberg et al., 1989; Hetherington, 1989; Stack, 1974; Stevens, 1988). Lack of a responsive, supportive network is associated with feelings of loneliness and being overwhelmed and is likely to negatively affect the adjustment of both mothers and children in single parent families (Barratt et al., 1996; Gaudin et al., 1993; Hanson, 1986; Stevens, 1988).

Strengths in Single-Mother Families

Single parent families are capable of meeting individual and family needs, adapting to normative changes and dealing with crises by organizing their resources and obtaining appropriate support (Carter & McGoldrick, 1989; Dubow & Luster, 1990; Furstenberg et al., 1987; Green & Crooks, 1988; Hanson, 1986; Hetherington, 1989; Vosler & Proctor, 1991; Wallerstein, 1991; Walters et al.,1988). Within families and the environment there are compensatory and mediating factors that may reduce the impact of potential risk factors (Edgeland, Jacobvitz, & Stroufe, 1988; Hetherington, 1989). Mothers can play a mediating role between these stressors and their children whether divorced, widowed or never married (Furstenburg et al., 1987; Hetherington, 1989; Wallerstein, 1991).

Although there is evidence of a higher incidence of negative outcomes for children from single parent homes, the etiology of these outcomes is multi-determined and includes the effects of income, educational attainment, geographic dislocation, domestic abuse, cumulative stress, the timing of crisis events in the family life cycle and other contextual factors (Vosler & Proctor, 1991; Walters et al., 1988). There has been a tendency in the clinical literature to blame mothers for causing their children's psycho-social problems without regard for contextual factors that impact on the mother-child relationship and on individual child development (Caplan & Hall-McCorquindale, 1989a, 1989b; Patterson, 1982). A tendency to attribute problems in single-mother families to a dysfunctional family form has been critiqued as unhelpful and found to have been based on assumptions informed by gender bias and work with clinical populations (Canetto, 1996; Walsh, 1982; Walters et al., 1988). There is strong evidence linking outcomes for

children living in single-mother families to the life course and adjustment of their mother (Belsky, 1984, Furstenburg et al, 1987; Luster & Okagami, 1993; Wallerstein, 1991) lending empirical support to programs and policies that support families as a way of contributing to the healthy development of children (Halpern, 1990; Kaplan & Girard, 1994; Wallerstein, 1991).

Section Two: Interventions with Single-parent Families

Single-mother families may experience any number of problems with regard to the instrumental or affective dimensions of family life. Much is written about addressing the needs of single parent families though individual and family level interventions using group and family therapy modalities (Kaplan & Girard, 1994; Kissman, 1991; Tolan & McKay, 1996; Walters et al., 1988; Wayne, 1979) but often program descriptions do not include outcome evaluation. Outcome studies tend to be problem related, rather than population specific so single mother families may or may not be explicitly identified as part of the population being treated and their inclusion must be inferred. Available research about the efficacy of family therapy is sparse, and often family therapy and psychoeducational groups are one part of larger treatment programs (Friedlander, 1998).

Structural family therapy has been reported as demonstrating effectiveness in reducing problems of families with delinquent children, characterized as disorganized, economically disadvantaged and in many cases, headed by single mothers (Nichols & Schwartz, 1998). Mothers, reported as undercontrolling or overcontrolling prior to the intervention were noted to have significant decreases in the use of coercive control and were more clear and firm in their interactions with their children after six months of structural family therapy. Although there was no control group and disengaged mothers

were noted to show no improvement in their interactions with their children, these results showed early promise for the use of structural family therapy with single-mother families when the presenting problem was a child experiencing behaviour problems (Roy & Frankel, 1995). Structural family therapy has been reported as more effective than controls and equally as effective as psychodynamic child therapy in reducing child behavioural problems (Roy & Frankel, 1995). It was also reported as less effective than social learning based parent training, although details about the family form of the population in which these results occurred were not discussed (Roy & Frankel, 1995).

A semi-formal project undertaken by one therapy group working with single-parent family clients (Walters et al., 1988) compiled a list of characteristics of these families that contributed to their positive functioning after divorce. These characteristics are formulated in the language of structural family therapy and talk about lines of authority, combining nurturing and managerial functions in the parent, flexibility and permeability of boundaries and alterations in the two parent family hierarchy.

Although family systems therapies have not been shown to be superior or more cost effective than other forms of therapy when the presenting issue is a child's behaviour problems, there is evidence that involving the family in treatment is of benefit (Roy & Frankel, 1995). Factors leading to successful outcomes in family therapy have not been clearly defined and the superiority of one school of family therapy over another has not been demonstrated. Family therapy that was intensive and that included a problem solving component along with child therapy and Parent Management Training (PMT) were reported as most effective in the treatment of child conduct disorders (Roy & Frankel, 1995). Evaluations of outcome studies provide some evidence that

socioeconomic status influences the kind of approach in family therapy that may be of value to the family. Higher income families have been reported to respond to feedback in the form of information and lower income families to respond to counseling (Roy & Frankel, 1995).

Many single mothers attend group parenting programs, generally behavioural in orientation, which have been reported as successful in reducing child behaviour problems (Patterson, Chamberlain, & Reid, 1982; Webster-Stratton, 1997). Earlier analysis of these programs identified single parenthood as one characteristic of those for whom these programs were of little benefit. Treatment failure was attributed to resistance of the parents or personal characteristics that tended to blame them (Patterson, 1982). More recent evaluations suggest that PMT is most effective when it occurs early, before chronic problems have been established, and that families who are unable to use the intervention effectively are characterized by poverty, single parenthood, maternal depression, social isolation and lack of social support (Webster-Stratton, 1997). Recognition that PMT may be useful to families can be combined with an understanding that stressors such as marital disruption and other family crises must also be addressed in treatment (Patterson et al., 1982). Some success in reducing child behavioural problems has been noted with interventions that provide highly stressed mothers, both married and single, with opportunities to discriminate between the stressors they perceive as coming from their children and those emanating from other sources (Wahler, Cartor, Fleischman, & Lambert, 1993). Evidence suggests that combining a number of treatment components, such as individual parenting and child social skills training with interventions that promote within-family change such as learning problem-solving,

communication and coping skills can result in improvements in child and parent behaviours (Webster-Stratton, 1997).

Programs designed for families at risk of child abuse also contribute to an understanding of what may be helpful to single mother families. Single parenthood, low income, difficult child behaviour and high levels of stress are all associated with risk for child abuse and neglect (Belsky & Vondra, 1989; Gelles, 1992; Halpern, 1990; Wiehe, 1996). There is general agreement that there is no one single cause for child maltreatment and little is known about what interventions are most effective with subpopulations identified as being at risk for abuse (Belsky & Vondra, 1989; Olds & Henderson, 1989). Interventions tend to focus on ameliorating associated risk factors such as isolation, lack of social support, maternal depression or the need for parenting skills (Howing, Wodarski, Gaudin, & Kurtz, 1989; Olds & Henderson, 1989). Studies suggest that a broad spectrum of services be made available to families at risk of child abuse and neglect (Roy & Frankel, 1995; Whipple & Wilson, 1996) and that parental stress and social isolation may be significantly reduced through participation in parent education and support groups (Teleen, Herzog, & Kilbane, 1989; Whipple & Wilson, 1996). Programs that are multifaceted and that can address numerous factors associated with maltreatment simultaneously appear to hold the most promise for preventing child abuse and neglect, although results from controlled studies are inconsistent and address the needs of families with very young children (Olds & Henderson, 1989). These programs promote early and sustained contact through home visits by trained personnel and program content that combines social support and parent education. These studies also

indicate the ineffectiveness of interventions in altering the material conditions of the families and the social environment that condone the use of physical punishment.

One small qualitative study evaluated the experience of participants in a parenting program, most of whom were single mothers (First & Way, 1995). The program was described as flexible, incorporated input for session agendas from participants, provided plenty of time to address immediate concerns of participants and covered topics such as discipline, listening to your child and dealing with anger and other feelings. The participants reported experiences of transformative learning that motivated them to question their basic beliefs and assumptions about parenting. This reportedly allowed them to alter previous patterns of relating to their children.

Studies evaluating family preservation programs indicate that combining family therapy and concrete services to single mothers and their children assessed as being at risk for child placement can result in fewer children being placed in care and an earlier cessation of services than a matched control group (Roy & Frankel, 1995). These interventions were multifaceted, had consistent staffing with low caseloads and interventions lasted over a year. They provided in-home individual, group and family counseling with the aim of reducing isolation, restoring social networks and providing parent education and communication training.

From this review it appears that single mother families experiencing problems with child behaviours may benefit from interventions that are flexible in their timing and ability to meet the need for emotional and material support, parenting education, problem solving and coping skills development in group and family therapy modalities.

Section Three: Theoretical Framework

General Systems Theory

General systems theory has been influential in the development of theory and practice in social group work (Schwartz, 1961) and family systems therapies (Becvar & Becvar, 1996; Minuchin, 1974). It places knowledge about individual human development within the context of groups, where development takes place (Macoby, 1992; Minuchin, 1985).

Benefits of Group Work

Groups, whether formed or natural, are the "primary medium for individual/social exchange" (Gitterman, 1986, p. 31) and the ideal context to address any issues that arise in human relationships. They have a number of recognized benefits for social work clients that include reducing feelings of isolation and stigma (Gitterman, 1986; Toseland & Rivas, 1995). Groups can provide a number of helping relationships and an environment where hope may be generated, mutual respect and support made available and where members can clarify and achieve their own goals (Corey & Corey, 1997). Groups can facilitate the examination of perceptions and behaviors that are related to the concern that brought members together. The group provides a context for gaining new information, exploring differences, trying out new behaviors and learning new skills as members give and receive peer feedback (Toseland & Rivas, 1995). An increased sense of mastery and control over the issues that confront them may also result in group members externalizing their experience (Gitterman, 1986; Toseland & Rivas, 1995).

Although there are many potential benefits to groupwork there are also some disadvantages (Corey & Corey, 1997; Toseland & Rivas, 1995). Groups may encourage conformity and member dependency. Scapegoating or exclusion of one member by other members can have a harmful effect, as can unsupportive responses after self-disclosure. Less assertive group members may not have their needs or problems addressed if more assertive members occupy group time exclusively. Group intervention may not be suitable if the potential member does not want to participate in a group, has an excessive need for privacy or confidentiality, is unable to communicate with others or if a member's behavior will result in predominantly negative interactions or cause others to leave the group.

History and Models of Group Work

Social group work has a long tradition in the social work profession, starting in the settlement houses of urbanized areas. Groups were found to be beneficial in promoting social change and assisting individuals to attain personal goals (Papell & Rothman, 1966; Toseland & Rivas, 1995). Early social group work, as conceptualized in the **social goals model**, was characterized by an emphasis on group members' strengths and a belief in their ability to take action on their own behalf. Group participants were assumed to be healthy and their problems to have arisen from social conditions such as unemployment, urbanization or family dislocation. They were referred to as members rather than clients, denoting a democratic stance between them and group workers. Services were community based with a mutual understanding between group worker and members of a shared concern for society. The social worker's role was one of influence and responsibility for raising social consciousness and consensus in groups through

modeling, stimulating and reinforcing behaviors and attitudes that could bring about social change (Papell & Rothman, 1966).

Group work involved sharing power and decision making with clients, complex interactions involving numerous people and simultaneous regard for the needs of the group as a whole and the individuals within it. These democratic group processes were defined and discussed in early practice literature that facilitated others finding ways to use these processes for specific purposes. This model of group work continues to be used in community agencies for recreation, education and social action and influences other models of group work (Papell & Rothman, 1966, 1980; Toseland & Rivas, 1995).

Based on the earlier success of educational, recreational and community group work, therapeutic groups for support, socialization and rehabilitation became prevalent (Gitterman, 1986; Toseland & Rivas, 1995). The **remedial model** of group work arose from the blend of social group work and social casework. The use of therapeutic groups in mental health and child guidance settings increased in the 1940s and 1950s primarily for remediation and therapy for individuals seen to be socially maladaptive or deficient. Program activities tended to be replaced by diagnosis and treatment based on the theories of psychoanalysis and ego psychology. Social role theory and an understanding of human needs assisted in the formulation of problems and treatment goals, which were defined by the worker or agency. Using this model, group workers act as change agents working toward specific treatment goals for each group member, defining group purposes and developing group norms consistent with these goals. This model of practice moved away from some of the democratic processes of earlier group social work but it also contributed to an understanding of how group work could be used in clinical

settings. The worker's authority derives from the mandate of the agency sponsoring the group, tasks and roles in the group are assigned, and there are often few opportunities for free expression and creativity of members (Papell & Rothman, 1966).

In the 1960s, the **reciprocal model** of group work was put forward as one modality in generalist social work practice (Schwartz, 1961). In this model, a group is viewed as reflective of and influenced by the larger systems around it whether the group is social, therapeutic or task oriented. Members can have diverse capacities and motivation for joining the group. The worker and group members are viewed as being in a reciprocal relationship with each other and part of a collective whole. The worker's role is one of mediating the relationships between the diverse and competing interests and demands of group members and other systems, which may include individuals, agencies, social institutions and society as a whole. The role of the worker is to perform specific tasks that promote the development of a system of mutual aid that may meet the needs of individuals, the group and society (Papell & Rothman, 1966; Schwartz, 1961; Toseland & Rivas, 1995). Some have critiqued this model of group work as idealistic due to the tendency to assume all members of society feel some affinity for the larger society and could find common ground if brought into contact with each other. Diversity due to race, culture, gender, life experience or a multitude of other factors may be acknowledged but downplayed due to efforts to find commonalties and mutual goals. Depending on the purpose of the group, disregarding diverse realities of group members may hamper its development (Glassman & Kates, 1990).

After an increase in the study of small groups during the 1960s and 70s, which contributed much to the development of small group theory, the use of group services

and professional preparation for social group work declined (Toseland & Rivas, 1995). There has been a recent resurgence of groups in therapeutic settings, due in part to its cost-effective nature in reaching numerous clients simultaneously. This increased utilization as a chosen modality has prompted a renewed interest in group work education and professional skill development as well as a rediscovery of the unique benefits of groups. Contributions from feminist scholars and workers have contributed to current group work practice (Corey & Corey, 1997; Garvin & Reed, 1995).

Feminist group work practice shares historical roots with early group workers who employed the social goals model, although many of these early writers and workers did not explicitly identify themselves as feminists. These early social workers were concerned about social justice issues and came together in communities to discuss activities in the political and public realm (Garvin & Reed, 1995). Contemporary feminists share similar concerns about social justice issues and continue to believe in the power of groups to raise the consciousness of members and promote individual and collective change efforts (Burt, Code, & Dorey, 1993).

Feminism is more of a framework than a model of practice. Although there are many, continually evolving schools of feminist thought, they share some basic tenets (Elliot & Mandell, 1998). All feminist theories attempt to understand social and institutional relationships through the lens of gender. Past and present gender relations are viewed as problematic and related to arrangements and inequities in society rather than as ordained or 'natural'. Feminist theorists advocate for social change that would rebalance current power inequities in society that result in oppression and exploitation of women. Feminist practice is guided by principles that include a positive evaluation of

women and the work they do in society, encouraging total development of men and women, validating social contexts, recognizing the differences in male and female experience and rebalancing perceptions of normalcy (Land, 1995; Russell, 1989). Feminist social work practice includes the essential components of support, empowerment, networking, an emphasis on women's experience and self-help. The multidimensionality of practice includes assessing the interplay between internal family factors and external factors and the varying levels of interaction across the life cycle (Kissman, 1991).

Feminist group work reflects these practice principles and can be used for the same purposes as groups using the reciprocal, social goals and remedial models. It emphasizes identifying gender issues and rectifying power imbalances between men and women to promote interactions that are not constrained by sexist values (Garvin & Reed, 1995). Feminist group purposes share an emphasis on the personal as political with both the social goals and the reciprocal model that view the member within his or her environment. Although the remedial model seeks to empower group members by enhancing self-efficacy it does not acknowledge the impact of power differences between individuals and the environment, as do other models (Garvin & Reed, 1995).

Members in feminist groups are encouraged to develop an understanding of how their own issues are related to issues of sexism and oppression, to support members during and outside meetings and to externalize change efforts to remove oppressive barriers in their environments and themselves. This externality of purpose is similar to the reciprocal and social goals models, however these models do not emphasize

members' responsibility to understand and modify oppressive influences (Garvin & Reed, 1995; Kissman, 1991).

Workers in feminist groups have similar roles to those using other models of group work, particularly the reciprocal model. Expressing one's values while being supportive of members' values, developing a mutual aid system, lending a vision of what life could be like, tuning in to members' feelings and needs and challenging forces that block change are roles shared by feminist and reciprocal group workers. Both models value human diversity but the feminist model predominantly addresses the influence of gender as the cause of oppression in members' lives (Garvin & Reed, 1995).

A **mainstream model** of group work practice draws from the theoretical positions and practice principles of the remedial, social goals, reciprocal and feminist group work models that can be enriched by contributions from psychotherapeutic and structured groups (Papell & Rothman, 1980). The mainstream model of groupwork is intended to meet the needs of a wide range of target populations and can be used with almost any group of social work clients in a variety of types of groups. It could be argued that the mainstream and the reciprocal models are essentially the same, except the mainstream group has been written about and used by workers who stress humanistic values and the need to pay special attention to issues of diversity in populations.

The mainstream group incorporates aspects of psychotherapeutic groups and structured groups into the framework. The support and interpersonal development aspects of psychotherapy group purposes are consistent with social group work. (Papell & Rothman, 1980). The psychotherapy group model makes assumptions about illness and cure for members that have subsequent impact on assumptions about the authority

of the worker. This contrasts with the social group work model that assumes shared authority between members and workers. The need to establish norms around issues such as reactions to free expression of feelings and self-disclosure in psychotherapy groups differs from the evolving norms established through ongoing interaction of the group and worker in a social work group. Combining the informality of social work and the neutrality and authority of the psychotherapeutic approach can assist social workers in demythologizing the expert/authority role. Specialized knowledge from psychotherapy about individual problematic behaviours manifested in groups, their effects on group processes and principles for problem management can also be helpful for social work groups (Papell & Rothman, 1980).

Structured group work, that primarily aims at helping individuals acquire life skills, resolve critical life themes and assist in the completion of life transitions also contributes to the mainstream model (Papell & Rothman, 1980). The encouragement of the expression of feelings and developing communication and interpersonal skills done in these groups are consistent with social group work models. Members in structured groups are viewed as learners, in need of a new skill or alteration in interactive style. The leader of a structured group is considered a teacher, a role that a social work group facilitator may take on as indicated in the mainstream group. Group members in the mainstream group are viewed as active, social learners and able to engage in group processes that will expand their skills in social functioning, whatever the purpose of the group. They are viewed as having the potential power to make a difference in the group and it is assumed that change and growth may occur when this power is exercised (Papell & Rothman, 1980).

As with feminist groups the mainstream model incorporates the effect of gender on members but also includes race, sexual orientation, socioeconomic status, culture and religion as potential sources of oppression (Papell & Rothman, 1980). As with the reciprocal and feminist group models the individual needs of the member, to belong, to establish affiliative bonds and to develop human capacities are affirmed along with the need for autonomy, separateness and the member's experience of difference (Papell & Rothman, 1980).

The essential role of the worker in the mainstream model is to promote contact between group members as they participate in group processes and work toward their individual goals (Papell & Rothman, 1980). This may require the worker to assume a variety of roles depending on the needs and characteristics of the group members, the group purpose, the size, duration and setting of the group and the stage of group development. The worker's leadership style, values, knowledge base and skills in group work will influence his or her ability to carry out the role (Glassman & Kates, 1990).

An important concept of this model is externality, or the effect of the group on individuals to take collective action and to respond to demands in the environment. The mainstream group model shares its emphasis on externality with the reciprocal, social goals and feminist group models. The group is seen as a potential reference group for members that can influence relationships and behaviors outside the immediate group experience (Papell & Rothman, 1980).

There are numerous examples of group work models with a rich history and potential applications for work with single mothers. In choosing a group work model it seemed that the mainstream model was an appropriate choice, as it allowed the

incorporation of important aspects of a number of the other models. The feminist model contributed the positive valuation of the experience and roles enacted by women, an emphasis on networking, social support, empowerment and self-help and a broadening of the definition of normal roles for men and women and of functional families. Added to this gender specific sensitivity was the mainstream model's emphasis on the contribution of diversity to the human experience and the need to address this in the context of group work. The potential client population included mothers from diverse cultural, racial and socioeconomic groups and a potential diversity of many other characteristics. It was expected that a considerable amount of time would be spent assessing members, composing the group and planning activities prior to starting the group. Skills in developing a mutual aid system could be incorporated from the reciprocal group method.

Small Group Theory

Group processes include communication and interaction patterns, group cohesion, and social control dynamics and group culture. Although they are discussed separately these processes are interactive. They are influenced by the group purpose, composition, setting, duration and the leadership style, skills and values of the worker and values of the members (Papell & Rothman, 1979; Toseland & Rivas, 1995).

Communication and Interaction Patterns

Communication, whether verbal or non-verbal, convey meaning through symbols. Reciprocal patterns of communication emerge between group members that are beneficial or harmful to developing relationships and working toward goals. The worker's role is to understand and promote helpful communication and to block or alter

harmful patterns (Glassman & Kates, 1990; Toseland & Rivas, 1995). Members are provided with feedback about their communications in order to check the meaning of the message and ensure that it was understood correctly. This prevents misunderstandings and conflict that may arise due to distortions in the way the message was sent or received (Toseland & Rivas, 1995).

Worker centered and group centered interaction patterns emerge in groups. Group centered interactions, that arise when members are encouraged to freely communicate with each other, are associated with increased social interaction, morale and commitment to group goals. Leader centered interaction is associated with more efficient attention to group tasks. Interaction patterns are influenced by emotional bonds between members, the cues and positive and negative reinforcement members receive for interactions, the development of subgroups, the size and physical arrangements of the group and the relative power and status of the group members. Workers assess group interaction patterns throughout sessions and can take action to promote patterns that help members work toward their goals (Toseland & Rivas, 1995).

Group Cohesion

Cohesion is the sense of feeling that one belongs and is accepted and accepting of others (Wood & Middleman, 1989). It is affected by the members' need for affiliation, the expectation of benefit or detrimental consequences to members and comparisons with other groups. Workers may enhance group cohesion by encouraging open communication, helping members define and achieve goals, promoting cooperation between members, keeping group size small enough to allow member participation and affiliative bonds to develop (Glassman & Kates, 1990; Toseland & Rivas, 1995).

Social Control Dynamics

Groups are able to function in an orderly manner due to the processes that gain compliance and conformity from group members. Group norms and the roles are unique to each group and develop through the course of the group. They are factors that establish social control in the group (Toseland & Rivas, 1995).

Group norms are the shared beliefs and expectations about what are acceptable and desired behaviours for group members. As norms are introduced and accepted, the degree of social control regarding behaviour exerted by the group worker is reduced because of the effect norms have on stabilizing and regulating behaviour (Glassman & Kates, 1990). The roles of group members pertain to shared expectations about the functions of individuals in the group and are closely linked to norms. Roles allow for a division of labour between group members and effect how members behave (Toseland & Rivas, 1995).

Without controls a group would be chaotic, unpredictable and unable to perform the function it was formed to carry out (Gitterman, 1989). Although social controls are necessary for groups to function, they can be restrictive and may interfere with some group processes. Members need and have a right to freedom, an acknowledgement of their individuality and independence. The worker and group members work together to define and modify these dynamics as required, balancing the need for conformity and deviation. The issues of authority and power in the group are of particular importance to social workers due to the high proportion of high risk and vulnerable populations they encounter in clinical practice (Gitterman, 1989; Glassman & Kates, 1990).

Although group workers emphasize egalitarian principles and promote self-determination as a goal for clients, they must bear in mind the social reality of power differences that impact interpersonal relationships inside and outside a group experience. The relationships between clients and worker begin with implicit and explicit power imbalances that may be compounded by differences in social class, ethnicity, race, sex, life experience and stage of development in the life cycle. By being honest, inviting client participation and supporting the choices clients have available to them, the worker can reduce the structural inequalities that exist between worker and client (Gitterman, 1989).

As the group becomes more autonomous, it is expected that the worker will exercise less authority (Glassman & Kates, 1990). The worker may make this expectation explicit so that the members and worker can discuss authority transactions. Testing worker authority is a normal part of any relationship between a client and worker and the worker must learn to assess whether challenges to worker authority are due to growing autonomy of the group or are a sign of group or individual dysfunction (Gitterman, 1989).

Group Culture

The values of individual group members and the group worker that arise from cultural, racial, ethnic and religious heritages blend in the group through communication and interactions. Stereotypes held by members and workers can inhibit group development and effective functioning. Mutual exploration of each other's value system and attempts to find common ground on which to relate to each other can result in a shared value system, or group culture. A shared group culture will have a positive

influence on the ability of the group to achieve its goals and meet the needs of its members (Glassman & Kates, 1990).

Leadership Style

Workers using the mainstream model of group work strive to be genuine, warm, and informal and to demystify professionalism in order to reduce the power imbalances and social distance between worker and members. Appropriate self-disclosure, sharing of feelings and concerns as well as modeling by the worker can enhance intimacy and trust and decrease feelings of defensiveness in the members (Papell & Rothman, 1980). Group work is never value free or neutral (Glassman & Kates, 1990). The processes and direction of any group are influenced by the values of the individual group members, the group worker's personal and professional values and the values and norms of the larger contexts of agency and community (Toseland & Rivas, 1995).

Learning about the central cultural constructs, the histories and values of the cultures of client groups and accepting and valuing diversity will facilitate the worker's ability to relate to clients and provide culturally sensitive practice (Becvar & Becvar, 1996; Glassman & Kates, 1990). Clarifying their own values and understanding their own racial and cultural heritage will increase the effectiveness of group workers in providing non-judgmental, culturally sensitive practice. An awareness of her own values reduces the chance the worker may impose her own values on group members and enhances the worker's ability to facilitate discussion of value-laden topics (Corey & Corey, 1997; Toseland & Rivas, 1995).

Skills of the Group Worker

Worker skills are those behaviors and activities carried out to move the group toward achieving its purpose. Different authors and group workers have compiled lists of foundation skills that group workers must develop in order to be able to effectively lead groups (Corey & Corey, 1997; Glassman & Kates, 1990). Many of these skills, such as active listening, reflecting, clarifying, summarizing and empathizing are used in any intervention with clients. Other skills, such as involving group members, attending to nonverbal behaviours, guiding group interactions and linking members' communications are more specific to group work. Some skills will be called on more at different stages of group development and others will be used throughout the life of the group. Theoretical knowledge about group processes and stages of group development will guide the worker's understanding of when these skills can most effectively be used (Corey & Corey, 1997; Toseland & Rivas, 1995).

Group Development

It is generally agreed that groups pass through a number of stages of development in which reactions emerge in members and workers in somewhat predictable forms (Glassman & Kates, 1990). As the group goes through its own particular evolution, knowledge of these group stages guides the worker in understanding members' reactions and behaviors and in making decisions about how to guide processes to facilitate group purposes. Although there are a variety of stage theme models, groups can generally be conceptualized into a beginning, middle and end stage. Group purpose, goals and characteristics of group members and the group worker affect each of these stages (Glassman & Kates, 1990; Toseland & Rivas, 1995). The following section will

discuss the worker activities and group tasks for each of the three stages of group development of a treatment group. The planning stage, which can be included as part of the beginning stage, is dealt with separately.

Planning

This stage of group development also known as pre-group planning (Corey & Corey, 1997) or pre-group formation (Toseland & Rivas, 1995) involves gathering data, assessing group members and facilitating group processes that will help ensure a group's success in meeting its goals and those of group participants. Prior to meeting potential members, the worker establishes the need for the group service and determines a group purpose ensuring it is consistent with the needs of clients and the mandate and policy of the sponsoring agency (Kurland, 1978).

Recruitment strategies are planned to reach the potential intended population (Kurland, 1978; Toseland & Rivas, 1995) and may require a lot of time, energy and imagination on the part of the worker, particularly when hoping to reach 'at risk' populations (Breton, 1985; Walsh, Hewitt, & Londeree, 1996). Once recruitment has begun, the worker begins to compose the group.

Group Composition

In composing the group, the worker chooses members according to their needs and the likelihood that the group, as planned, will meet those needs. In a treatment group, the worker chooses members who share the same or similar purposes and some similar personal characteristics such as age, level of education, cultural background, similar life stage or type of problem. The **homogeneity** of purpose provides a basis for members to begin their interactions. The homogeneity of personal characteristics will

vary from group to group. It is necessary to ensure that members have enough in common to facilitate the work of the group (Toseland & Rivas, 1995).

The group should also have some **heterogeneity** with respect to members' coping skills, life experience, knowledge and problem solving abilities. This diversity within group membership provides a rich resource for vicarious learning, modeling, support, validation and mutual aid. Diversity of gender, age, maturity, sociocultural background and socioeconomic group should also be considered. Diversity, that can enrich group experience must be weighed along side the potential it has to reduce communication and group interaction (Glassman & Kates, 1990; Toseland & Rivas, 1995).

Members can possess a wide variety of behavioral characteristics but should be willing and able to communicate with others in the group, accept other people's behaviors, be able to get along with others who have different opinions from them and have some understanding of their own behavior. A worker may establish criteria for excluding some from group membership, such as those who cannot accept feedback, who are antagonistic to others or who have conditions that make it impossible for them to participate on a regular basis (Toseland & Rivas, 1995).

The **size** of the group will vary according to group purpose, the complexity and type of problems group members are addressing and the availability of members. There is no ideal number for treatment groups, however, five to seven members are considered conducive to accomplishing the purpose of most (Toseland & Rivas, 1995).

Whether a group has **closed or open membership** is another consideration when forming a treatment group. There are advantages and disadvantages to both types

and the choice of one or the other will be based on group purpose and practical considerations. In an open group members enter and leave the group throughout its course. New members replace those who leave in order to maintain a constant size and ensure the continuation of the group. Open membership may adversely affect group cohesion and group development and will affect the kinds of activities, topics and goals of the group. Open groups can accommodate members who come to need a service after the group began, they can reach many clients and because of the flexible nature of people and the group process, they can be used effectively to meet some clients' needs (Toseland & Rivas, 1995).

Closed groups have an established membership from the beginning to the end of the group. They are preferable when the group is designed to meet an educational or skill building purpose. They have the potential to develop high levels of cohesion and stability of roles and norms that result in high morale and cooperation among members. The disadvantages of closed groups include the risk of conformity within the group due to a lack of new ideas, viewpoints and skills and the risk of too few members for meaningful interaction if members drop out (Toseland & Rivas, 1995).

Group Stages

Prior to the first group meeting the worker and members selected for the group begin the **contracting** process about group procedures and individual goals. The worker and members gain a mutual understanding about the purpose, time, duration and the types of activities the group will involve as well as expectations about attendance and confidentiality (Toseland & Rivas, 1995). Having completed the pre-group planning stage, the group convenes.

Beginning Stage

The beginning stage, also known as forming and storming (Tuckman, 1963) and the initial and transition stage (Corey & Corey, 1997) is characterized by an approach-avoidance conflict in members and the worker as they work toward group formation. The natural tendency to resist group pressure and maintain individuality, combined with anxiety about and a desire for acceptance by the group fuel this normal conflict. As the members progress through the beginning phase, roles and norms begin to develop and members test them out. The member is adjusting to issues relating to trust, authority, responsibility and leadership (Glassman & Kates, 1990; Toseland & Rivas, 1995).

The worker can facilitate these adjustments by normalizing members' feelings and behaviors, working to establish group norms, clarifying group purpose and facilitating members identifying their own goals. " The normative crisis that signals the end of the beginning stage is a consideration of the standards that will be used to guide members in their interactions" (Glassman & Kates, 1990, p. 75).

Middle Stage

The middle stage, also called the working stage (Corey & Corey, 1997) and the norming and performing stages (Tuckman, 1963) is characterized by a focus on goal achievement. Members work toward individual and group goals identified during the planning and beginning stages and that continue to evolve and become more cofcrete as the group progresses. In a short term group these goals may be limited but clarifying and reminding members of their goals will help them to be achieved (Glassman & Kates, 1990; Toseland & Rivas, 1995).

The tasks of the worker in this stage are to (a) prepare activities and agendas for group meetings that are consistent with the purpose of the group; (b) structure the group by setting agendas, starting and ending groups on time, and provide activities that involve members in practicing new skills or desired communication patterns; (c) involving members in activities and decisions and empowering them by encouraging efforts to achieve their goals, to try out new behaviors inside and outside the group, and to express a belief in their strengths; (d) working with member resistance, and (e) monitoring member progress toward goals.

Ending Stage

The ending of a group, also called the final stage (Corey & Corey, 1997) is characterized by separation and reflecting on accomplishments. The end of group involvement may be planned or unplanned. In either case, termination is an important stage in the life of a group and its members (Glassman & Kates, 1990; Toseland & Rivas, 1995).

Unplanned termination is frequent in voluntary groups and may occur as a result of faulty selection of members, a poor fit between the group, the group leader and the member, or external events. Exploring a member's reasons for termination may assist the worker in preventing future unplanned endings (Toseland & Rivas, 1995).

The planned ending of a group often generates strong feelings and doubts about accomplishments. These feelings can be addressed so that they do not impede members meeting their goals and moving on to others. Other tasks of the worker are (a) helping members maintain and generalize changes they have made; (b) preparing members for the end of group by discussing the planned ending, by encouraging supportive

relationships outside the group, and by supporting group members' self reliance; (c) helping members plan for the future; (d) making referrals, and (e) evaluating the group (Toseland & Rivas, 1995).

Applicability of Group Work for Single Mother Families

Groups have been used to address the needs of single mothers seeking support in their parenting role (First & Way, 1995; Webster-Stratton, 1997). Support groups for single mothers have been used as one way of preventing or reducing risks factors that place them at risk of problem parenting (Telleen et al, 1989). Psychoeducational groups can combine these functions, bringing together members who are assessed as being "at-risk" for potential disturbance in functioning (Toseland & Rivas, 1995). Psychoeducational groups are generally time-limited, structured groups that blend education, skill development and practice, discussion of problems experienced outside the group and support. These components are recommended for interventions with single parent families with concerns about children (Halpern, 1990; Howing et al., 1989; Tolan & McKay, 1996; Whipple & Wilson, 1996).

Efficacy of Psychoeducational Group Work

In their discussion of the literature reporting on the efficacy of group work Toseland and Rivas (1995) found that groups with clear agendas, specific purposes, structured meetings and homogeneous concerns of members were reported as more effective than groups with less structure when specific information and coping strategies where the focal interest of members. In those groups where obtaining support was the major goal, structured groups were reported to be less effective than those with flexible

group structures. Less structured groups were reported to allow time for members to talk about their concerns and to offer and receive support.

Structural Family Therapy

Prior to the development of family systems theories psychosocial problems had been located almost exclusively within individuals, were defined as psychopathology and required a resolution of past experiences. Family systems therapies view the individual within the context of his or her family and, for the most part, focus on the presenting problem (Becvar & Becvar, 1996; Nichols & Schwartz, 1998).

Structural family systems therapy was developed in clinical work with underorganized families many of who were impoverished and led by single mothers (Colapinto, 1991). The focus of intervention was to understand the immediate situation, solve the presenting problem in a relatively brief period of time while always remaining aware of the influence of contextual factors. The goal of treatment was to bring about behavioural change in family members, not just the child whose behaviour had brought the family into contact with the service. This approach expanded to include the community in the assessment and interventions with families (Aponte & Van Deusen, 1981; Colapinto, 1991).

Theoretical Orientation

Structural family therapy views individual behaviour within the primary context of the family that is embedded in a cultural and social context at a given point in history (Minuchin, 1974). Families develop structures, or implicit and explicit arrangements, that influence transactions between members and with those outside the family system. Within multiple contexts, individuals experience their own realities and develop a sense

of self, which includes feelings of belonging and separateness. While the family is viewed as a "whole", individuals within the family must also negotiate degrees of differentiation and integration with the family and other systems (Colapinto, 1991). Structural therapists become part of the family's context, take a here-and-now focus and direct change efforts at dysfunctional structures or organizational patterns. Changes in the behaviour of family members will occur in response to changes in context (Aponte & Van Deusen, 1981; Colapinto, 1991).

Functional Family

Structural family therapists maintain that there are a wide variety of behaviours that can be functional within the context of a family and its society (Aponte, 1976; Colapinto, 1991). Families are seen as: (a) open systems, subject to input from the internal and external environment, and always in transformation; (b) undergoing development, adapting to different individual and family stages by restructuring, and (c) maintaining continuity and enhancing the growth of its members by adapting to changed circumstances. Family life is normally stressful and difficulties in coping and cooperating are expected (Colapinto, 1991; Nichols & Schwartz, 1991).

Subsystems

Structural therapy assumes that differentiated subsystems are necessary if a family is to perform its primary function of supporting its members and adapting to the demands of the social environment. Subsystems can be parental, spousal, sibling and parent-child. Functioning is assumed to be maintained by a hierarchical division of power between parental and sibling subsystems, a complementarity of roles between adults performing parenting tasks and idiosyncratic expectations that family members

have of each other (Minuchin, 1974). Acknowledging a hierarchy in the family structure is not prescriptive of any kind of division of roles, but it implies that families need some kind of structure, with differentiation of child and parental functions (Colapinto, 1991). The integrity of a subsystem is maintained by rules defining who carries out the functions and how they are done. The definition of functional subsystems and families has evolved through the application of the therapy model with single parent families and the feminist critique of power imbalances and role allocations based on gender (Canetto, 1996; Colapinto, 1991; Walsh, 1982; Walters et al., 1988).

Spousal Subsystem

The individuals within a spousal subsystem must develop the skills to negotiate mutual accommodation and complementarity of roles. Partners must give up a part of their separateness to gain a sense of belonging in the new system that, ideally, will foster mutual interdependence (Nichols & Schwartz, 1998). A spousal subsystem can be a major source of emotional and developmental support or it can bring out negative characteristics in partners and become a source of stress (Emery & Tuer, 1993; Minuchin, 1974). Boundaries that protect it from interference but allow contact and input from other systems must be established (Carter & McGoldrick, 1989; Nichols & Schwartz, 1998).

In single parent families the affective and supportive functions of the spousal subsystem must be obtained through the formation of other subsystems, which may involve individuals from outside the household (Brown, 1989a, 1989b; Hines, 1989; Kissman, 1991; Walters et al., 1988).

Parental Subsystem

A parental subsystem is formed with the arrival of a child and functions to socialize and provide for the child (Nichols & Schwartz, 1998). The parental subsystem may be formed without the formation of a spousal subsystem (Hines, 1989). The tasks of parenting require constant modification in the amount of guidance and autonomy the parent provides to a child, grounded in an understanding of developmental and idiosyncratic needs (Carter & Mc Goldrick, 1989; Macoby, 1992). Power differences between the parental and child subsystems are based on the parents' greater competency and knowledge about the world, their access to resources and their greater physical strength and size. The authority a parent has with respect to his or her child is necessary to function in the parental role (Colapinto, 1991; Macoby, 1992). A weak parental subsystem may establish restrictive control that will become excessive when that control is ineffective. Interventions with families negotiating parent-child transactions must ensure that participants from both subsystems are supported (Minuchin, 1974).

Those in the parenting role form a parenting alliance through their negotiation of childrearing, financial and household functions (Emery & Tuer, 1993). Issues of gender and sex-role functioning will impact these negotiations and role definition. The highest rates of marital dissatisfaction, conflict and divorce occur at this stage of the family life cycle for two parent families (Carter & McGoldrick, 1989; Macoby, 1992).

In single parent families, the parental subsystem may take on different configurations and alignments may cross hierarchical and/or household boundaries in order to find ways to accommodate to the needs of family members (Colapinto, 1998; Emery & Tuer, 1993; Kissman, 1991; Walters et al., 1988).

Sibling Subsystem

Sibling subsystem relationships are often the first place where children learn to negotiate, cooperate and compete with peers. This subsystem requires a boundary that allows its members to have privacy, pursue their own interests and explore their environment in accordance with its members' developmental stages and individual abilities (Minuchin, 1974; Nichols & Schwartz, 1998).

Extrafamilial Systems

External systems such as work, school, extended family, friends and social agencies are powerful organizers of family structures. They may be sources of stress or support for individual family members. Their effects are included in assessment and restructuring (Colapinto, 1991; Kaplan & Girard, 1994; Minuchin, 1974).

Family Dysfunction

Families are assumed to be constantly transforming, developing systems with adaptive processes that allow them to accommodate to pressures from within and outside the system. Adaptation involves a range of patterns of interaction and the flexibility to mobilize them as required, allowing individuals in the family to grow and maintaining the continuity of the family. A conceptualization of function and dysfunction rests upon an understanding of the social context in which a family operates. The requirements for the survival and growth of individual families are dictated by the economic, historical, cultural and ethnic context of which it is a part (Aponte & Van Deusen, 1981).

Dysfunction, manifested in behavioural disturbance, occurs when a family has difficulties finding alternatives to their current patterns of interaction and fails to adapt

and restructure in the face of a normative developmental crisis or an unexpected event (Nichols & Schwartz, 1998). The family may adapt to stress by becoming stuck in rigid transactional patterns and may resist or avoid exploration of alternative ways of relating (Colapinto, 1991).

Goals of Therapy

With normative models of family and individual development in mind, the structural therapist enters the family's system and explores the changing realities of its members and the family as a whole. The structural therapist seeks an understanding of how the family has organized itself to deal with the demands placed on it. The presenting symptom is presumed to serve a function in the family and to be the result of dysfunctional family processes. Change efforts are geared toward altering the family organization. This reorganization allows the family to mobilize its resources, find alternative ways of relating to resolve the presenting problem and to become more flexible in realigning itself to accommodate to future demands (Colapinto, 1991; Minuchin, 1974).

Theoretical Concepts

Structural family therapy emphasizes organizational issues or the structures of the family that govern members' transactions. Goals of therapy centre on correcting dysfunctional hierarchies and differentiating between subsystems. Although structural therapy draws much from systems theory, it also relies on metaphoric concepts such as boundaries, roles, mapping and structures to assist in assessment and planning interventions (Colapinto, 1991).

Structures

Structures refer to the organizational patterns the family develops to carry out its functions. Families vary in the variety of structures they have and their ability to shift their organization to meet goals or create new structures to accommodate to new situations. They vary in their consistency in using structures and in their continuity in identity as they evolve and adapt over time and can be seen as underorganized or organized (Aponte & Van Deusen, 1981).

Boundary

Boundaries are the invisible rules and roles in a family delineated by who is in and who is out of any given operation. Boundaries can be drawn around generational, gender, functional or interest groupings. Boundaries can be strengthened, loosened, defined or changed. Ideally, boundaries are open enough to allow transactions within and between subsystems and clear or firm enough to allow the subsystem to function (Nichols & Schwartz, 1998). In divorced families, restructuring establishes a clear boundary separating the divorced couple from each other while still allowing contact between each parent and the children. Problems regarding boundaries may occur when stresses or problems in one subsystem are consistently negotiated through other subsystem. Difficulties may also arise when parent-child relationships become more intense due to increased time spent together and mothers increase their instrumental and emotional reliance on their children (Nichols & Schwartz, 1998).

Hierarchy/Power

Hierarchy refers to the boundary that delineates the leader(s) of a group from the other members (Aponte & Van Deusen, 1981). It refers to the relative power or

influences that one member or subsystem in a family has over the outcome of any given operation. Power is generated in subsystems through alignments between members and activates the system to carry through on a planned action. Generally, the executive or parental subsystem has more power relative to the sibling subsystem. Problems may arise if members lack functional power to carry out their assigned activities or when family arrangements prevent members from acting in an age appropriate manner. An example of a dysfunctional distribution of power and an inappropriate hierarchical boundary is the parental child (Nichols & Schwartz, 1998). In single parent families, hierarchical boundaries may be more flexible and permeable than in two parent households, allowing the family to function (Kissman, 1991; Walters et al., 1988).

Alignment

Alignment refers to the patterned ways that family members relate to each other in opposing or joining in any operation. The most frequently discussed alignments are coalitions or alliances. A coalition can be overt or covert and involves two or more members of the family working in opposition to another. A stable coalition is one in which two members join against another in an inflexible pattern. An alliance is a joining of two members in a supportive relationship. Boundaries define who has the role of rulemaker in the family, alignment refers to whether or not the rule enforcement is supported or opposed, and by whom (Aponte & Van Deusen, 1981).

Triangulation

Triangulation refers to the process in which one family member is called upon by two other family members to side with each against the other. Siding with one member is defined as attacking by the other. In this situation the member asked to choose sides may

be immobilized and exhibit problem behaviours due to conflicting loyalties. Common examples of triangulation are conflictual marital partners or a mother and grandparent in a parenting alliance demanding the loyalty of a child (Aponte & Van Deusen, 1981).

Detouring

Detouring is a form of stable coalition that serves to diffuse the tension between the members of the coalition by attributing problems in the system to a third party (Minuchin, 1974). Those in the coalition may join in taking a solicitous or a hostile stance toward the designated problem member and maintain an illusion of harmony in their relationship. An example would be a problematic spousal subsystem that reinforces deviant behaviour in a child. Concern about the child's problematic behaviour helps them avoid addressing the difficulties in their relationship. The boundary within the spousal subsystem is diffuse and the boundary between the parental and child subsystems is rigid (Minuchin, 1974).

Complementarity

Individuals in the family system are part of a whole. The actions and experiences of one member of the family affect the other members of the family. Complementarity describes the nature of the relation between members as being reciprocal and balanced, fitting together like pieces of a puzzle rather than in sequential two-way interaction (Colapinto, 1991). Complementary relations can contribute to the functioning of the family when members negotiate reciprocal roles. Difficulties arise when the complementary relations activate negative aspects in another or inhibit growth. Change can occur in families where negative complementary processes have been established if one or both parties in the negative interchange can find a different way of responding to

the other. This is known as non-complementary behaviour or, doing the unexpected. Doing something different, provides an opening to establish new ways of relating that can then become established complementary positive processes (Christensen & Thomas, 1980; Minuchin, 1974).

Family Cohesion

Family systems are seen to relate to each other along a continuum of involvement that ranges from high levels of involvement, called enmeshment, to minimal involvement, called disengagement. Most families operate within the very wide normal range and will likely have elements of both enmeshment and disengagement between members that will alter over time (Colapinto, 1991). Enmeshed families or subsystems within families have diffuse boundaries and differentiation of members is low. These arrangements may threaten autonomy or enhance development depending on the stage in the family life cycle, current stresses or cultural expectations. Disengaged families or subsystems have rigid boundaries, autonomy is high, and communication with other systems is difficult. Members in one system may be unaware of the actions or needs of other systems. Supportive actions may not be taken until stress levels are high. Operations at either extreme of this continuum may produce problems (Minuchin, 1974).

Therapy Processes

The goal of treatment is to transform the family system, which involves changing the way family members relate to each other. Transformation occurs as the individual realities of family members are challenged and alternatives are offered that make sense

to them. This challenge alters the expectations that govern their interactions resulting in changes in the way they relate to each other (Nichols & Schwartz, 1998).

The assessment and intervention processes that facilitate family transformation are interactional and inseparable. They include joining, assessment, formulation of a family map and restructuring. They are discussed separately, but in reality occur simultaneously and continue throughout the therapeutic relationship (Colapinto, 1991; Minuchin & Fishman, 1981).

Joining refers to the actions taken by the therapist to be accepted by family members so that she may participate in family transactions and eventually challenge them (Colapinto, 1991). Joining shows the family it is respected, is considered unique and allows the therapist to experience the reality of its members and feel the stress and pain they feel without becoming absorbed in the system. The therapeutic system formed through joining allows an assessment of the current interactional patterns and agreement to be reached on the nature of the problem and the goals for change. *Maintenance* operations are those in which the therapist acknowledges or supports family structures and formulations about their problems as they are presented confirming an understanding of the realities of their life together (Minuchin & Fishman, 1981). *Tracking* involves the therapist encouraging family members to communicate and behave with each other as they would normally, thus revealing their underlying structures, patterns of behaviour, thinking and affective expression patterns (Minuchin, 1974). *Mimesis* is the process by which the therapist accommodates to a family's interactive style and affective range, generally in spontaneous fashion.(Minuchin, 1974).

Assessment is an ongoing, interactional process that begins with the initial telephone contact with the family and evolves from the experiences and observations made in the process of joining the family (Colapinto, 1991). A family may conceptualize its problem as being present in one of its members and be oriented to the past. The family therapist views the whole family as the target of therapeutic efforts and attempts to broaden the focus of the family with regard to the presenting problem. This shift in focus emphasizes the current context of the family and their interactions in the here and now. Assessment yields a **family map** that identifies problematic structures and helps conceptualize therapeutic goals for the family. The therapist redefines the problem for the family, including the family interactions in the formulation (Minuchin & Fishman, 1981).

Assessment includes conceptualizing the family structure, flexibility, cohesion, life context, developmental stage and the role of the identified member's symptom. *Family structure* is the preferred interactional patterns of family members. The therapist develops an understanding of the hierarchies, power distribution, alliances, complementarity of roles and boundaries of the family and its subsystems. Idiosyncratic family features are identified along with the effect they have on communication and affective expression (Minuchin, 1974).

Family flexibility, or the family's capacity for change, is assessed. Is the family able to identify and mobilize alternative structures to address the problem? Can it tolerate deviation from current patterns of interaction, power distribution or subsystem membership? Is there an expressed desire to develop new structures to deal with new situations?

Family cohesion, or the degree to which the system is sensitive to the actions of its individual members, is assessed. A family will fall somewhere on a continuum between enmeshment and disengagement and is likely to have variations between members and at different stages of family development (Colapinto, 1991).

Family life context, or the sources of stress and support in the family's environment, is analyzed.

Family developmental stage and the performance of age appropriate tasks at each stage are examined. The family life cycle stage and the stage related developmental needs of individual family members are considered. Stress in families occurs at the time of life transitions such as the arrival of a child, a marriage, children leaving home or starting school. Dysfunctional behaviours may arise in response to stressful events (Colapinto, 1991).

The role of the identified member's symptoms and its relation to family structure is examined (Colapinto, 1991). For example, is the problem behaviour part of a triangle that diffuses conflict or protects another family member? Does the family support the symptom passively, as members accommodate to the symptomatic behaviour?

Restructuring operations are purposeful, planned interventions that challenge the family in an attempt to bring about a therapeutic change (Nichols & Schwartz, 1998). ***Enactment,*** considered a central operation in structural family therapy, is the encouragement by the therapist of family members to interact in their usual patterns (Colapinto, 1991; Minuchin & Fishman, 1981). Once patterns are understood, the family is asked to engage in activities that will restructure dysfunctional transactions.

When the therapist *marks boundaries* rules about who is included in subsystems and how and when they carry out their functions are made explicit. The responsibilities between and within subsystems are recognized, as are the differences between the generations. Boundaries can be clarified, strengthened, loosened or otherwise altered. Bearing the structural map of the family in mind, the therapist may work with subsystems, form alliances with individual members or block communications that interfere with the interaction of other members (Minuchin & Fishman, 1981).

A therapist may *escalate stress* in the family as a way of disabling dysfunctional interactional patterns the family uses in response to stress. Denial and detouring are often seen in families and may involve the identified patient (Colapinto, 1991). By introducing a stressful event into the therapy session the therapist provides the family with the opportunity to experiment with new and different structures and to grow. Blocking usual transactional patterns, particularly those that reinforce the dysfunctional relations, is one example of escalating stress. Emphasizing differences that the family minimizes or ignores so that different opinions can be discussed, developing implicit conflict where conflict has been diffused or avoided and joining in an alliance or coalition with an individual member or subsystem are also ways of escalating stress or *unbalancing* the system (Colapinto, 1991).

In some cases, especially those where the presenting symptom is painful or dangerous, the therapist may choose to *utilize the symptom.* The family may be unable or unwilling to focus on anything but the presenting symptom so it must take priority. The therapist may *focus on the symptom*, engaging the family in problem solving efforts. As the symptom recedes, therapy may shift to the underlying structures. The therapist may

exaggerate the symptom, to increase its intensity and elicit a response from appropriate family members. *De-emphasizing the symptom* may move the family towards an awareness of a larger context and also move the focus away from exclusive attention on the presenting problem member. *Moving to a new symptom* of a different family member may reveal the function of the symptom to the family or may shift the family's view of their problem, as might *relabelling the symptom* in interpersonal terms (Minuchin, 1974).

There are numerous other restructuring techniques (Minuchin & Fishman, 1981) the variety and number limited only by the imagination of the therapist (Jung, 1984). Techniques, however, must be integrated into the therapist's personal style and are not generically applied (Colapinto, 1991). The therapist acts from a position of respect for the family and its values and the technique is applied to move the family toward its goals.

Critique of Structural Family Therapy

Structural family therapy has been criticized for being judgmental, controlling and pathologizing (Colapinto, 1991). Theoretical arguments that refute these criticisms are provided by Simon (1995), Wetchler (1995) and Colapinto (1991) although Simon (1995) notes that the way that structural family therapy is practiced may not necessarily be consistent with the theoretical underpinnings. A basic assumption of the structural family therapy framework is a belief in the family's inherent competence to marshal its resources and to solve its problems. Problems are perceived to be due to outdated structures rather than the pathology of its members or the family form (Colapinto, 1991). Structural family therapy has always advocated a depathologizing stance when assessing problems in families, eschewing labels and viewing a family within its historical and current context (Ault-Riche, 1986).

As to structural family therapy being judgmental, Simon (1995) and Wetchler (1995) point to the framework's assumption of the uniqueness of each family. The therapist joins with family members and is encouraged to be open to corrective feedback from clients. Joining helps to ensure the therapist does not impose her own values and expectations on the family although there is an expectation that all families will pass through a series of normative stages (Colapinto, 1991) and that the negotiation of values is an important aspect of the therapeutic relationship (Aponte, 1985). Others (Jung, 1984; Napoliello & Smith Sweet, 1982) view structural family therapy as applicable for use with Chinese and Native American families, respectively, in part because it is not judgmental and is able to accommodate the beliefs about and realities of family life for members of these cultural communities.

Enactment, one of the fundamental processes of structural family therapy, puts the family at the centre of the therapeutic process and gives the family responsibility and control over the ultimate direction of the therapy process (Wetchler, 1995). The therapist takes a directive, interactive approach that requires the therapist to be genuine and respectful of the family as they explore the meanings and values of what is 'normal' to them. The directive approach, which may appear to be controlling to some, gives family members some impetus to get 'unstuck' from their previous patterns of interaction (Simon, 1995).

Structural family therapy has been criticized, along with family systems therapies in general, for implicit and explicit assumptions about the nature of men and women and of families. These assumptions may imply an acceptance of the unequal distribution of power between men and women in society. Feminist and sociological scholars have

contributed much to the examination of family processes to determine if and how they take the effect of gender into account, how they conceptualize families and how they include contextual factors in formulations about family dynamics (Ault-Riche, 1986; Walters et al., 1988). A feminist analysis demonstrates that the benefits associated with families (nurturing, commitment, intimacy, collectivity) may accrue to men and children, often at the expense of women's social, financial, sexual and psychological freedom (Baines et al., 1998). Family systems therapy can inadvertently reinforce the needs of the family or of a relationship over the needs of the individual. This may disadvantage women in families, especially if the arrangements restrict their growth and freedom without acknowledging or supporting their contributions. Structural family therapy operates on the premise that a family, whose form and membership is defined by its members, has to find a balance between maintaining the integrity of the family as a whole and meeting the needs of its individual members (Minuchin, 1974; Simon, 1996).

Complementarity, when seen as a mechanism to distribute responsibility and resources in families, is negotiable but assumes an equal distribution of power between adults in the family. This implies men and women have equal choice and opportunity in taking on roles. It may be used to reinforce ideas about the 'natural' roles of women and men and 'normal' families that do not reflect the real talents, interests or circumstances of family members (Walsh, 1982; Walters et al., 1988). Sex role stereotypes, gendered divisions of labour and definitions of what constitutes a normal family may but do not have to be perpetuated in families. The expectations members have of each other, their beliefs, roles and previous dysfunctional patterns may be redefined and negotiated within the structural therapy framework (Kissman, 1991; Simon, 1996; Walters et al., 1988).

Domestic abuse has been examined extensively in the field of family therapy (Bograd, 1992). Purely systemic formulations assume there are reciprocal relationships between all members of the family system, with abuse playing a stabilizing or instrumental role. Systems formulations, in effect, blame the victim and diffuse the responsibility for the abuse, with destructive and sometimes fatal results (Bograd, 1992). These formulations do not account for the unequal power that different participants in an interchange hold within the family system. Although a demanding toddler may play a part in a sequence of events, she does not play an equal part in subsequent verbal or physical abuse by her irate mother. An abused family member, whether a child or an adult, does not have equal power, options or an equal ability to change the cycle of interaction (Walters et al., 1988).

Structural family therapy has no theoretical mechanism to account for the inequities of social power in families. Hierarchical divisions within the structural family therapy framework can be taken to mean that some members have the unquestioned right to exercise 'power over ' others and imply an acceptance of patriarchal arrangements between men and women and between adults and children (Ault-Riche, 1986). The need for the parental subsystem to adjust to the changing needs of children as their development progresses is part of the structural framework and its proponents advocate an authoritative parenting style versus an authoritarian one (Colapinto, 1991; Nichols & Schwartz, 1998). Parental authority exercised through restrictive control is seen as evidence of a weak parental subsystem and excessive control is seen as most likely when control efforts were ineffective (Minuchin, 1974). These premises are consistent with egalitarian values and gender sensitive practice (Walters et al., 1988).

Structural family therapy acknowledges the influence of the family's historical, cultural and economic context developing an understanding of the family problem (Ault-Riche, 1986; Colapinto, 1991; Simon, 1996). Intervention and change efforts continue to take place predominantly within the family, however, application of the structural family therapy method by some includes external structures in the formulation of problems and in the therapeutic process (Aponte, Zarski, Bixenstine, & Cibik, 1991; Kaplan & Girard, 1994; Kissman, 1991). Structural therapists have also been active in exploring the oppressive and disempowering effects of social service systems that are meant to assist families in an effort to affect policies that address the needs of families in society today (Kaplan & Girard, 1994).

Applicability of Structural Family Therapy to Work with Single-Mother Families

Structural family therapy seems to be a logical choice for work with single parent families because it was developed with a population that included low income, multiproblem, single parent families (Colapinto, 1991). This early work contributed to an understanding of the effects of context on family structure and function and marked the beginning of theoretical frameworks about disengaged and enmeshed family relationships (Colapinto, 1991). It is currently used in preventive programs for 'at risk' populations (Aponte et al, 1991; Kaplan & Girard, 1994; Tolan & McKay, 1996), and is the most widely practiced of the family systems therapies (Nichols & Schwartz, 1998). As long as the presenting problem has an interactional component, the model is applicable and it can be adapted to ensure gender (Ault-Riche, 1986; Walters et al, 1988) and cultural sensitivity (Jung, 1984; Napoliello & Smith Sweet, 1992). Although social learning based parent training is reportedly more effective than structural family therapy

in reducing child behavioural problems (Roy & Frankel, 1995) it is also reported that single parent families are among those who do not benefit from behaviourally based programs alone (Webster-Stratton, 1997). It may be that some single parent families can benefit from structural family therapy sessions as well as other treatment options to improve their family functioning (Kaplan & Girard, 1995).

Work with Single Parent Families

A variety of writers emphasize that the single parent family is an intact family unit that requires special consideration when therapists provide services to them (Kissman, 1991; Walters et al., 1988). Structural family therapy affirms the legitimacy, viability and unique qualities of the single parent family as an initial step in normalizing and destigmatizing single mothers and their children (Kissman, 1991). The therapist and family may co-create a context where members can internalize positive images and definitions of their family (Walters et al., 1988).

Assessment includes an exploration of the impact of external factors and available supports inside and outside the family (Colapinto, 1991; Kissman, 1991). Healthy adjustments that include hierarchical boundaries and alliances not necessarily confined to the nuclear family are confirmed or encouraged. Functional cross-generational alliances can also be part of healthy adjustment, with the adult always maintaining appropriate responsibility for decision making (Walters et al., 1988).

A therapeutic alliance can be formed between the single-mother and the therapist, creating a generational subsystem. This temporary subsystem lends support and corroboration for the adult views of the mother by confirming her sense of reality and providing opportunities to explore options possibly adding to the mother's limited

resources (Walters et al., 1988). This alliance will likely take a less directive approach than some structural therapy stances, as the goal of the alliance is to support the mother in her role as parent, not to replace or supplant her.

Therapy with single mothers should include an affirmation of their strengths and abilities and an acknowledgment of areas where growth can occur. Confirming a sense of herself as an individual and strengthening self-respect allows the single parent to effectively establish herself in her executive role in the family (Kissman, 1991). Healthy single-parent families have identified defining clear lines of authority, combining nurturing and managerial functions in one parent, forming alliances inside and outside the family unit and loosening generational and hierarchical boundaries as ways of contributing to healthy functioning after divorce. These family adaptations reportedly help maintain the integrity of the family as a whole and promote the growth and autonomy of individuals (Walters et al., 1988).

Linking single mothers with other individuals and community resources is another important aspect of therapy (Kissman, 1991). Once the therapy concludes, the therapeutic generational alliance will end. Mobilizing an ally in the mother's extended family or friendship network and encouraging links with community resources promotes the development of both instrumental and affective supports. It is important to assess a mother's social network, as not all are inherently supportive. Problems may arise when a single mother relies on family members for assistance at the expense of her own autonomy in making decisions for herself and her children (Kissman, 1991).

The stage in the family life cycle, the route to single parenthood, the length of time as a single-mother family and the presenting problem will influence the therapy

process. The formation of a single parent family is conceptualized as a transition requiring negotiation of boundaries, formation of subsystems and alliances (Carter & McGoldrick, 1989; Kissman, 1991). Brown (1989a & 1989b) provides models of family transition after the death of a spouse and after divorce or separation. Stages with associated tasks for family members are presented that, if resolved, allow the family to restabilize and proceed developmentally in its new form. Hines (1989) provides a model of family life stages for low-income single-mother families. As with all models, the stages are not prescriptive, comprehensive or resolved in consecutive fashion but can guide an understanding of families and planned interventions.

Some single parent families will have family structures characterized by inconsistent leadership, shifting or unclear boundaries and a lack of consistency and flexibility of structures with which to respond to the multiple demands from external and internal factors (Aponte, 1976; Hines, 1989). Structural family therapy with these multiproblem families directs change efforts at communication patterns, structures required for effective parenting, conflict resolution, coping and the affective system (Aponte, 1976). Family therapy is one part of a multifaceted approach that also includes assessing and advocating for the relevant material needs of families and dealing with crisis in a myriad of areas (Kaplan & Girard, 1994).

Summary

Single-mother families are at significant risk of experiencing problems in adjustment due to stresses arising from factors within and from outside the family system. Structural family therapy and group therapies may be effective in meeting the therapeutic needs of these families, particularly when the presenting problem is a child

behaviour problem. Structural family therapy allows the therapist to address not only the presenting problem but also the family dynamics that reinforce the problem. Group interventions with single mothers assume change comes from members' experiences in relationship with others in similar circumstances and concerns. Groups may be effective in addressing members' needs for support and skill development within the context of a mutual aid system. Efforts are made to promote the development of this mutual aid system so that members can work toward their individual goals. Both interventions acknowledge the effect of the context in which families operate and can be used in cross-cultural settings.

PART TWO: THE PRACTICUM

CHAPTER TWO

PRACTICUM DESCRIPTION

Setting

The practicum was carried out at a Winnipeg inner city counseling centre affiliated with the Faculty of Social Work and the Department of Psychology at the University of Manitoba. The Elizabeth Hill Counseling Centre (EHCC) offers free services to adults, children, adolescents, families, couples and groups provided by students-in-training from the affiliated faculties. Faculty advisors and permanent staff on site provide regular student supervision. Service may be requested directly or by referral from other professionals such as teachers, counselors, social service agency staff or health care professionals.

Clients

Single-mother families with a latency-aged child identified as having behavioural or emotional problems were sought for a Parent-Child Group Program. My particular role in this program was to facilitate a psycho-educational support group for mothers whose children would be attending a concurrent social skills group. Those interested families for whom the group program did not appear to be suitable were offered family therapy with me, or were referred to other suitable services. Potential clients were identified from the EHCC waiting list and through direct contact with Winnipeg One School Division staff and Child and Family Service (CFS) workers throughout the city. Program announcements were posted in social service agencies and also in local newspapers and on radio and cable TV to recruit families for the group intervention.

Recruitment took place over a five-month period. Although professional contacts at schools and CFS were supportive of the program, few of the families they approached self-referred. Eleven intake interviews were completed with clients who self referred after hearing about the group program from a school counselor (5), other counselor (3), Child and Family Services caseworker (2) or newspaper notice (1). One mother declined all services and one requested family therapy that would include all of her children. The group program was unsuitable for four families. Reasons for its unsuitability included suspected child sexual abuse requiring investigation, severe child behaviours that would endanger the safety of other group members, active substance abuse and chronic illness of the mother. These families were referred to appropriate services outside EHCC. Intake appointments for family therapy were arranged with two additional families, after telephone contact determined that the group intervention would not be suitable for them.

Of the original five mother-child dyads accepted into the group program, three completed the 10 week group intervention, engaged in formal termination processes and went on to attend the final portion of the program. Two dyads withdrew from the group program and did not participate in formal termination processes. Three families were seen in family therapy. An analysis of the group intervention is presented in Chapter Three and one of the structural family therapy cases is presented in Chapter Four.

Procedures: Group Program

All mothers were self referred and most initially contacted the clinic by telephone to discuss the program and their particular situations and concerns. The Parent-Child Group Program and the process of therapy for clients participating in a student

practicum and research study were discussed with each mother. A brief description of the group program included: the group purpose, length of sessions, frequency and duration of the program; the group format with separate groups for mothers and children followed by a group with mothers and children meeting together and; the kinds of topics that might be discussed. If the program seemed suitable further assessment interviews were arranged, consents obtained and assessment instruments administered. Clients were provided with more details of their and their child's role in the group program and the two facilitators' roles as student clinicians. At the completion of the assessment, clients were advised of the proposed start date for the group and were encouraged to contact the facilitators with any questions or concerns prior to beginning and throughout the group program.

Group Composition

A group combining the attributes of psycho-educational and support groups was determined to be an effective format to meet the overall goal of strengthening the mother-child relationship. Increasing the mother's empathy and age appropriate behavioural expectations for her child, developing parenting skills and competence in the parenting role and identifying factors outside the parent-child relationship that impact on parenting could be addressed in this type of group format. Psycho-educational groups that provide information to members and opportunities to process it with a group of peers can be effective when they are closed and time limited (Rose, 1989; Toseland & Rivas, 1995). The specific information, the amount and timing of its presentation depended on the particular learning needs and circumstances of the group members and are summarized in a group session outline (Appendix A). This approach to agenda

development has been described in the literature and suggested as useful when working with highly stressed parents (First & Way, 1995; Rose, 1989; Whipple & Wilson, 1996).

Due to the nature of the problems experienced by the children, the beginning skill level of the facilitators and the multifamily group portion of the program, it was decided that six dyads was the maximum number that could be accommodated. This limited the number of participating mothers and presented the risk that the group size would be quite small if anyone dropped out.

Programs that run for at least a few months have been reported as more likely to result in changes in parent behaviours and attitudes (Whipple & Wilson, 1996). It was hoped that the program could run for most of the school year, with the separate groups running through the fall and winter and the multifamily group concluding in the spring. In the end, due to recruitment difficulties, the group started at the end of February, ran for 10 weeks and started with five families.

The group met one evening a week, with a break after session five that coincided with the school Spring Break. Each evening meeting was comprised of three parts: brief check-in and check-out activities at the beginning and the end of the meetings that included mothers and children together and separate mothers' and children's group sessions that lasted approximently sixty minutes. After completion of the ten-week program, mothers and children repeated the assessment measures, a Client Feedback Form (Appendix B) and participated in an exit interview with the group facilitators.

Assessment interviews and group sessions were videotaped for supervision purposes. Written records were completed of the assessment, intervention, client progress and outcomes in accordance with EHCC procedures.

Procedures: Family Therapy Clients

All three family therapy clients had initially requested the group program but this mode of intervention was not suitable for them for a variety of reasons. Clients were given an explanation of the process of therapy for clients participating in a student practicum. If they were not already receiving services from another agency and gave their verbal consent to participate in family therapy sessions, an intake interview was arranged. Videotaping and written records were kept in accordance with EHCC requirements, as described for the group intervention. Additional notes about sessions, planned interventions and reflections were kept for supervision and report writing.

All families were seen at EHCC except for two sessions that took place in the home of one client family at the time of termination. One family, described later in this report, participated in family therapy with a co-therapy team. One client family, consisting of a single mother and her four children, was seen for a total of five sessions over a two-month period. The presenting concern was behavioural problems in the eldest child, a 12-year-old son. Sessions were used to explore the impact of multiple stresses on the family structures arising from crowded living quarters, a legal dispute, abuse by the mother's boyfriend, and strained relations with extended family. Structural changes were accomplished by supporting the mother in her executive role as she made arrangements to move to a larger apartment, establish age appropriate responsibilities and rewards for her eldest son, and negotiate child care arrangements with extended family. The negative effects of abuse were explored prompting changes in the mother's relationship with her boyfriend. Although additional sessions were offered, the family determined that the presenting problem was resolved and discontinued sessions.

The other family therapy client attended 17 sessions over a six month period. The family consisted of a divorced single mother and her two sons, aged 7 and 11 years, who were half- brothers. The eldest child's repeated school suspensions were the identified problem. The family was in transition after the mother left a physically abusive marriage. External stresses included work, school and long hours in daycare and limited social support. The goal of therapy was to clarify the parental role in the family and increase communication between the mother and her son and between the mother and school staff. A family support worker, collateral contact with school and day care staff and family therapy sessions to discuss the family's restructuring after the divorce were some of the interventions. Exploration of the effects of abuse on the family and its members was initiated. Although further sessions were offered, family therapy ended as the presenting problem abated and the school year ended.

Supervision

Dr. Diane Hiebert-Murphy, my Faculty Advisor and the Chairperson of the Practicum Committee provided primary supervision for both the group and family therapy interventions. David Charabin, Director of the EHCC and an adjunct member of the Faculty of Social Work, and Linda Perry, a member of the permanent counseling staff at EHCC and an adjunct member of the Faculty of Social Work completed the Practicum Committee, provided advice, approved the practicum proposal and reviewed the completed practicum report.

Group Supervision

In the initial stages of group formation, supervision meetings were held every two or three weeks and included the children's group facilitator, Dr. Hiebert-Murphy and me.

Potential group dyads, assessment information and appropriate case management activities for dyads accepted and not accepted for the group program were discussed. Dr. Hiebert-Murphy was also available to discuss cases more informally at the EHCC and by telephone, on an on-going basis. Once the group was formed and sessions started, weekly two to three hour supervision meetings were held that included a second children's group facilitator. These sessions provided opportunities to exchange impressions and concerns about the needs and problems of the mothers and children in the groups and share plans for joint and individual group sessions. Dr. Hiebert-Murphy provided advice regarding specific activities and guided and monitored discussions.

Family Therapy Supervision

Dr. Hiebert-Murphy provided supervision for two or three hours each week to discuss the families attending weekly family therapy sessions with a co-therapist joining supervision sessions regarding one family. Formulations and specific interventions were discussed and Dr. Hiebert-Murphy monitored and evaluated activities.

Evaluation

The practicum was evaluated from a number of different perspectives. Outcomes for clients were measured using the Child Behaviour Checklist (CBCL) and Parenting Stress Index (PSI) that were administered pre and post-intervention. These measures were compared to determine if any changes had occurred in the mothers' or children's identified problem areas. A Client Feedback Form (Appendix B) and a post-group interview with mothers provided a qualitative measure of the intervention and asked for opinions about the clients' experiences, their satisfaction with the therapist and a self-assessment of the benefits of the group program.

An evaluation of my own learning goals was ongoing. My conceptual knowledge of the group and structural family therapy interventions and my practice skills were subjectively measured in the regular supervision meetings and in reflection on my practice experience.

Child Behaviour Checklist (CBCL)

The CBCL (Achenbach & Edelbrock, 1983) records the social competencies and behavioural problems of children as reported by a parent or adult who knows them well. The tool provides a description of a child's behaviours that can be compared to a normative or non-clinical population of children of similar age and gender. It has been found to differentiate clinical from non-clinical populations and is meant to be part of a comprehensive assessment of a child and not a diagnostic tool on its own.

The CBCL was developed from a psychiatric paradigm and six of the eight behavioural domains can be grouped into internalizing and externalizing behaviours. Behavioural subscales are grouped into withdrawn, somatic complaints, anxious/depressed, thought problems, social problems, attention problems, aggressive behaviours and delinquent behaviours. Subscales can be viewed separately or combined to obtain a total score. Total scores can be compared to normed group scores to determine if a child is exhibiting behaviours that are clinically significant (Mooney, 1984).

The social competency sections are more subjective and have been found to be less useful in distinguishing clinic-referred from non-clinic referred children. This section can give some idea of how a parent sees his or her child in terms of school and social status in comparison to peers (Mooney, 1984).

The normative samples are reported to correspond with the clinical sample with respect to race, socioeconomic group and parental relationship. Insufficient cultural and racial diversity of both populations may make the tool less valid for First Nations, non-white and non-black communities (Mooney, 1984).

Inter-rater reliability between parents and test-retest reliability are reported as high. Subscales have a range of reliabilities. The total problem behaviour index reliably distinguishes disturbed from non-disturbed children (Mooney, 1984).

Behaviour problem scales seem to have high face validity, as they are empirically based on a large sample of clinical children's behaviours. The scales are based on problem behaviours and as long as users bear that in mind the tool will be used as it was intended, and not as a normative scale. The social competency section appears to have face and content validity, however the items were arrived at subjectively, are not exhaustive and appear to be similar for all age groups (Mooney, 1984).

Construct validity for the problem behaviour scales is indicated by high correlation with other measures of parent perceptions of their children and has increased as studies using the tool have been carried out since it was first introduced (Achenbach & Edelbrock, 1983).

Parenting Stress Index (PSI)

The PSI (Abidin, 1995) is a standardized pen and paper self-report designed for use as a screening and diagnostic assessment technique to identify parent-child dyads that may be at risk for the development of dysfunctional interaction patterns. In identifying stressed parent-child systems, it is hoped that children at risk of developing behavioural and emotional disturbance could be identified early and interventions to reduce risk

factors could be undertaken. Individual scores are compared to a normative score and critical cut-off scores are provided.

The tool was devised by Dr. R. Abidin, based on the assumption that if there are stressors present in a family, there is an increased likelihood that high stress levels will be experienced by the family that may result in dysfunctional parenting. An extensive review of child development, parent-child interaction, attachment, child abuse and neglect, child psychopathology, child-rearing practice and stress literature was the basis for the list of dimensions that make up the instrument. The Life Stress and the Total Stress scales indicate if there are stresses outside the parent-child relationship and if the system is experiencing stress, respectively. The PSI is divided into a child and a parent domain each comprised of subscales. The child domain attempts to capture the parent's perception of his or her child's characteristics and the effect of these characteristics on the parent. It is comprised of six subscales entitled Adaptability, Acceptability, Demandingness, Mood, Hyperactivity/Distractibility and Reinforces Parent. The parent domain is comprised of seven subscales entitled Depression, Attachment, Restrictions of Role, Sense of Competence, Social Isolation, Relationship with Spouse and Parental Health. These subscales attempt to capture principal parent characteristics and family context variables that have been identified as impacting upon a parent's ability to function as a competent caregiver.

Test retest reliability reports are moderate to high for both the child and parent domains and the total scores (Abidin, 1995). It has been found to be valid for use with a diverse variety of racial and cultural communities as well as diverse non-English speaking

cultures. Content, construct and concurrent validity are reported as being sufficiently high.

Client Feedback Form

The Client Feedback Form was devised by the student clinician and was administered following the conclusion of the 10-week group program (Appendix B).

CHAPTER THREE

THE GROUP INTERVENTION

Section One: Planning and Forming the Group

A group program was proposed by staff at the EHCC to meet the treatment needs of single-mother families in which a latency aged child was identified as having behavioural problems. The purpose of the program was to improve the relationships within referred families by supporting the mothers in their parenting role and helping the children develop social skills (see Appendix C).

Assessment

Group members were accepted into the group if they met the criteria established for the group (Appendix C), if they could attend regularly and if their goal was to improve their relationship with the identified child as a way of addressing his or her behaviour problems.

The Members

Susan and John

Susan, a 28-year-old Caucasian single mother of two, entered the group due to concerns about her children's frequent arguments, and her 9-year-old son's temper tantrums and destruction of personal belongings when angry. Susan expressed feelings of rejection by her children and doubts about her parenting abilities. Stressors on the family included a shared custody arrangement, limited fixed income, and Susan's social isolation. Conflictual relationships with extended family and her ex-partner's new wife and verbal abuse by her ex-partner were identified as additional sources of stress. Susan reported limited sources of support. She had no previous group experience.

Formulation

The results of the assessment suggested Susan was committed to her role as a parent but appeared to have difficulty distinguishing the individual needs of her children and the possible impact of custody arrangements and her eldest son's verbal and physical abuse on John's behaviour. She appeared to rely on her children for feedback and support of her parenting.

Goals

Susan's goal was to learn parenting skills to address situations with her children, particularly those involving anger. She hoped the group could provide opportunities to discuss parenting with other mothers and learn about child development.

The group was seen as a way of providing Susan with opportunities to connect with other mothers, thereby reducing isolation, supporting and validating her positive parenting and possibly increasing her confidence in her parenting abilities and decreasing her reliance on her children for support. Personal issues and external stressors impacting her parenting could be identified and addressed. Child development information could assist her in developing age appropriate behavioural expectations. Discussing the impact of previous and current abuse by her ex-partner and her son's abusive behaviours might be of benefit.

Betty and Nancy

Betty, a 22 year old, Aboriginal single mother of one child, joined the group due to concerns about her 7-year-old daughter's temper tantrums, aggressive behaviours toward peers and teachers and destruction of property. Betty reported feeling concerned, frustrated, angry and embarrassed by Nancy's behaviours. Stresses on the family included

Betty's young age and inexperience parenting, frequent changes in school and housing locations, long hours at work and in daycare, low income, and conflictual relationships with extended family members. Betty's supports included extended family members, supportive same-aged friends, regular employment and supportive school services. Betty had previous group experience in a parenting program she had attended intermittently.

Formulation

The results of the assessment suggested that Betty was a young parent, struggling to meet the developmental challenges of young adulthood and parenting her latency aged daughter after a period of living apart. Her expressed desire to develop her relationship with Nancy appeared to be thwarted by negative feelings and a lack of knowledge about and confidence in her parenting. Nancy's negative behaviours were likely due to a combination of past and current factors including experiences of loss and difficulties in adjustment to new living arrangements.

Goals

Betty's goal was to talk about the mothering role with other single mothers who were also experiencing difficulty with their child's behaviour and to learn ways to deal with and change Nancy's behaviours. The group was seen as a way of providing Betty and Nancy with an opportunity to participate in an activity together, and to normalize and validate Betty's parenting experiences. It was assumed that her participation would reduce her anxiety about parenting and decrease her isolation from parenting supports. Providing child development information could assist Betty in developing age appropriate behavioural expectations and increase her empathy for her daughter. Sharing

coping strategies with other mothers was expected to help in the development of her own coping skills.

Jane and Wendy

Jane, a 35-year-old Black, single mother of one 7-year-old daughter, joined the group due to concerns about Wendy's verbal and physical aggression, temper tantrums, attention difficulties and impulsiveness that had resulted in almost daily in-school suspension and rejections by her peers. Jane was feeling anxious, frustrated, hurt and discouraged by Wendy's behaviours. Other stresses on the family included recent increases in Jane's work schedule, the family's social isolation, increased time in out of home daycare and recent problems with school staff and extended family members. Jane's supports included members of her extended family, some close friends, her job and supportive school and medical staff. Jane had no previous group experience.

Formulation

The results of the assessment suggested Jane was feeling rejected and anxious about her child who, it appeared, might be exhibiting attention difficulties. Jane appeared to be experiencing stress due to a lack of support and confidence in her parenting role although she also demonstrated a number of strengths in this area of functioning.

Goals

Jane's goal was to find ways of managing Wendy's behaviours and to talk with other mothers about decisions she felt she may have to make about Wendy's schooling and service options. It was assumed the group would provide supportive contacts with other mothers and that group relationships could validate and support Jane's parenting ideas and be a sounding board as she considered options for Wendy. The group could

provide Jane with opportunities to identify and address the impact of external stresses on parenting and on Wendy. It was expected that these activities would increase Jane's understanding of and empathy for Wendy.

Brenda and Joel

Brenda, a 45 year old, divorced mother of three, requested the group intervention due to concerns about her 9-year-old son's physical and verbal aggression with peers and siblings. Brenda expressed feelings of frustration, embarrassment and anger about Joel's behaviours. Stresses on the family included continued difficulties between Brenda and her ex-husband and shared custody arrangements. Brenda's supports included her professional job and salary, supportive extended family and friends and school based behaviour management initiatives. Brenda's reported positive previous group experience.

Formulation

The results of the assessment indicated that Joel's negative behaviours were straining the parent-child bond. Brenda appeared to have developmentally inappropriate expectations of Joel, who appeared to exert power in their relationship more appropriate to an adolescent. She did not appear to understand the possible impact of external and internal stressors on Joel and their possible link with his current behaviours.

Goals

Brenda's goal was to provide Joel with opportunities to develop insight about his anger and find healthy ways of managing his feelings. She hoped to demonstrate her support to Joel as he made efforts to change. The group was seen as a way for Brenda and Joel to participate in a planned activity together while Joel developed social skills. It was expected that Brenda might have difficulty completing the group program so

contracting, anticipating barriers to attending sessions and discussing the effect on Joel of not following through with the intervention were used as a means of facilitating her continued participation. Child development information and exploring the impact of external stressors were expected to assist Brenda in identifying age appropriate behavioural expectations and promote her empathy for Joel.

Lesley and Dawn

Lesley, a 39 year old, Caucasian, divorced mother of three, requested the group program due to concerns about her 9-year-old daughter's temper tantrums, verbal and physical aggression with peers and siblings, attention seeking behaviours and decline in school performance. Lesley identified feelings of concern, frustration, anger, embarrassment and helplessness regarding Dawn's behaviours. Stresses on the family included a resumption of contact between Lesley's ex-partner and the children after an extended absence, Lesley's long hours at a low paying job and strained relationships with her ex-partner and his extended family members. Supports included school initiated programs for Dawn, Lesley's large social network of younger and same-aged friends and supportive extended family members. Lesley also felt confident in her ability to parent based on previous successes with her two older children. Lesley had previous experience with a parenting group where she learned behaviour management strategies. She described these as helpful with her other child but of limited usefulness in managing Dawn's behaviours.

Formulation

Dawn's behaviours were negatively affecting her relationship with her mother and with the school. Multiple demands on Lesley's material and emotional resources as well

as her own need and desire for adult relationships may have been making it difficult for her to provide Dawn with age appropriate support and guidance. The family was adjusting to the end of Lesley's relationship with Dawn's father and the formation of a new relationship with a male friend. In spite of these difficulties there appeared to be a strong affective bond between Lesley and Dawn. Lesley appeared to be determined to effect positive change in their relationship.

Goals

Lesley's goal was to provide Dawn with opportunities to learn ways to manage her behaviour and to demonstrate her support and affection for Dawn by attending the group program with her. Lesley hoped talking with other mothers whose children had problem behaviours would be helpful, however she expressed doubts about the possible benefit of the group in finding ways of managing Dawn's behaviour.

Contact with other mothers experiencing parenting difficulties was expected to reduce Lesley's feelings of isolation in her parenting role, normalize her feelings and validate and support the important part she plays in Dawn's development. Interactions with other members were expected to support Lesley's positive efforts and prosocial activities with Dawn and assist Lesley in separating external stressors from those exerted by Dawn. Child development information and discussions about the effect of external stressors on children was expected to assist Lesley in developing age appropriate behavioural expectations and increase Lesley's empathy and understanding of Dawn's needs.

Group Composition

The group members shared similar types of problems with their children's behaviours, shared the single parent family form and each member's purpose in attending the group was to strengthen her relationship with a child similar in age to other members. All were working or would soon return to work outside the home. There were a number of diverse characteristics in members. Members had a variety of coping skills, life experience, knowledge and problem solving skills that could be shared with others through modeling, vicarious learning, support and validation.

Age, cultural background, and educational level varied widely. Ages ranged from 22 to 40, with three members over age 35 and two, 28 years or younger. Two Caucasian members were divorced and one Caucasian, one Black and one Aboriginal member had never married. Two members had families comprised of themselves and their child; the others had two or more children. Two members appeared to have coping strategies that suggested they might discontinue the intervention if it became too stressful; another appeared to have difficulty managing anxiety that might affect group processes. It was assumed that members shared enough characteristics to begin interactions and it was hoped that their heterogeneity of strengths would enhance group processes.

Section Two: Group Sessions

Beginning Stage (Session One through Four)

Attendance: Session One: Brenda, Lesley and Jane attended/ Betty and Susan absent;

Session Two: Lesley, Jane and Betty attended/ Brenda withdrawn, Susan absent;

Session Three: Lesley, Jane and Susan attended/ Betty absent.

Session Four: Betty, Jane and Susan attended/ Lesley absent.

Session Themes: Why am I here? Why are you here? ; What is a Mother? ; Mothers' stresses and how they cope and; What do mothers want to help their children do?

The purpose of these sessions was to reduce members' expected and normal anxiety about group participation, develop their feelings of trust in the group process and develop group cohesion and communication between members (Toseland & Rivas, 1995). To facilitate these purposes I initiated a number of activities that provided structure. The group purpose was clarified and members were asked to define their own goals within the overall framework of strengthening their relationships with their children. Agendas were provided for sessions and group rules and procedures were introduced that would facilitate group activities (Toseland & Rivas, 1995).

As expected in the beginning stage of a group, members were initially hesitant to speak directly to each other and communication was generally leader directed. I had met with each of the group members on a number of occasions prior to the group so mine was a familiar face. Members' comments frequently pointed out their differences from other members, exerting their individuality. Changes in group attendance and the withdrawal of one member after the first session impeded members' efforts to get to know each other. Although these behaviours in members are not unexpected in this type of group (Toseland & Rivas, 1995) they reduced the group to three members at each session making working in pairs impossible. Communication was intimate due to the small group size at a time when members might have wanted some distance from others. Fluctuations in attendance also caused some anxiety about the continuation of the group, negatively influencing the development of cohesion. Providing time in the group session to process the withdrawal of one member allowed the remaining members to discuss

their concerns. Members' ambivalence about joining a group was normalized. The group members' difficulties and efforts to attend sessions were validated and supported and attending the group was framed as one way of strengthening their relationship with their children.

To facilitate member communication and exchanges of information about themselves, members participated in a variety of structured activities. For example, each mother was asked to write down what she thought was her greatest strength and her greatest difficulty as a mother. After recording their thoughts, mothers briefly met in pairs and read and discussed what they had written. It was believed that having an opportunity to think about the information they would be asked to share and talking in pairs was likely to reduce anxiety, and allow carefully considered self disclosure, and that group cohesion was likely to develop through participation in an activity that included all members. Other methods for facilitating exchanges of information were a feelings checkin at the beginning of each session, brainstorming about group rules and about topics for group sessions, and engaging in facilitated discussion about the session themes. Early group themes centred on the mothering role.

Some group norms were developed using a brainstorming session about group rules. It was believed that getting input from members about how they would act with each other would build cohesion and reduce anxiety about issues of confidentiality. This process appeared to increase members' anxiety so a more directive approach was taken. Rules that I had formulated prior to the session were presented. These rules were thought to facilitate respectful group processes. Members were asked for their input on these ideas and consensus was reached. Clarifying members' statements, validating

members' positive and negative feelings and supporting their positive statements about their child and the importance of the parent-child relationship modeled behaviours for members with the expectation that they would influence group norms.

Themes for group sessions were based on information gathered in the pre-group assessments and input from members during sessions. Members were encouraged to identify topics they thought would help them meet their goals for the group and I introduced a number of themes. Although general or common group goals were discussed, individual goals remained largely unexplored in the group format. Susan's goal of wanting to learn child management strategies and Jane's goal of wanting to talk over decisions about her child's treatment options and learn child management strategies were specific. In early group sessions time was spent isolating specific child behaviours or situations the mothers found stressful. As some members identified negative feelings or described their attempts to change their child's behaviour Susan was noted to frequently change the subject by introducing new problems. It appeared she was experiencing difficulty discussing the affective component of interactions with her children. Efforts were made to gently redirect Susan's comments back to the theme of the week or the discussion at hand.

Having members clarify their goals and linking them in discussion with each other would likely have made connecting weekly themes to their goals more explicit. It might also have provided opportunities to adjust some unrealistic expectations for the group in some members. Susan's early demand for problem solving appeared to be based on a belief that child behaviour management skills would meet her goal of knowing what to do in any situation with her children. Inviting members to help Susan

with her goal might have generalized the discussion to include all members and allowed the accumulated experience of members to become a resource for Susan. Her attempts to block discussions about the affective component of interactions with her children might have been an opening for others to identify their own feelings and difficulties with strong negative affect when dealing with their children's negative behaviours.

The format for discussion was leader centred and the process for problem solving was introduced early in the life of the group. The assumption was made that all members would perceive using the problem solving method as a way of meeting their needs as mothers. Members had not developed effective ways of communicating with each other and did not appear to be comfortable enough in the group to spontaneously share their ideas with each other.

Group members were encouraged to note the similarities of their problems and concerns in an effort to foster feelings of being 'in the same boat' as others (Gitterman, 1986). Members gave many nonverbal cues indicating they may have had similar experiences to others. I labeled the cues and invited members to talk about similar experiences. This method appeared to be an effective way of including members but non-verbal cues indicated some members continued to be anxious when called on to talk about themselves to the group. Communication between members was impeded by my anxious habit of talking and providing information, supporting me as an 'expert' and preventing members from offering their own positive suggestions for dealing with their problems.

At times, in an effort to emphasize their similarities, communications about their differences were not explored. During one session when Jane spoke about her decision

to go ahead with a recommended treatment option for her daughter that involved taking medication, I clarified and supported her decision. This appeared to block communication from Lesley who had had to make a similar choice in the past. Due to previous contact with Lesley, I knew she had strong negative opinions about medication and my support of Jane was likely a way of protecting her from any challenge from Lesley. Instead it appeared these actions left this difference between them unexplored and may have closed off possible communication between them.

Group rituals were established that included round robin checkin using a feelings thermometer, introduction of the weekly theme and activities, a snack, journal writing and summarizing the session. These provided a predictable format and a variety of ways to communicate. Because of the frequent changes in membership and attendance these procedures also seemed necessary to increase members' comfort level and provide structure while they continued to get to know each other. The feelings thermometer, a self rating scale, was completed as part of the checkin with the children and provided mothers with a way of identifying their current feelings. This provided opportunities to normalize affective responses and link them to their own behaviours. Members continued to be uncomfortable identifying their feelings and generally moved into telling the group about concrete events. This difficulty was not explicitly noted or explored with members.

At the end of each session, members reflected on what had been discussed and prepared a summary statement about the group's activities to tell the children. Summarizing the session marked the end of the weekly meeting and provided opportunities to formulate ways of talking about adult activities in ways that children can

understand. Having a mother volunteer to tell the children about their session activities modeled speaking in front of a group for their children and provided a bridge between the children's and mothers' groups at check-out. This proved to be a difficult task for all members and for the first two weeks, no one would volunteer. An incentive of flowers for the group spokesperson was provided in the third week. Thereafter the mothers established a rotation of volunteer spokesperson and helped each other word the summary. Mothers were encouraged to record their goals for the group and their thoughts or questions about any of the sessions in their journals with written responses from me.

Throughout these early sessions members continued to be wary of each other at the beginning of sessions, likely due to the continuing unpredictability of attendance and the resulting low levels of group cohesion. Within each session communication became more spontaneous, eye contact increased and members began to speak directly to each other when the format allowed open discussion. Communication was likely largely leader directed due to the frequent use of activities that promoted this type of communication pattern such as brain storming and using the problem-solving model. Members continued to rely on me to clarify members' statements but they began to offer different opinions or add to each other's ideas and offer spontaneous advice in response to other's problems.

By the end of the fourth session the group had established a regular format that provided opportunities for all members to participate in sessions about mutually agreed on topics and had group rules agreed on by all members. Jane had emerged as a leader in the group, disclosing information about herself and her child and sharing her ideas for

coping and child management with humour. Susan appeared to have taken on the role of seeking information and solutions to problems, at times prior to a problem being clearly defined. She was most likely to ask for practical advice and she also began to take risks and disclose information about herself and her feelings about her current difficulties, particularly her concerns about the abusive behaviours of her older son. She spoke frequently but this appeared to stimulate discussions. Lesley's gruffness was becoming a notable characteristic. She continued to be reserved but offered her opinions and was supportive of other members, particularly when they were distressed. Betty catalyzed discussions by defining problems, seeking information and giving her opinions on subjects under discussion.

A group culture was slow in emerging, likely due to the diversity in group members (Toseland & Rivas, 1995). Betty initiated discussion of cultural differences and their impact on parenting choices. Members present at this session acknowledged the negative effect of racist and other oppressive messages on children and adults, which was linked to problems with bullying and fighting that their children experienced. They connected this to influences in the larger environment that seemed to condone violence as a solution to problems. The mothers appeared to reach consensus about the desire for non-violent child management strategies.

The introduction of the problem-solving model was consistent with my plans for the group and appeared to meet Susan's request for concrete problem solving strategies. I assessed Susan's difficulty in talking about her strong negative feelings when confronting her children's anger as an individual problem and did not consider how her avoidance of this aspect of the parent-child relationship affected the group as a whole.

Susan's efforts to keep the group agenda focused on parent management techniques without considering other members' input and her efforts to deflect discussions away from emotional responses to parent-child interactions were not recognized as a challenge to group processes such as reaching consensus on group direction. Lesley's hesitancy to define a goal for herself was also not understood as a sign of ambivalence to engage in the group and risk disclosing information r trying out new ideas. Both of these members' behaviours presented challenges to group development. Although these behaviours are consistent with the approach-avoidance behaviours expected in the early stages of group development (Gitterman, 1989), they also represented behaviours consistent with the crisis of authority and power in group development (Glassman & Kates, 1990) that I did not fully appreciate. As the fourth session came to a close Susan requested the group do role-plays and practice problem-solving strategies. In the previous weeks group members had discussed their roles as mothers, the difficulties they experienced juggling the demands of work and home, they had identified a number of coping strategies and had practiced the problem solving model. It appeared the group had developed to a point where they could focus on working together to accomplish their goals.

Middle Stage (Sessions five through seven)

Attendance; Session Five; Susan, Jane and Lesley attended/Betty absent.

BREAK

Session Six: Lesley, Jane and Susan/ Betty assumed withdrawn

Session Seven: Susan and Lesley attended/ Jane absent

Group Themes: How do you respond when your child misbehaves?

Mom's Rights and Children's Rights; Punishment versus Discipline.

The goal for these sessions was to use the group problem solving method learned in earlier sessions and role-plays to address specific problems and integrate the effect of external and internal stressors on mothers' parenting choices and goals for their children. Child development information, parental stressors and coping strategies, and themes introduced in earlier sessions were integrated into discussions during planned activities.

The middle or working stage of group development focuses on providing opportunities for members to work toward individual and group goals that have been defined in the beginning stages of the group (Toseland & Rivas, 1995). Group goals had previously been defined in general terms such as providing mothers with a place to talk about their concerns about their children, obtain information about child development, support others in their efforts to find solutions to their problems, and share strategies for coping. As noted earlier, discussions about individual goals had been limited and not shared within the group. I had largely defined the goals for the group with input from members. Susan's goal of applying the problem-solving model to situations emerged as one that all members seemed to support.

During session five, some members appeared ambivalent about the direction the group was taking. Betty's absence may have been partly due to the suggestion by Susan that the group do role-plays, made at the end of the previous session. It was difficult to check this out with her after the fact, but it did seem possible that this type of planned activity would cause her to feel anxious. Lesley was not assessed as to her readiness to engage in the role-play, but when she volunteered to participate her readiness was assumed. Challenges to the work and to me as an agent of social control came from Lesley who appeared to be resistant to the idea that changes in her behaviour could also

assist her child and support her efforts to learn social skills. She advocated the use of physical and verbal punishment to correct child behaviour. Other members responded to her comments by giving their non-verbal and verbal agreement that their children 's behaviours often induced a desire in them to strike their children. I responded with a non-empathetic response that quashed the discussion. The session continued with the group engaging in a problem-solving exercise generating ideas about different ways to respond to children's challenging behaviours that did not include corporal punishment. Susan and Jane commented on the negative effects of yelling and spanking that they had experienced as children. This appeared to strengthen their bond and allied them with me. Lesley's comments were reframed as a desire on her part to help her child understand the need to respond to rules and to those in authority and were affirmed as evidence of her concern about her child's future.

This discussion occurred the week after Lesley had been absent and members had spoken at length about the effects of violence and abuse on themselves and their children, and had begun to establish some shared values or a group culture. Attempts to have the other members summarize the previous session, and thus include Lesley in the group, were unproductive. It was unclear if this was due to a subgroup that excluded Lesley or if external stresses made remembering the previous session difficult. Susan was noted to give non-verbal cues of agreement to Jane and they were observed speaking directly to each other during sessions. These members rarely spoke directly to Lesley and her interaction pattern was to continue to direct her communication to me or sit quietly while others spoke, often looking exhausted. I summarized the previous session including content about child development. I attempted to convey the group members'

comments about bullying and their expressed desire to find ways to parent without using physical punishment. I, the authority figure, delivered this value statement. A role-play earlier in the session appeared to have triggered feelings of anger in Lesley and challenged her to try out a new behaviour that had been planned prior to the actual role-play. These factors and her own values likely contributed to her challenging my comments about the use of corporal punishment.

The planned break occurred after session five and opportunities to explicitly address the challenge and reframe the group discussion in more empathetic terms had to be deferred for two weeks. I had been slow in identifying that Lesley's expression of her strong opinions about discipline not only challenged my values about child management strategies but was also a normal part of the group development theme of authority and power (Toseland & Rivas, 1995). Although the topic of using corporal punishment was reintroduced at the beginning of session six, and I acknowledged I had not picked up on the frustration and other feelings that prompted their comments, members were hesitant to reopen the discussion.

The use of themes about balancing the needs of mothers and children and the use of pro-active discipline rather than reactive punishment were explored over the next two sessions. The choice of these themes was based on my hope that the content of the themes would generate discussions about the common concerns and experiences of the members and provide opportunities to explore their differences within the group context. Activities planned to explicitly address the differences in the members' values and attitudes regarding child management strategies and to take measures to include Lesley were impacted by a number of factors.

Attendance patterns influenced the work in these sessions and was likely influenced by previous discussions about differences and the low levels of cohesion in the group. Betty was assumed to have withdrawn after being absent for two weeks in spite of her expressed desire to continue in the program when I contacted her by phone between sessions. Her departure generated concerns about the continuation of the group and meant that a member who had opened up discussions about values and who might have contributed much to these discussions was gone. The loss of another member may have influenced Susan's late arrivals at two sessions and Jane's absence without notification at the seventh session. Members' discomfort with explicit requests to discuss each others' differences while engaging in group activities may have also influenced these attendance patterns, along with a number of increasing external stresses in the lives of members. Jane's work schedule had increased and shift times were altered. Susan had entered a work trial and her childcare arrangements fell through resulting in her bringing both her children to the centre during sessions. Lesley's chronic illness flared up and her fatigue was evident in sessions further reducing her previously reticent participation.

My anxiety and inexperience made it difficult to formulate ways of addressing the growing alienation between Lesley and Susan. Both also had communication styles and coping patterns that deflected my efforts to have them exchange their views openly with each other. I continued to express a belief in the group and helped members recall their purpose in joining the group and acknowledged their difficulties in attending and the slow and difficult nature of change. Leader centred activities, such as brainstorming, were used to provide members with opportunities to discuss their continuing parenting

challenges and current coping patterns. Members continued to highlight their differences in life experience and opinions about parenting. These behaviours are consistent with those seen at the beginning of group development, where members have an approach avoidance pattern of interaction. On the occasions when they acknowledged the tough times each had come through and the difficulties each faced, I noted and supported their comments. Susan continued her role as the member who pushed for solutions, asking clarifying questions about Lesley's experiences and previous parenting successes with her older children. She reported trying out strategies discussed in the group at home with some success. Lesley continued in her role as the skeptic, challenging some of the members' strategies for child management but was also noted to be supportive and sympathetic about their problems. She sympathized with Susan's distress at her son's verbal abuse and problems with her ex-partner and offered supportive comments. It was difficult to determine if her fatigue was due to her illness or from apathy. Jane continued to provide many thoughtful suggestions about dealing with problem behaviours and maintained her leadership role. Her successes with her daughter provided her with special status in the group. Her sense of humour often lightened the atmosphere in the group and her presence appeared to instill hope in Susan.

Labeling members' differences in life experience as a resource for others was an attempt to reframe their differences and highlighted their shared concern about their children's future and current behaviours. The reemerging theme of spanking was framed as a difference in the way each wanted her children to learn how to get along in the world and be safe.

Telephone contact with Susan outside of sessions was crisis oriented and dealt with the impact of her partner's abuse. Offers to meet with Susan in individual sessions were declined, as were suggestions that she use crisis lines for support and to talk about abuse issues. Susan denied that Lesley's comments were impacting her feelings and continued to state her desire to work on her relationship with her child through the group program. Attempts to contact Jane outside of sessions went unanswered.

The group remained at the beginning stages of development. The value conflict, my response to the challenge to my values and me as the representative of social control and possibly the members' hesitancy to use the group to explore alternative responses to their problems affected group development. Communication continued to be constricted and hesitant. During group activities members directed their comments to me, partly because of the nature of the activity, but previously more open communication was not forthcoming. Cohesion was low, with membership down to three mothers. Late arrivals and nonattendance resulted in most sessions having only two members to participate in activities.

In retrospect, Lesley's comments about her feelings of frustration and anger generated by her child's behaviours and my response to them felt like a turning point in the group. Examining my own values about parenting practices has helped me understand part of my reaction to her comments. My anxiety about both my roles as a group worker/leader and an advocate of non-violence resulted in an inability to reach for the feeling rather than dwelling on the content of Lesley's remarks. At the time of the role-play, Lesley had difficulty staying in the role of a patient parent responding to Jane as the misbehaving child. Although her frustration and anger were validated, the

discussion turned to generating options for responding to children's aberrant behaviours before these feelings were fully explored. Another option may have been to facilitate Jane in her role as the acting out child and ask her to describe her feelings as her 'parent' voiced her anger and frustration. Anxiety about addressing Lesley's strong affect influenced the decision to make the discussion less intense and in effect, avoid her strong negative feelings. Lesley had risked disclosing those feelings and connecting them to her frustration and fear about her child's future at the time they occurred in the group might have brought the group to a different level of relationship. Connecting her responses to possible feelings in her child could also have contributed to members' empathy for their children.

There were other aspects of my leadership style and activities that I could have altered to promote group development. I found Susan's interaction style, that deflected and discounted information she had requested and her anxious responses during session activities difficult to address, but chose to carry on without discussing this with her. Providing more feedback to members about their communication would likely have facilitated members giving each other more direct feedback to each other. Explicitly discussing group processes and previous group experiences might have facilitated group development as members explored their expectations for this group based on their past experiences. Susan's previous experience with parenting classes for infants and toddlers appeared to be driving her desire for the same kind of information for her older children. However information provided was rejected and did not appear to meet her need. Time in group sessions might have been devoted to a discussion about what to do with what you know about your child's needs and could have included all of the members. The

fluctuations in membership and attendance induced anxiety about the continuation of the group and also influenced my decisions about challenging members due to fears that they would withdraw from the program.

Ending Stage (Sessions eight, nine and ten)

Atendance: Session Eight: Susan and Jane attended/ Lesley absent;

Session Nine: Susan and Lesley attended/ Jane absent;

Session Ten: Lesley and Susan attended/ Jane absent.

Session Themes: Who is in my child's world?; Where do I get my ideas for parenting?; What I like about being my child's mother.

The planned ending stage of a group generally deals with the separation of the members after their involvement together and reflection on members' accomplishments. Strong feelings and doubts about accomplishments are expected and can be addressed so members can continue to pursue their goals or define others for themselves (Toseland & Rivas, 1995).

The goal for these final sessions was to review what the members had discussed over the previous weeks and to prepare for the end of the mothers' group. The separate mothers' group was to conclude to allow the second part of the group program to proceed. It was hoped that all three members could attend these sessions before they would begin weekly parent-child group sessions but this did not turn out to be the case.

The themes chosen were intended to help members turn their attention toward identifying stresses and supports in their child's social environment, reaffirm their role as mothers and the part they could play in the lives of their children and celebrate their positive interactions and feelings about their children. Session activities included having

mothers draw and discuss an ecomap about their child's world, doing an exercise that identified sources of positive ideas about mothering and, in the final session, making a card telling their child what they liked about being a mother to him or her. These cards were presented to the children at the final checkout. Coping strategies were reviewed and reinforced. Efforts to change their own behaviours were recalled and supported. Themes also encouraged members to explore sources of support outside the group.

Group attendance was a factor in this final stage of the group. Lesley's absence in session eight meant she missed a session that might have helped her isolate the stresses and supports in her child's life. This activity might have supported and amplified her empathetic feelings for Dawn. Drawing out this aspect of Lesley and Dawn's relationship may have altered her role in the group as the skeptic to include the affective warmth and concern I was aware she brought to her parenting role. Jane's absence due to her child's illness and to her altered work schedule, although legitimate, meant that her positive influence and success in parenting were not available for others to explore and celebrate with her. It was also not possible to explore if her absence was due to negative feelings about the group process or other factors. Susan continued in her role as the seeker of answers.

Cohesion continued to be low however Susan's and Lesley's continued attendance was taken as an indicator that they were gaining some benefit from the intervention. As the sessions concluded Lesley and Susan began to reveal some of their strong negative feelings and doubts about themselves in their role as mothers, indicating a degree of trust between them.

Members continued to direct most of their comments through me as they explored the weekly themes. When members expressed their belief that they had to make some changes in order to alter their child's behaviours these communications were linked. Members were asked to speak to each other about their feelings and ideas about how to relate to their children. Communications were tentative but included some eye contact and sympathetic responses.

Their doubts about themselves and the benefits of the group intervention were normalized as part of the ending of a group and used as an opportunity to review their goals. Members were asked to identify feelings associated with the end of the group. They named their disappointment that problems were not solved and their concerns about what to do next. Members were encouraged to identify aspects of the group program they had found useful. These included talking about their frustrations and concerns about their children with others, hearing stories about how others cope, written materials and reference books to get ideas for parenting, involving their child in a group activity and doing something with their child. Members were encouraged to continue those activities that had assisted their efforts for change as a way of externalizing their experiences and were asked to think about their goals for the coming parent-child group.

Both members engaged in discussion about the next portion of the group program and made plans to attend. Post-group interview appointments were arranged and post-group measures and a client feedback form were handed out. Members were asked to complete and return these forms at the time of the interview. At the post-group interview members were able to provide me with verbal feedback about the program.

Members who had terminated earlier were contacted by telephone to discuss their withdrawal and to discuss other service options. In-person interviews were offered to one family but were declined. Letters were sent to both families acknowledging their decision to withdraw from the program and providing information about future group programs.

Section Three: Evaluation

Group intervention clients completed two standardized measures before and after the group (i.e. the CBCL and PSI). The following is a discussion of the results of these measures and some clinical interpretations.

Jane and Wendy

The **CBCL** scores indicated that from Jane's perspective, Wendy was exhibiting Total Behavioural scores in the borderline clinical range, marginally reduced from the pre-test score in the clinical range. The internalizing behaviour scores continued in the borderline clinical range and the externalizing behaviour scores had reduced from the clinical to borderline range (Table 1). Examination of subscales indicated a shift in problem areas. Attention, withdrawn, aggressive and social problem scores, all elevated before the intervention, were no longer rated as clinically significance although delinquent behaviours were rated as clinically significant, an increase from the rating prior to the intervention.

The **PSI** indicated Jane had experienced some reductions in stress from prior to the intervention (Table 2). The Total Stress score was no longer elevated. The Total Child domain score continued to be elevated (90-95th percentile) with some small reductions in subscale scores and an elevation in the mood subscale. Adaptability

Table 1

Results of Pre-Test and Post-Test Child Behavior Checklist T-Scores for Group Members.

	Pre-Test			Post-Test		
Group Members	**Total T**	**External T**	**Internal T**	**Total T**	**External T**	**Internal T**
Jane	71	72	69	67	68	70
Susan	58	66	57	61	68	63
Lesley	75	76	73	75	77	67
Brenda	64	73	66	n/a	n/a	n/a
Betty	69	76	67	n/a	n/a	n/a

Note. A score below 67 indicates a non-clinical rating. A score between 67-70 indicates borderline clinical behaviors. A score above 70 indicates behaviors of clinical significance.

Table 2

Results of Pre-test and Post-test Parenting Stress Index Percentile Scores for Group Members.

	Pre-Test				Post-Test			
Group Member	Total Stress	Total Parent Stress	Total Child Stress	Life Stress	Total Stress	Total Parent Stress	Total Child Stress	Life Stress
Jane	93	80	95	99	80	50	90-95	95
Susan	90-95	95-99	70	90	98	99	90	90-95
Lesley	65	20-30	90-95	55-60	99	90-95	99	70
Brenda	90-95	80	99	95	n/a	n/a	n/a	n/a
Betty	90-95	70-75	95-99	99	n/a	n/a	n/a	n/a

Note. Scores are reported as percentiles. Scores above 85 indicate significant stress levels.

was no longer elevated indicating Jane was finding Wendy capable of responding to her efforts and expectations. Scores in the Parenting Domain indicated Jane was feeling competent in her parenting role, and felt a reasonable degree of attachment to Wendy although she was experiencing some stress due to the lack of support in the parenting role.

During the **post intervention interview**, Jane reported positive change in Wendy's behaviours but continued to feel frustration about the need for constant attention and correction. Establishing routines and consistent reinforcement of defined rules appeared to have contributed much to positive changes. Childcare arrangements with extended family had been negotiated and appeared to be meeting Jane and Wendy's needs. This appeared to have reduced some of Jane's stress financially and emotionally. Jane identified talking with other mothers, discussing ways of dealing with situations and identifying the need for self-care as three factors that had been helpful to her over the past few months. Her absence from the group sessions was attributed to an increased work schedule and the need to balance activities outside the group. She identified a continued need for support and the need to provide Wendy with structure and to find time to enjoy activities together. She planned to complete the parent-child portion of the group program.

The **Client Feedback** form indicated Jane had found the intervention very helpful and that she would return to a similar program and recommend it to others.

Susan and John

CBCL scores (Table 1) indicated that according to Susan, John's overall behaviours were substantially unchanged from prior to the intervention. Both Total T

and Internalizing T scores were in the non-clinical range pre and post-test. Externalizing T scores were rated in the borderline range, as was the case at the pre-test. Problems continued to be identified with aggressive behaviours.

PSI scores (Table 2) indicated Susan continued to experience significant stress with an increase in her stress in both the Parenting and the Child domains. Susan identified new sources of stress associated with John's demandingness, adaptability and mood. This may have been due to a closer examination of John's behaviour separate from his sibling, combined with her increased demands on him to conform to behavioural expectations. It may also have been that John's behaviour was being influenced by his mother's return to work and his developmental need to individuate. The elevated total Parent Stress score indicated Susan was experiencing a crisis in her role as a parent. Subscale scores indicated she continued to have a strong desire to carry out her parenting role, felt attached to her child but continued to feel stress in the areas of competency, isolation, and relations with her ex-partner.

At the **post intervention interview**, Susan described a number of external stressors that she recognized as having an impact on her parenting, particularly the time pressures and energy required as she returned to work. Susan reported a number of rules she had defined for her household and routines and strategies she had successfully implemented which appeared to increase her fears about her children's rejection of her. Her ex-partner's verbal abuse, her eldest son's verbal and physical aggression and fears about her children's loyalty continued to be concerns. Susan also expressed concerns about balancing the demands of her new relationship with a male friend and the needs of her children. Her boyfriend was identified as a potential support around parenting issues.

The group intervention was identified as a source of emotional and parenting support. She identified hearing other mothers describe their situations and coping strategies and having opportunities to talk about her own concerns as helpful. She planned to continue in the program and attend the parent-child group.

The **Client Feedback** Survey indicated Susan had found the intervention of some value and that she might attend similar programs and might recommend it to others with similar problems.

Lesley and Dawn

CBCL scores (Table 1) after the intervention indicated that from Lesley's perspective, Dawn's overall behavioural ratings were largely unchanged from those prior to the intervention, with Total T and Externalizing T scores continuing to be clinically significant. The Internalizing T score was reduced from clinically significant to borderline.

PSI ratings (Table 2) indicated a significant increase in Lesley's Total Stress and Total Parent Stress scores and a continuing clinically elevated Total Child Domain score. The increase in stress may have been due to a number of factors outside the parent-child relationship. The impact of these factors appeared to have brought Lesley to a crisis in her relationship with Dawn.

During the **post intervention interview** Lesley continued to struggle in defining the role she might play in helping Dawn make desired changes. External stressors continued to exert their effect on Lesley making it difficult for her to find the energy to address Dawn's demanding behaviours or to find the time to spend in activities with her. Loss of the family daycare subsidy and serious illness in a close family member were two

significant external stresses. Sibling conflicts emerged as a primary concern and contributed to stress. Possibly most significantly, an exacerbation of Lesley's chronic disease contributed to her fatigue, decreasing available energy for parenting. Lesley was evaluating her ability to continue to parent Dawn fulltime and was exploring options, such as having Dawn live with her father.

Lesley indicated the group intervention had been of some value in providing her with opportunities to hear about other's parenting difficulties and to realize her child was not alone in experiencing behavioural problems. She stated her intention of completing the group program by attending the parent-child group.

The **Client Feedback Form** indicated Lesley was mostly satisfied with the mothers' group intervention, that it was occasionally helpful, that she might return to the program and might recommend it to others.

Summary

A number of factors must be considered in summarizing the evaluation results of the group program. In trying to determine if it was successful, the CBCL results for members who completed the program indicate that ratings of the children's problem behaviours remained largely unchanged with minor reductions in some scores. The PSI scores indicated that there were some significant increases in Total Stress and Parenting Domain scores for two members and a reduction in Total Stress and Parenting Stress scores for one group member. The one member who reported a reduction in parenting stress was absent for much of the last part of the program, so it is difficult to connect improvements to effects of the intervention. This would indicate that the program was not successful in reducing child behaviour problems, which might be expected with a

program of short duration that attempts to effect change in complex problem behaviours and has little capacity to alter external forces acting on group members. PSI scores could indicate that the program was associated with an increase in stress for some members. External factors may have influenced increases in PSI ratings, but factors in the program must also be considered.

Recruitment of 'at risk' populations is reportedly difficult (Tolan & McKay, 1996) as was the case with this program. The selection of members, dictated by low recruitment response, resulted in a group composed of members with a broad diversity of age, life experience, route to single parenthood, socioeconomic status and racial and cultural backgrounds. Low recruitment also resulted in the group being smaller than originally planned and substantially shortened from six months to ten weeks in order to fit it into the potential population's school year.

The diversity of the members and the high levels of stress contributed to how the group unfolded. In the early stages of the group program the two members who dropped out were the youngest and most economically disadvantaged member and the oldest, most educated and most economically established member. These extremes of diversity likely contributed to feelings that the group was not suitable for them. During pre-group assessment these members were also both identified as the most ambivalent about joining the group and efforts to contract with them to complete the program were unsuccessful. It is difficult to determine if they would have remained in the group if I had more experience and skill in group work but the importance of assessing member's coping patterns when forming groups (Rose, 1989) is more apparent to me now.

The early loss of group members, varying attendance, the small group size and the diversity of the members contributed to low levels of cohesion in the group, as did my limited skill in facilitating the development of a mutual aid system. The common factors between group members were their significant levels of stress emanating from their children's behaviours and a variety of external stresses. High levels of stress, strong negative feelings about themselves and their children and interactive styles that likely contributed to members' social isolation also made it difficult for them to feel safe with each other and to invest in efforts to understand each other's differences. The limited time the group had together each week meant that there was one hour to convene the group, allow members time to talk about current issues and introduce and discuss a theme. My efforts to stress the similarities between the members so that areas of common interest could be discussed resulted in less opportunity for them to connect with each other and downplayed their diverse experiences. Less content from me and more facilitation of member to member interaction might have increased cohesion. An examination of my own unexplored values might have better prepared me for the inevitable challenge to authority that became a divisive issue. In future I would likely spend more time having members explore their varied assumptions and values about parenting and provide information as required or requested.

In the end, those members that completed the mothers' group all went on to the second part of the program and indicated the helpful aspects of the program were talking with other mothers and hearing their stories and ideas. This gives some indication that members found the intervention of some value.

CHAPTER FOUR

STRUCTURAL FAMILY THERAPY INTERVENTION

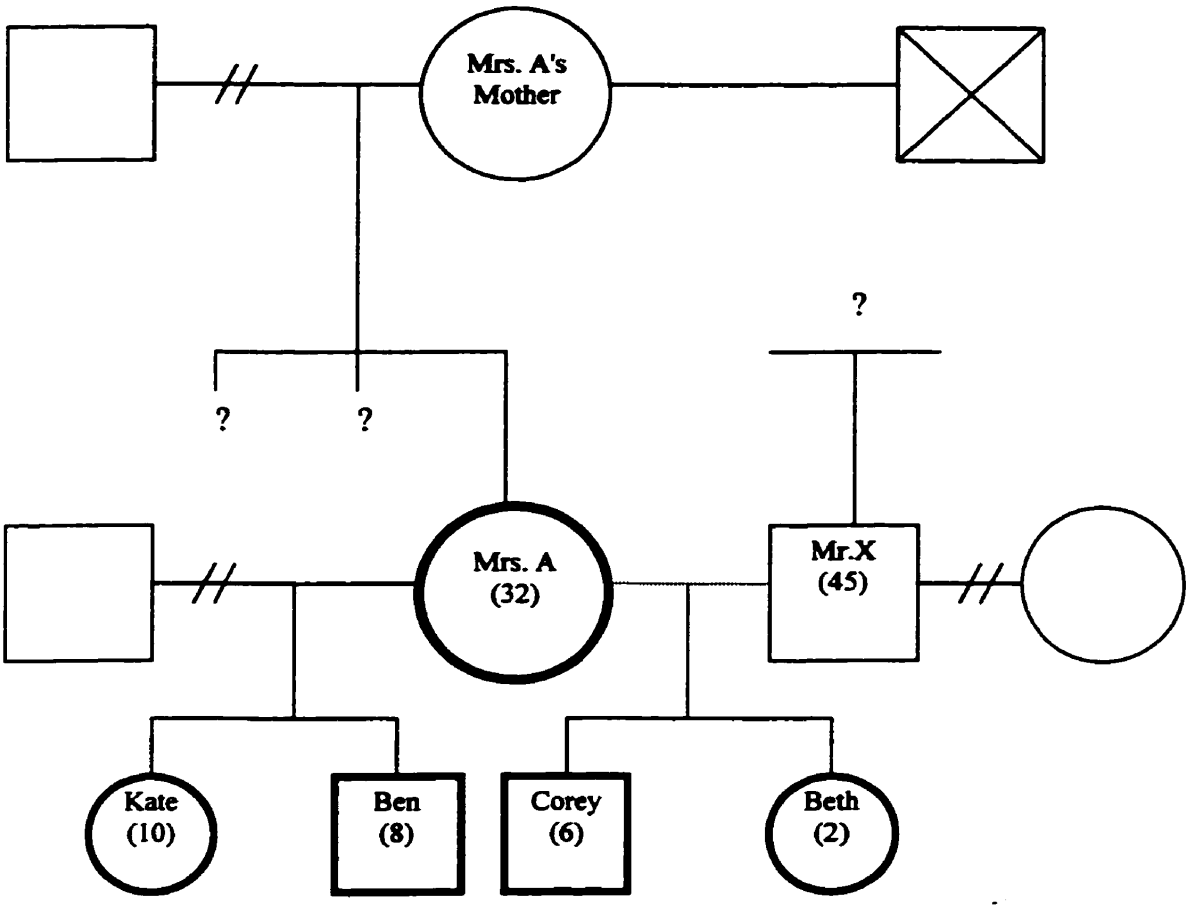
The A Family

The A family (Figure 1) consists of a divorced mother (32) and her four children. Two children, Kate (10), Ben (8) are from a previous marriage and two children, Corey (6) and Beth (2) are from a current relationship with Mr. X. At the time of the intervention Mrs. A was expecting her fifth child, her third with Mr. X. with whom she had an unsettled relationship. Mrs. A relied on social assistance and she and the children live in a three-bedroom townhouse close to the elementary school the children attend. Mr. X had always lived separately from the family. He reportedly spent time with his biological children and contributed financially to the household on a semi-regular basis, often in the form of gifts or outings that excluded Mrs. A and her two oldest children.

Presenting Problem

Mrs. A contacted EHCC to inquire about the Parent Child Group Program for her and her 8-year-old son, Ben who reportedly had longstanding behavioural problems at home and school. Mrs. A appeared to attribute Ben's negative behaviours to a difficult temperament and longstanding difficulties between them. The school was providing supportive programs with improvements noted by staff in Ben's behaviour and academic achievement. At home, Ben's behaviour was reportedly the cause of arguments between Mr. X and Mrs. A. and the cause of Mr. X's hesitancy to live with the family. Mrs. A expressed some urgency to address Ben's behaviours prior to the arrival of her next baby. The timing of the group made it unsuitable for her but she accepted an offer for the family to attend an intake interview. Mr. X was invited to join the intake session.

Figure 1: Genogram



Assessment

Mr. X did not attend any sessions. Attendance during the initial assessment sessions was affected by: (1) Mr. X's preventing Corey and Beth from attending the second and third sessions, and (2) Mrs. A's difficulties in arranging childcare. The co-therapy team met with the whole family and with a number of subsystems: Mrs. A individually; Mrs. A, Kate and Ben; the sibling subsystem; and with Kate and Ben, the older sibling subsystem.

Structure

The A family is a blended single-mother family with a number of subsystems. The family composition was continually in question, with some suggestion that Mr. X might join the family permanently. His joining the family appeared to be contingent on Mrs. A proving her ability to parent, which was gauged by the behaviour of her eldest children, particularly Ben. There had been discussions in the past about Ben living with extended family and alternatively that Corey and Beth live with Mr. X. Both of these suggestions were unacceptable to Mrs. A.

The parental sub-system consists of Mrs. A. who has sole custody of her four children, two from a marriage that ended in divorce 6 years previously. A rigid boundary appeared to exist between Mrs. A and her ex-husband who has no involvement with the family. A diffuse boundary appeared to exist between Mrs. A and the father of her younger children, who has frequent but unpredictable contact with them. Mrs. A expressed a need for secrecy about Mr. X's identity and activities and discussion of their relationship appeared to induce anxiety in family members.

There was evidence that when he is present in the home Mr.X and Mrs. A have a complementary parenting relationship in which Mrs. A is the ineffectual parent and Mr. X is the competent, rule setting parent. Mrs. A appeared to defer to him on parenting issues but had little power over when he visits, who he includes in activities and how he spends financial resources. Mr. X also reportedly exerts his power by verbally and emotionally abusing Ben, Kate and Mrs. A and suggesting he leave the relationship and take permanent custody of Corey and Beth. When parenting on her own it appeared that Mrs. A manages the children's daily affairs and household tasks with assistance from Kate, her eldest child. Mrs. A is isolated in her parenting role due to a rigid cross-generational boundary having cut off previously supportive contact with extended family at Mr. X's insistence.

The parent-child hierarchy was somewhat confused making the boundaries between Mrs. A and her children unclear. Mrs. A's parental authority was being challenged by: (a) a lack of practical assistance necessary to parent four children with different developmental needs; (b) Mr. X's undermining of her family rules and his verbal and emotional abuse; (c) ambivalence about her own parenting abilities and; (d) her attempts to bring Mr. X into the family.

She exerted her power in the system when she brought all of her children to family sessions. She persisted despite Mr. X's insistence that her two eldest children were the problem and despite Mr. X's threats to obtain custody and his efforts to prevent Corey and Beth from attending sessions. Her organizational strengths were evident in her rapport with the children at weekly sessions and in the children's reportedly regular attendance at school and extracurricular recreational activities. Although Mr.X had taken

Corey and Beth to live with him for brief periods in the past, Mrs. A perceived this as his attempts to exert his authority on parenting issues and not serious attempts to gain custody.

The sibling subsystem is comprised of two distinct subgroups defined by who fathered the children with rigid boundaries between them. There was evidence of complementarity between the two groups with the older children viewed as 'bad' and the younger children viewed as 'good'. Kate and Ben were not generally included in outings or gifts from Mr. X and there appeared to be prohibitions about Ben and Kate playing with the younger children when Mr. X was in the home. It appeared there was some flexibility in the boundaries between the sibling groups when Mr. X was not involved in activities. Kate reportedly helped with childcare and played with Corey and Beth. Ben rode bikes with Corey and they occasionally slept in the same bedroom.

A weak alliance appeared to exist between Kate and Ben, made evident by Kate's occasional defense of Ben when she perceived facts were being misrepresented. There appeared to be a weak alliance between Mrs. A and her older children in response to Mr. X's exclusion of them from activities with her and the younger children. There was a strong coalition against Ben by the rest of the family. This appeared to be based on family members' expectations of his negative behaviours and was possibly due to fears of Mr. X's rejection if they formed an alliance with Ben.

The family as a whole was experiencing a period of relative equilibrium that Mrs. A seemed to understand would be unbalanced by the arrival of her next child. The children appeared to be experiencing chronic anxiety due to the unsettled nature of the

parental sub-system, witnessing frequent quarrels between Mr. X and their mother and persistent questions about family membership.

Flexibility

The A family was in the process of reorganizing itself in preparation for the inevitable arrival of a new member making existing patterns of interaction open to suggestion and change. Previous experience after the birth of her last two children was also challenging Mrs. A and her children to be ready for the possibility of Mr. X attempting to obtain custody of "his" children. The family had previously found ways of coping after the dissolution of Mrs. A's marriage and with the unpredictable pattern of Mr. X coming and going from the family. As the older children individuated their needs were changing, requiring different types of parenting activities from Mrs. A. and challenging the family's previous coping mechanisms. Mrs. A had previously experienced the benefits of in-home family support services that allowed her the opportunity to learn and apply parenting skills when the children were younger. She had not acted on suggestions made previously by school counselors to develop her relationship with Ben but appeared open to ideas that included all of her children.

Cohesion

An emotional attachment between family members was evident, in spite of the divisive nature of the discussions about family membership. There appeared to be a diffuse boundary between Mrs. A and her younger children made evident by reported difficulties with separations for school and at bedtime. Their young age, Mrs. A's anxiety about custody, the children's response to witnessing their parents arguing and the unpredictable nature of their parent's attention may have influenced this closeness. There

appeared to be a rigid boundary between Mrs. A and the two older children made evident by Mrs. A's lack of affective warmth and her critical remarks and adult like expectations of them. It was likely that feelings of jealousy, confusion and hurt were part of their response to their isolation in the family.

Life Context

Mrs. A gained some affective support and limited material and parenting support for the younger children from Mr. X. It was unclear if cultural values or previous life history were affecting Mrs. A's expectations about her own and Mr. X's parenting roles. Mrs. A's European-born mother remarried a man from Asia after divorcing Mrs. A's father. Both Mrs. A's ex-husband and her current partner share her stepfather's cultural heritage.

Community organizations and school offered opportunities for the children to develop age appropriate skills and social relationships. All of the children participated in a boys or girls club and a sport. The school was involved in meeting both Ben's and Corey's special needs. A school counselor had been a support for Mrs. A and the children for a number of years. Mrs. A's neighbor was willing to provide childcare in emergency situations, but Mrs. A did not feel she could confide in her. Although Mrs. A felt she could ask her mother for assistance if necessary, she was reluctant to do so.

Stressors on the family included their small living space. Should Mrs. A lose custody of her younger children, her income would be reduced. Continued social assistance would be contingent on her finding work or entering a work training program. Mrs. A's limited education and lack of job experience would limit employment prospects.

The school also placed demands on Mrs. A and the children with respect to academic and peer group development.

Family Stage

Mrs. A was caught between family forms and she had children with different developmental needs and another infant on the way. She identified herself as a single parent, with a blended sibling subsystem. It was unclear how Mrs. A and the children negotiated the transitional stages after the divorce (Brown, 1989b) six years ago. Mrs. A appeared to be hoping to form a co-parenting relationship with a partner who was ambivalent about his commitment to her and appeared to reject her older children from her marriage. The family appeared to be experiencing some of the frustrations of negotiating the process of blending families (McGoldrick & Carter, 1989).

The family was also preparing for the arrival of a new family member that required adjustments within the family system and each of its members at the emotional and practical level (Carter & McGoldrick, 1989; Minuchin, 1974). Mrs. A's need for help in running the home and caring for the children appeared to impinge on Kate's individual development and fuelled Mrs. A's resentment of Ben's need for her special attention. Both Ben and Kate were attempting to negotiate the developmental tasks of school aged children (Bradt, 1989). Mrs. A appeared to have unrealistic expectations that they assist her with adult tasks and meet the demands of school and the social environment without her support and input. She appeared to find parenting her latency aged children challenging and may have been abdicating discipline and other structuring routines to the schools and, when possible, to Mr. X. Increased contact between Ben and Mr. X appeared to exacerbate Ben's problem behaviours.

Role of the Symptom Bearer

A number of different interpretations could be made about Ben's role as the symptom bearer. Ben appeared to have a temperament that made him difficult to parent and contributed to his difficulty with social and academic development (Belsky, 1984; Patterson, 1982). His behavioural problems were longstanding and the family may have become accustomed to them, maintaining them as part of the family's normal transactional patterns. Ben served as an effective scapegoat for the family. Problems in the parental/spousal subsystem were detoured through Ben. Mrs. A could attribute Mr. X's lack of commitment to her to Ben's negative behaviours. Mr. X could remain uncommitted to a co-parenting relationship as long as Ben continued to behave "badly". The other children's behavioural difficulties could be blamed on Ben's negative influence. The other children were also afforded a measure of protection from negative attention as long as Ben's behaviours were the focus of attention.

Tentative Hypothesis

Mrs. A, a single parent, was experiencing difficulty maintaining an effective power hierarchy due in part to her desire to bring Mr. X into the parenting system, the unpredictable and manipulative nature of this relationship and the challenge of parenting four children. Ben's behavioural problems were possibly a product of a poor fit between his and his mother's temperaments and his affective response to Mr. X's verbal abuse and rejection. Ben's behaviours appeared to be a continual drain on Mrs. A's energy and a flashpoint for Mr. X's criticisms and rejection of her as a partner. This rejection, in turn, increased Mrs. A's negative feelings toward Ben. Ben appeared to be further isolated in the family due to Mr. X's prohibitions about Ben having contact with his half

siblings and possibly due to fears in his mother and siblings that in supporting Ben they risked Mr. X's abuse and rejection. Mr. X's sporadic and restricted parenting support came at the price of Mrs. A isolating herself from other supports and adhering to Mr. X's ideas about parenting, which appeared to be confined to the needs of his developmentally younger children.

Goals

1. To strengthen Mrs. A in her parental role to facilitate her meeting her children's developmental needs for guidance and nurturance.
2. To clarify the rules and roles in the family so that age appropriate behavioural expectations, consequences and rewards could be established for Ben and for all of the children.
3. To facilitate communication between the children and Mrs. A regarding necessary adjustments to accommodate the arrival of the new family member.

Interventions

My co-therapist and I met with the A family for 13 sessions between February and April. After terminating the co-therapy relationship at the end of the school term, I met with the family for a further 4 sessions, 2 of them home visits after the birth of Mrs. A's baby.

The process of joining with the family and with each individual during the assessment stage was influenced by; (a) the fluctuating, unpredictable number of people in each session; (b) the children's young ages; and (c) the anxiety in the system (including the co-therapy team) aroused by Mr. X's coercive activities designed to prevent Mrs. A from bringing Corey and Beth to sessions.

One of our early joining maneuvers was to accommodate to the unpredictable attendance of the children at sessions, empathizing with Mrs. A's frustration and anxiety and the children's confusion and fear regarding Mr. X's activities. Supervision and Mrs. A's comments about the recurrence of this behaviour pattern assisted in our understanding Mr. X's threats to take custody of the children as an enactment of a recurrent transaction pattern and evidence of the power dynamics in the system.

Individual sessions with Mrs. A were important in joining with Mrs. A. and also helped mark a generational boundary between her and her children. She was encouraged to define the problems in her family from her point of view and to reveal sensitive information about her relationship with Mr.X at her own pace. Her need to support Mr. X's role as her co-parent in front of the children and to discuss her doubts about him away from the children were validated. The information gained in individual sessions assisted us in accommodating to the realities and restrictions on Mrs. A's options. Assessing family membership and functioning were part of weekly joining activities with Mrs. A. We were encouraged that we had successfully joined with Mrs. A as she continued to attend weekly sessions in spite of obstacles and when she began to risk new behaviours in sessions with the children.

My co-therapist playfully accommodated to the sibling subsystem, joining with the children easily. Greeting each child by name, asking about their activities and remembering events or comments from previous sessions was an effective way of joining with them initially and from week to week. We took the children's eager weekly greetings and participation in activities during sessions as evidence of our successful joining with them.

Explaining the plan for the session and providing structured activities, such as making and discussing family drawings, appeared to reduce their anxiety. It also provided opportunities for modeling taking turns and listening to each other, necessary skills in any family. Containing the children's exuberance and limiting joining activities was a weekly challenge requiring humour and planning. Joining at the start of each session provided evidence of the power that four children exert in transactions. We saw it as an enactment of some of the dynamics in the family and a point around which Mrs. A and the therapists could join.

Maintenance operations were used to assist different subsystems and individuals in expressing their points of view while we assessed their affective response to the topics discussed. We chose not to manipulate seating arrangements to better illustrate the dynamics, as we felt this would have isolated the vulnerable children in the family in a way that we suspected might be hurtful. Tracking family discussions during assessment about family rules, sleeping arrangements and ideas about how to get along assisted in keeping the family on topic and allowed everyone an opportunity to have input. The family's apparent coping mechanisms were noted that included diverting attention from anxiety producing topics by competing for attention, interrupting, and changing the subject. Family interactions were noted that continually isolated Ben in sessions.

Exploration of how the family had attempted to solve the presenting problem of Ben's negative behaviours revealed family structures that contributed to the problem. In particular, it was noted that despite Mrs. A's awareness of appropriate child management strategies, the rules within the family were unclear and varied depending on whether or not Mr. X was in the home or not. The unpredictable nature of Mr. X's arrivals and

departures kept the family system off balance and differences between Mr. X and Mrs. A regarding rules for the children made the application of child management strategies inconsistent. In addition, Ben's adherence to rules was disregarded and it appeared the rules were applied differently to the other children. We identified problems in the parental subsystem as having a significant impact on the presenting problem.

In a feedback session with Mrs. A Ben's behaviours were acknowledged as difficult and longstanding. They were relabeled in interpersonal terms as being a challenge for a parent to respond to and also made more intense when Ben was feeling anxious. Possible sources of anxiety for Ben were noted such as discussions about the possibility that he live somewhere else and Mr. X's harsh treatment of him. We broadened the problem to include the whole family when we suggested that all of the children were unsettled and unhappy about the dynamics in the family around Mr. X, particularly their mother's anxiety and the indecision about who was in and who was out of the family. Behavioural observations were made about each of the children, reframing some of their behaviour as a response to the stress in their environment. Mr. X's expectation that Mrs. A 'fix' her children was labeled as unrealistic and likely increasing everyone's anxiety, making the children's behaviours more of a problem.

We contracted with Mrs. A to use sessions to help the family figure out ways of organizing themselves to "get along" and to address the pressing need to prepare for the arrival of the new baby. Although she appeared to want to discuss co-parenting issues this was not possible given Mr. X's nonparticipation in family sessions. Later in the therapy process when Mrs. A reasserted that Ben was the cause of the family problems the co-therapy team maintained a transactional formulation. Information gathered

throughout the course of sessions was used to support the formulation and a new therapeutic contract was negotiated that focussed on her relationships with her older children.

Working with subsystems was helpful on a number of occasions. After completing the assessment we first met with Mrs. A alone to provide her with feedback of our formulation and a treatment contract was defined. We affirmed Mrs. A's position as the executive in the family system, responsible for decisions about the children and the therapy process. Meeting with Mrs. A alone also continued to help define and reinforce appropriate generational boundaries between her and the children. Discussions about her relationship with Mr. X, parenting concerns and her strong negative feelings about her older children were framed as adult topics most appropriately discussed away from the children.

Subsystem work also facilitated exploration of the frequent crisis events that often involved Mr. X. Frequently during the session time, time was spent separately with each subsystem if it appeared a generational boundary seemed appropriate to discuss a particular topic. This sometimes involved one co-therapist meeting with the children while the other met with Mrs. A. Efforts were made to reduce the formation of alliances between one therapist and a subsystems that met together. Ending the session by meeting with the whole family, sharing information about what was discussed in age appropriate language and alternating co-therapists with each subsystem were some of the methods used.

Subsystem work with the siblings was geared toward developing the children's sense of cohesion, providing them with experiences together solving problems, or taking

turns speaking about a given topic. The unpredictable attendance of the children made planning interventions with the children a challenge and we attempted to find ways to address their affective response to family arrangements.

Family and sibling sessions often involved art such as family drawings or pictures depicting events before and after an event. These activities included everyone, modeled a way of communicating, provided a forum for discussion and reduced anxiety around some difficult issues. Art was used throughout sessions as a way to facilitate discussion about family membership, getting along in families and expected changes after the arrival of the baby. The termination visit with the family involved having them talk in an allegorical way about living together. Each member drew an animal, described its characteristics and then placed it in an environment that the family drew together.

With Mrs. A's consent, we contacted both the school counselor and the social worker providing service to the family. This provided opportunities for us to share relevant information and to define and clarify our respective roles with the family. The school support staff suggested some initiatives they could offer the family. The role of family sessions was to work on issues of communication and preparations for the birth of the new baby, which school staff identified as a previous trigger for crisis in the family.

We attempted to form a therapeutic alliance (Fishman, 1988) between ourselves and Mrs. A that could lend her support as the executive in the family, corroborating her views and providing opportunities to explore options. Care was taken not to challenge her alliance with Mr. X and set up a power struggle. The need to monitor whether our interventions challenged Mrs. A's alliance with Mr. X was a theme throughout all

sessions. Probing about previous and possible family arrangements clarified those structures in the family that were causing difficulties in attaining Mrs. A's goals for the family. Mr. X's power over rules and prohibitions about how to organize her household appeared to limit the flexibility of Mrs. A's structures. During discussions about how Mrs. A organized the children's recreational activities she described how previous arrangements that met Mrs. A's organizational needs and provided the children with supervised age appropriate activities were vetoed by Mr. X. An intervention that attempted to realign the family around sharing domestic chores and childcare appeared to challenge Mr. X's prohibitions about close contact between the two sibling groups. Arrangements that crossed hierarchical boundaries, and that have been reported as contributing to healthy functioning in single parent families, were not acceptable under current family arrangements.

Mrs. A was supported in her executive role in the family by affirming the viability of single parent families and naming what we perceived to be her strengths as a single parent (Walters et al., 1988). These comments appeared to be asyntonic to the family system in which Mrs. A assessed herself as an inadequate parent and was actively attempting to form a co-parenting relationship. Mr. X's power to define 'good parenting' was bolstered by Mrs. A's isolation and affective and financial need for his assistance. As opportunities presented themselves we highlighted and supported observed and reported behaviours consistent with Mrs. A's expressed view of desired child or parenting behaviours. Mrs. A's ideas about fair rules and sharing family resources were supported and clarified as were any positive comments she made about her children. Her

difficulties and concerns about her children were validated, as was her need for practical instrumental assistance.

An intervention involving family problem solving escalated the stress in the system and activated a number of responses. The children's anxious responses to discussions about the arrival of a new family member were named and normalized as resulting from strong feelings about anticipated but unspecified changes to family arrangements and relations. The influence of imagination and discussions overheard between her and Mr. X were explored. Mrs. A's parental role in supporting the children and helping to reduce their anxiety was supported. We gently challenged Mrs. A to discuss her plans for the arrival of the baby with her children as one way of supporting all of them.

These discussions appeared to unbalance the system. Outside of therapy sessions, Mrs. A asserted her power in her relationship with Mr. X and negotiated support in parenting from extended family members and a commitment from Mr. X to help more with the children. The intervention also resulted in Mrs. A reasserting that Ben was the cause of problems in the family and was accompanied by a request by Mr. X to attend sessions. He was invited to do so but later declined, conveying a message through Mrs. A that his purpose in wanting to attend the session was to inform the co-therapy team that we should focus on changing Ben's behaviour. We questioned whether our interventions had unbalanced the system too far and if Mr. X was reasserting his power over problem definition in exchange for concessions to Mrs. A regarding parental support. Supervision allowed us to appreciate that we had not effectively addressed the children's affect as

they discussed an anxiety charged topic, likely increasing their anxiety and affecting their behaviours at home.

We were challenged at this point to accommodate to Mrs. A's choices for herself and her family. We hypothesized that Mrs. A's power to define the problems in her family were challenged by her reliance on Mr. X and her desire for his participation in the family. Around this time Mrs. A disclosed her concerns about leaving Ben and Kate alone with Mr. X due to her concerns about his harsh treatment of them. Continuing to join with her and the older children while continuing to assert a transactional formulation of the problem were important maneuvers and supported by our previous joining experiences. Sessions with Kate and Ben were framed as an opportunity to strengthen their relationships with Mrs. A., opening up communication between them and establishing age appropriate expectations and parental rewards and punishments. Interventions with Mrs. A and her older children were directed at clarifying the generational boundary and loosening the rigid boundary between them. Mrs. A was coached to respond to her children's comments and questions as family arrangements were discussed.

The complementary relationship between the younger and older sibling subsystems was labeled and Mrs. A tolerated inquiries about Ben and Kate's possible feelings about being labeled 'bad' with difficulty. Mrs. A disclosed her difficulties in praising her older children but had difficulty identifying what made this difficult for her. She recognized Mr. X rejected her older children making it difficult for her to support them when he was in the home.

The complementary parenting relationship between her and Mr. X was challenged gently by relabelling Mrs. A's parenting practices as soft in response to Mr. X's more harsh approach, which she spoke of with concern. We relabeled some of Mr. X's behaviours as abusive. We hypothesized that Mrs. A's difficulty in tolerating this relabelling might have been due to her own coping methods that tended to minimize the verbal and emotional abuse Mr. X directed at her, a common response to abuse in intimate relationships. Concerns about Mr. X's harsh discipline appeared to influence Mrs. A's inability to attend a parenting program at the school that required her to arrange childcare for all of her four children. Mrs. A's fears about her older children's emotional wellbeing were validated and her efforts to protect them by not leaving them alone with Mr. X. were supported.

As Mrs. A asserted herself in her role as the rule maker in the house this set the stage for a discussion of Mr. X 's role in this aspect of family life. Mrs. A began to report supporting her children and facilitating their discussions with Mr. X, and identified behaviours of Mr. X that contributed to problems and contradicted her established rules. Ben's behaviours at home were reported to be less of a problem, which Mrs. A attributed to clarity in rules and Mr. X's consistent presence as a co-parent. Although movement was made in these areas, positive changes continued to be lost in negative affect and anxiety in the family remained high as the expected arrival of the baby approached.

Co-therapy came to an end as the school year concluded and my co-therapist ended her student placement. A session with the whole family included a summary of aspects of family life that we had talked about over the course of family sessions. The

'party' arranged for the last co-therapy session was framed as an ending and a beginning with associated mixed feelings.

After the birth of her baby, Mrs. A. expressed her readiness to conclude our therapeutic relationship and agreed to my coming to her home to terminate sessions. She appeared to have experienced a period of success in maintaining discipline in her home and expressed a belief in Ben's ability to 'behave well', a shift in her previous perceptions. She attributed much of this improvement to her receiving consistent help with parenting and Ben's inclusion in family activities. Mrs. A appeared to have reevaluated her mothering abilities and identified some of her perceived strengths. The family appeared to have organized to accommodate its new member that included the half- brothers sharing a bedroom. The therapeutic relationship seemed to have provided Mrs. A with support through a stressful period during which she exerted her power in the relationship and negotiated help with parenting.

Our final meeting occurred shortly after Mr. X once again asked for custody of the children. Mrs. A's response indicated a shift in her previous assessment of this issue, openly questioning his motives and previous assumptions about herself. We identified supports available within her family and in the community. The end of our relationship was accepted with some sadness as the family turned to face the next challenge in their lives together. As much as I felt uneasy about ending our relationship in the midst of what I perceived to be another crisis, Mrs. A's assertions that they would manage and that perhaps her family would not be like the one she'd planned were a testament to her resilience.

Evaluation

Evaluation measures were not completed by this family due to a combination of factors. Initially the family was not going to be included as part of the practicum. Questions about whether or not Mr. X would be attending sessions, prompted an assumption that therapy would focus on negotiating the tasks of forming a blended family. When it became apparent he was not going to attend the crisis about custody and possible domestic abuse issues distracted me. Inexperience and lack of skill in using clinical measures were coupled with my anxiety about the problems in the family. By the time the therapy team had joined with the family, a number of interventions had taken place and the opportunity for administering pre-intervention standardized assessment measures had passed. As the sessions concluded, having no pre-intervention measure for comparison, administering a post intervention measure seemed moot. Although Mrs. A was asked to complete the Client Satisfaction Questionnaire, it was never returned to the clinic.

Despite the absence of objective measures, some subjective comments about the treatment goals will be made. Mrs. A indicated that she had successfully negotiated alliances with extended family members and the father of her youngest children for help with childcare, thus gaining practical support in her parenting role. She indicated there had been a reduction in the presenting problem and she attributed changes in her son's behaviour to a consistent approach to parenting achieved by getting help in her role from her partner.

The question remains as to whether or not interventions helped to strengthen Mrs. A in her role as a single parent. I understand the phrase, "strengthening her in her

role" as having a different meaning that I had previously given it. I recognize I had expectations that Mrs. A might embrace her role as a single parent and work from a position of heightened awareness of her strength. In fact she taught me that she was using her considerable strength and persistence to maintain her family in difficult circumstances. Her efforts to alter her single parent status by forming a more stable alliance with Mr. X was one of few choices she had available to her in her constrained circumstances. It does seem likely that the therapeutic alliance provided Mrs. A with validation of her need for instrumental parenting assistance and supported her as she negotiated assistance from people in her network without threatening the stability of her family. This parenting assistance, although withdrawn after a time, carried her through a stressful period and provided the family with a positive experience together.

Supporting Mrs. A in her parenting role during sessions also provided the children with opportunities to speak to her as the parent in charge and to give their input about some aspects of family life. This allowed the family to experience themselves differently together.

As with any unbalancing of a system, the reactions are unpredictable and may not represent structural change that would result in long-term resolution of the presenting problem. Mrs. A's alliance with Mr. X in the parenting subsystem presented the possibility that the distance between Mrs. A and Ben and Kate would increase and problems would reemerge in his behaviour at a later time. A phone call to the school at the close of family sessions indicated that while Ben's behaviours were reportedly improved at home, they had worsened at school.

Some of the rules in the family were made explicit. Clarifying the rules can be reevaluated as a method of achieving the goal of supporting Mrs. A in her parenting role. Discussions about rules highlighted the lack of clarity about membership and roles in the parental subsystem and challenged the family pattern of secrecy about Mr. X. Mr. X's influence was evident in almost all family transactions, although his absence from formal sessions made his influence difficult to see initially. Discussion of rules opened the system and allowed examination of family structures that were contributing to the presenting problem. The goal of establishing age appropriate behavioural expectations and strategies was hampered due to the need to first define the boundaries around the child and adult subsystems and clarify the dynamics of the parenting alliance.

Communication was facilitated between Mrs. A and her children about a variety of previously restricted aspects of family life. Some of the strong affect and taboos that blocked their normal communication were identified and different forms of communication were modeled. It is difficult to assess the effect of in-session interventions on the on going function of the family. Mrs. A's comments about the benefits of more open communication and her reported attempts to support her older children when they spoke to Mr. X may have been influenced by interventions.

PART THREE

ANALYSIS AND CONCLUSIONS

CHAPTER FIVE

COMMON THEMES

Although all clients referred to in the practicum report shared the single parent family form the diversity of their circumstances, route to single parenthood and personal characteristics were notable and impacted their specific concerns and movement toward their goals. Some common themes emerged relating to factors within each family and in their external contexts.

The Family in Context

Structural family therapy and group interventions both stress the importance of viewing individuals and families in their broader contexts (Colapinto, 1991; Glassman & Kates, 1990). Context shapes individual and group identities and behaviours. Socioeconomic level and the availability of social networks were two significant organizers of the families in the practicum. Limited income restricted choices in how family members spent their time together and in peer activities. Efforts to establish more financial security by returning to or increasing hours at work impacted families in a variety of ways. Employed mothers generally expressed positive feelings about being able to provide for their families financially and being engaged in activities with other adults. Work activities often resulted in children spending long hours in paid childcare with associated expenses. Previous family routines were altered that were identified as stressful for children. Time and energy for shared family activities were reduced. Missing

shifts, refusing overtime and sick days all reduced available income as all clients occupied job categories with few if any benefits.

Social supports in the form of family or agency childcare, school, after school programs, and community clubs provided families with important options for recreational and age appropriate supervised activities. Those families that had these resources available and were able to use them indicated they were a significant source of support.

A variety of concerns also arose about accessing acceptable sources of support. Childcare concerns included costs and relying on other adults or extended family to care for children. Lesley continued to foster the relationship between her children and their paternal grandparents despite ambivalence about close contact with her ex-partner's family. Her children were able to spend time with them during breaks from school when Lesley needed to work. A small increase in salary resulted in her losing her childcare subsidy and ended her use of school daycare services. Leaving an older sibling to care for the children after school exacerbated sibling tensions and increased parent-child stress.

Jane renegotiated a previously supportive relationship after a period of alienation. She clarified and explained acceptable strategies for child management so that she and her mother could resume their previous arrangement of sharing childcare responsibilities.

Other clients experienced additional stress as they returned to work and made new childcare arrangements. Increased contact between Susan's children and her ex-partner's new wife, unsuccessful arrangements with family members and concerns about potential caregivers harsh discipline strategies were some examples of new stresses. Mrs.

A's efforts to negotiate a co-parenting relationship reduced contact with previously supportive extended family and increased her reliance on her partner. This appeared to reduce her power in making choices about her children's activities and rules in her family.

For most of the referred children, school held academic and social challenges they were struggling to meet. At the same time, academic and extracurricular programs offered opportunities to enhance children's development and give them the skills to allow them to succeed in our society. Shrinking budgets, large classrooms and overtaxed teachers and support staff are some of the factors that may make it difficult for children with special needs to get necessary supports at school. For Jane, Betty, Lesley and Mrs. A. school programs and services had been supportive and induced positive change in their children's behaviours. When improvements were noted, however, services were withdrawn and problems reemerged. This aspect of school based services seems to contribute to problems in families. It appears to assume behavioural change can be brought about in a short time and services are withdrawn before new behaviours or coping skills have been internalized. It appears that consistent programs, most of which would require a lot of human and material resources are a necessity if the needs of children with behavioural disturbance are to be met in the school context.

Mothers expressed concerns about how to speak with staff who were challenged by their children's behaviours and placed demands on the mothers to find ways of correcting their children's behaviours while at school. Differing assumptions about the role of the school in correcting behavioural problems and constraints on mothers' time and energy due to multiple demands challenged efforts to establish a consistent approach between home and school. Encouraging mothers to lobby for services for their children,

communicate with school staff and develop partnerships to meet their children's needs were part of both interventions.

Searching For Strength

An assumption of strength and competency in families and individuals is a basic premise of both the structural family therapy approach and group interventions (Minuchin & Fishman, 1981; Wood & Middleman, 1989). Solutions to problems are assumed to be dormant and only need the opportunity to be mobilized. It was these theoretical assumptions and a personal conviction that people are more motivated to change and risk new behaviours when their strengths are recognized that guided my interventions.

All families in the practicum presented with serious concerns about child behavioural problems and each of the women understood the negative impact of these behaviours on their child's current and future development. All families had experienced and found ways of coping with significant life stresses in the past. In spite of negative feelings about their children and about themselves they all took action and risked asking for assistance from strangers, indicating a strength and commitment to their families.

At the same time I noticed that clients found it difficult to identify personal and family strengths or they took them for granted. It was not enough that I could identify and name what I perceived as their strengths as so often their problems seemed to overshadow those aspects of their lives that were going well. Maintaining a belief in my clients' strengths and finding the right time and context in sessions to draw out those strengths was an ongoing process. Understanding the context in which each client family

lived and encouraging them to examine their previous efforts to adapt to the stresses and strains of family life also facilitated an understanding of their strengths.

Within the group context there was ample opportunity to validate clients' strengths. Although a mutual aid system did not materialize in which members validated each others' ideas and activities, I gave positive feedback about efforts to try something new, spend time with a child, do some self care or any number of activities that would reduce stress and foster the mother-child relationship. These activities were designed to promote a group culture where these kinds of activity were supported and modeled and members could gain ideas and information. Jane provided many examples of her efforts and I believe Susan gained hope and ideas from her. Lesley provided examples of her previous successes in parenting her older children that were framed as experience she could use to sustain her efforts with her youngest child. Jane and Susan were beginning to tentatively challenge Lesley's harsher parenting strategies early in the group. All of the mothers appeared to appreciate comments that acknowledged the difficult challenges their children's behaviours presented and their continued efforts to remain in relationship with them.

Although Mrs. A experienced ongoing criticism of her parenting from other sources and she was disconcerted by direct praise of her parenting, I believe that she appreciated the recognition of her parenting efforts and her ideas. She was open to praise and validation of her mothering of the younger children and this strength was used as a springboard for exploration of what her mothering would look like for older children. Despite Mrs. A's expressed difficulty in feeling and showing an appreciation for her older

children's strengths she persisted in attending sessions in which she was coached to speak with her children about their strengths.

Multiple Stresses

Although the social context for each family was unique the multiple stresses in the lives of the mothers was a common theme that added intensity to the problems presented and to therapeutic interactions. I was often aware of the strong negative feelings the mothers were experiencing and my understanding of their isolation instilled a sense of urgency to support them in some meaningful way. An impulse to protect the children from negative experiences and to help the women escape their circumstances were quickly evaluated as counterproductive to the goal of supporting the family in their current dilemma. Conceptualizing problems with a focus on individuals, assigning blame or thinking linearly, all recognized pitfalls when working with families (Minuchin & Fishman, 1981; Swift, 1995), emerged frequently as I searched for an understanding of the multitude of influences impacting clients.

Both the group intervention and the structural family therapy interventions guided my understanding of the families from a systemic perspective. In formulating the family's problems from an interactional perspective, focusing on strengths and establishing goals I not only had to find some way of conveying this formulation to the families, I also had to continually remind myself to see the families systemically and in context. Finding the language of strengths without minimizing the difficulties is part of my ongoing learning. Neither intervention impacted the external contexts of the families and that reality was one I had to come to accept. This realization provided motivation to

understand and learn what might be useful to families seeking professional clinical services.

The therapeutic system in both the family therapy and group interventions had the potential to serve as temporary support systems and parenting alliances. They both offered opportunities to talk about concerns, explore options and make choices consistent with the realities of their individual contexts and needs. The family therapy intervention offered Mrs. A opportunities to discuss her parenting and other adult concerns in a generational alliance with the therapy team. The group intervention provided opportunities to discuss parenting concerns with a number of other adults and to develop temporary supportive relationships within the group context. The interventions implicitly and explicitly affirmed the legitimate need for support in parenting and its benefits to the parent-child relationship. Locating acceptable sources of support continued to be a challenge for many, constraining options that would enable them to make desired changes. As a clinician, I came to understand more clearly how the context of each family constrained or enhanced their choices.

Family Violence

Although never the presenting issue, family violence emerged frequently throughout the interventions and increased the intensity of interactions in the therapeutic process. Child abuse and abuse of women is well substantiated as an endemic phenomena in Canada and worldwide (Johnson, 1996) so its emergence as a theme in this highly stressed population came as no surprise. A tension arose between my professional responsibility to report and try to prevent abuse and my understanding of the limited options, multiple stresses and the intense affect in my clients. Although I

have been actively involved in individual counseling with abused adults and am involved in social action against violence, work within families was more complex. I would have to agree with Bograd (1992) that those in the helping professions have difficulty finding constructive ways of dealing with abuse issues within families. A theoretical understanding of the negative effects of abuse, coupled with an awareness of the vulnerability to abuse in client families sustains a desire to find effective ways to address abuse issues therapeutically.

Susan's and Mrs. A's responses to abuse in their adult relationships appeared to be influencing their current functioning. Both clients minimized or avoided discussion of the abusive behaviours directed at them or their effects which is consistent with a theoretical understanding of some of the ways that people respond to abuse (Johnson, 1996). It was difficult within the context of the therapeutic contracts we had established to address abuse issues directly. Structural family therapy has no theoretical mechanisms to address intra personal responses associated with abuse although there is an understanding that issues of power and control impact family interactions. Understanding abusive behaviour as an attempt to exert control provided an opening for raising the topic in the therapeutic relationship.

The contexts in which both Susan and Mrs. A found themselves likely limited their perceptions of their options in addressing the abuse they were experiencing. Susan had left a physically abusive relationship but continued to have contact with her abuser in a co-parenting arrangement. She perceived herself as less powerful than her ex-partner who had greater material and social resources. Her experiences of abuse were likely

contributing to her lack of confidence in her parenting and may have been making it difficult for her to effectively address her son's abusive behaviours.

Mrs. A's partner's manipulative behaviours, withholding of financial resources and emotional and verbal abuse was directed at both her and her children. Her experiences of abuse were also seen as an impediment to her exerting her power in her family and negatively influenced her self-perception. She made some small steps towards acknowledging the negative effects of her partner's behaviours, reducing his contact with her older children but felt she had limited options when it came to altering her situation.

The use of corporal punishment and harsh parenting methods emerged in the group and family therapies. The early beginnings of group culture were formed around discussions about the negative effects of abuse and the desire to find alternatives to physical punishment in current parenting practice. Group members wanted to discuss this aspect of child rearing however the use of corporal punishment became a divisive issue in the group and impeded the development of the mutual aid system.

I found I had to rely on interventions outside the structural family therapy framework and group work models to address abuse issues directly. Advocating the use of non-physical child management strategies was consistent in both interventions as was naming and reframing behaviours as abusive and validating and normalizing some of the responses to abuse. Both interventions attempted to find ways to reduce abuse potential by supporting the mothers in their efforts to protect their children, increasing supportive relationships and encouraging empathy in the highly stressed parents. In the group intervention reaching for the feelings behind clients' comments about abuse, linking

members' feelings and generating discussion between them could have been a more constructive response than censure. Having responded with censure made reopening the subject more difficult and increased the natural reticence of group members to discuss the topic.

Use of Self in Therapy

The use of self in therapy requires interaction, vulnerability and awareness of self in combination with selected use of technical knowledge and skills (Minuchin, 1974). Developing trust between clients and worker is the primary concern in therapeutic relationships (Kaplan & Girard, 1994). Joining with clients is a fundamental use of self in structural therapy (Colapinto, 1991) that establishes trust. The therapeutic relationship that results provides the environment in which clients can feel safe enough to explore alternatives and make planned change. Although described as a technique, joining is the name given to how each individual therapist engages with clients. It is done throughout the process of the therapy and involves not only activities but also attitude.

The goal of joining with clients is to be accepted enough to be able to participate in transactions so as to gain an understanding of the family structures and strengths. At the same time the therapist must be able to step out of any given transaction and create distance between her and the family to allow restructuring. Joining presents not only the possibility of connecting with clients, but also the possibility of being inducted into the family system and rendered ineffective as an agent of change (Minuchin & Fishman, 1981).

In joining with group therapy clients, the goal is to instill trust in the group process and begin preparations for the development of the mutual aid system in which

transactions will take place. Through contracting and discussion of goals for the program the therapeutic alliance begins with the expectation that the therapist's role will diminish as the group progresses (Toseland & Rivas, 1995). The group intervention required different skills to develop a safe environment for therapeutic change and the use of self was influenced by this fact. Empathizing and staying in the here and now with clients contributed to the building of an environment where members could risk self-disclosure and begin to develop relationships with others.

In the process of joining with clients a number of emotional reactions were engendered in me. With all of the clients, whether in the group or family interventions, I was able to genuinely empathize with the concern and frustration they felt regarding their children. I came to a better understanding of their limited options and their vulnerability. Personal reflection and supervision provided opportunities to understand how my responses affected therapeutic efforts. It was not enough to be aware of my internal reactions. It was more important to understand how those reactions affected my interactions with others and my ability to formulate interventions to assist clients in planned change. Shifting my awareness to a belief in the mothers' abilities and other strengths in the families provided the fuel for continued efforts to stay with clients emotionally and cognitively as they explored alternatives.

Despite efforts to the contrary I formed an alliance with the scapegoated child in the A family which affected my ability to empathize with Mrs. A's frustration with his difficult behaviours and compromised the generational alliance we were developing. The realization of these effects and supervision assisted me in my making efforts to join with the family without being absorbed into it (Minuchin, 1974). It also dramatized the

tendency to take sides when choices have to be made about how to meet the individual needs of family members.

Joining involves an ongoing acceptance of and curiosity about clients alternating with questioning their ways of doing things and suggesting there are alternatives (Colapinto, 1991). Being curious and accepting was initially straightforward. As I became overwhelmed with content and searched for some way of changing the dysfunctional structures I had identified this became more difficult. The challenge for me was to find the language of suggestion to present alternatives and then tolerate the family's reactions to the challenge. I was hampered in this aspect of the therapy process due to concerns that my suggestions might appear prescriptive. The tendency for new therapists to qualify their remarks or make hesitant suggestions and the unhelpful nature of these activities is discussed in the literature about structural family therapy (Nichols & Schwartz, 1998).

As a student therapist I found myself preoccupied at times by my development of a theoretical framework and learning techniques to use in sessions. I felt uneasy as I attempted to work with groups of clients rather than individuals, to try out techniques and still be genuine in my interactions. Continuing to empathize with clients in both interventions challenged my abilities to tolerate strong affect and induced transference and other reactions. My attempts to cope with these reactions by emphasizing information and technical strategies interfered with my use of self in interchanges with clients and hampered the therapy process.

In both group and family therapy modalities the use of self is not an application of techniques but involves an understanding of individuals as being in connection with

others, constantly in transformation. A wide definition of normal family life is required as well as a depathologizing stance. There are many similarities between structural family therapy and group work as it was done in this practicum. The differences lie in the mechanisms for change. In structural family therapy the therapist's efforts are directed at altering dysfunctional family structures. The family is actively involved and the therapist decentres herself as the family is encouraged to interact and try out new patterns.

In group interventions the mechanisms for change are factors in the group such as the generation of hope, cohesion, modeling, exchanging information and the universality of concerns. The use of self is directed at promoting the development of the mutual aid system that allows members to explore alternatives with a group of others who share common concerns and to gain new ideas and try out new behaviours.

Use of Structure in Interventions

Structure was used to understand all client families and in planning both the group and structural family therapy interventions. Families are naturally formed groups whereas the mothers' group was comprised of the parental subsystem of a number of families and members needed time and opportunities to build affiliative bonds. Understanding families structurally helped me make sense of what I was seeing when watching clients interact. Identifying the families' hierarchies and subsystems lent clarity to their strengths and difficulties in carrying out their roles and in being in relationship with others. Both interventions addressed the concerns of the parental subsystems, those of the child subsystems and the parent-child subsystems. Both interventions also stressed the importance of examining the effect of external systems on family structures.

Having conceptually separated the family into subsystems, the goals for clients became clearer. The unique nature of families is not challenged by this conceptualization, as each family is free to define how children are to be raised, the goals for the family and who comprises the parental alliance. The varied external factors can then be understood as they impact individual family members who have different roles in the family.

Another type of structuring, or planning, was used for each family or group session. Prior to family sessions an intervention was formulated that it was hoped would move the family toward the established goals. Group sessions also had planned agendas and rituals that provided sessions with structure. Weekly themes were used as a springboard for exploration of how each family dealt with aspects of family life. The imposition of structure was meant to reduce anxiety, promote communication between members and promote planned change. Having a plan also reduced my anxiety by giving me the illusion of some control with the undesired effect of increased member to leader communications and interfering with the development of the mutual aid system.

Due to the multiple stressors in the lives of the clients, planned interventions and agendas were often laid aside to address current issues brought to sessions by clients. The A family often presented with issues concerning Mr. X. who did not attend sessions making enactment of transactions impossible. The central dysfunctional structure in the family was unavailable in therapy. Unpredictable attendance by the children not only altered planned interventions, the reasons for the children's absence also generated strong affect in those who did attend. Within the structural therapy framework it is possible to use the issues brought to sessions to work toward structural change by focusing on interactive processes.

The content of the family's story often interfered with my ability to see the underlying structures until the session was almost over. I came to understand that the content rather than the processes of the family's stories tended to organize my thinking during sessions. Watching videotapes of the sessions made this aspect of the therapy process clear to me and I was struck by the number of times family members offered openings for discussion of important issues that I had missed during the session. Inexperience and working with another student therapist who did not share the structural formulation of the family made changing the shared plans for the session added to the complexity of the session work. Colapinto (1991) has suggested that structural family therapy can be difficult with a co-therapy team due to its directive nature. My experience would support this observation, especially if the students are practicing different approaches to clients.

In the group, the checkin often took the group onto a topic that seemed unrelated to the planned weekly theme. It was important to let members have time to discuss their concerns. Relating concerns to a common theme was hoped to develop cohesiveness in the group but often resulted in me stopping the flow of conversation and adding unnecessary content. In this case structure was unnecessary and intrusive.

On occasion, members who had returned after missing a session needed to be brought up to speed on what the group had done the previous week. The group was structured with a psychoeducational component so it was necessary for all members to have some exposure to previous themes. In session four, Betty returned after a week's absence. The session theme was put aside to allow time for the group to summarize the themes from previous weeks with good results. In week five, Lesley returned after a

week's absence and the decision was made to proceed with planned activities. This decision to adhere to an agenda focused more on content and less on the group processes.

CHAPTER SIX

CONCLUSIONS

My learning objectives, to increase my knowledge and understanding of issues facing single parent families and to develop my skills as an agent of change using the structural family therapy and group interventions were met, although I recognize my learning is only beginning. Meeting my objectives was due largely to the supervision I received, the support of my committee and fellow students at Elizabeth Hill Counseling Centre and the willingness of the families with whom I worked to share their experiences with me.

I would agree that the way to help children is to help their families and that services must be geared toward families rather that individuals (Kaplan & Girard, 1994). As society is organized now, families are responsible for raising their children on their own. We seem to pay lip service to the needs of children and the important role of families in meeting those needs. If an adult is disadvantaged, preventing him or her from providing an optimum environment for their child, it is the child who is punished for the adult's difficulties. It isn't until a problem emerges that services become available, and these are fragmented and provided to individuals who can prove their need by the severity of their problems, the extent of their "failure". The punitive nature of social programs and services add to the complexity of parenting, especially single parenting. We understand the risks for both children and adults associated with family disruption, low income, poor housing and social isolation. Raising children is a community responsibility and one that we as a society must take seriously. The need for a comprehensive preventive approach to meet the needs of families before they present with serious

dysfunction seems obvious to me. Schools, that play a central role in the lives of children, are a logical place for service delivery. A comprehensive childcare program is also long overdue.

Understanding how external context is an organizer of single parent families was an important part of my learning. Families were vulnerable to small changes in the external environment that were beyond their control and necessitated frequent family reorganization. The families I met demonstrated a resiliency and strength of purpose in keeping their families together despite difficult circumstances. They taught me much about the affective bonds within families.

My understanding of the issues facing single mothers has been expanded from my own personal experience as a child raised in a single parent family. I now include in my framework a more mature understanding of the complexity of issues that impact the single-parent family. The important role the mothers play in these families was evident and the impact of their context on their ability to make necessary adjustments was an ongoing tension. Maintaining a family, rather than an individual focus, and viewing the family in a broad social context was useful as it helped me avoid pathologizing behaviours and falling into a blaming stance.

I found the structural family therapy framework enhanced my ability to understand what I was seeing when I met families, whether I worked with them in the family therapy or group modality. The content of each family's history and idiosyncrasies demonstrated their uniqueness. Defining their subsystems, boundaries, alliances and hierarchy made it possible for me to establish therapeutic goals that addressed the

family's presenting problem. The effect of external factors and major life stresses and transitions then fell into place as organizers of these central family structures.

Although the problem presented by all families was a child's problem behaviours, factors impacting the families and the presenting problem emerged over the course of the interventions. These included the adjustments necessary after divorce or separation which included co-parenting arrangements, changing schools, homes and childcare arrangements. Family violence and the formation of new adult relationships also emerged as factors that affected parent-child relationships and children's behaviours. The importance of elevating the parent to facilitate their reorganization of the family emerged as an important part of the work. The multiple stresses on the family and the individual mothers impacted their ability to make desired changes.

The goal in both modalities was to support and elevate the single-parent subsystem in the family hierarchy as a way of strengthening the parent-child relationship. In this case the focus shifts to an individual in the family on whom society places an important and complex responsibility. Both modalities emphasize a de-pathologizing stance, a here and now orientation, specific goals, planful interventions, the relevance of social context and the different roles that members of any group assume. Neither intervention influenced the external structures that result in increased vulnerability for single-mother families due to economic disadvantage and limited consistent instrumental support.

Structural family therapy provided the framework to see the family structures and used content as a means of understanding the structures. The here and now orientation of the therapy limited interventions to those attending sessions. People outside the

family system, and who did not attend sessions, were unavailable for direct intervention in sessions. The effects of abuse and the power imbalances in adult relationships could not be addressed within the theoretical framework of structural family therapy. It remains unclear to me if interventions like marking boundaries and clarifying roles had any effect on the presenting problem. The intervention had no way of actually providing the practical assistance Mrs. A needed to meet family's needs which clearly impacted her ability to organize her family.

The group was more conducive to the support aspect of therapy, as members were grappling with similar circumstances and their challenges could be normalized and validated within the group context. Didactic information could be imparted as a platform for discussion about how to organize family relations among a group of peers. Transitions stimulated by changes in family membership and maturation could also be normalized as members came to understand that others were dealing with similar needs to reorganize to accommodate to these changes. The affiliative bonds, that are present in a family group, had to be fostered in the group intervention. Hopefully practice will develop the skills necessary to promote the development of a mutual aid system.

Evaluation of the effectiveness of the interventions was measured by clinical observations, pre- and post-CBCL and PSI scores, client interviews and a written Client Feedback form. Positive changes were noted in the family therapy client and in one family who participated in the group program. The Client Feedback forms indicated that the group intervention was regarded as having some value to all clients. The exit interviews at the conclusion of both interventions were most informative in providing feedback about what clients found helpful and what could have improved their therapy

experience. It is likely that clients' responses about the interventions were influenced by the fact that I had also provided the service they were being asked to evaluate.

In the final analysis, the interventions and practicum experience provided me with the opportunity to understand the complexity of the therapeutic relationship, my role within that relationship and the central position that clients have in making decisions about their choices. Writing has clarified my thinking at a theoretical level. If my experience during this practicum is any indication, the real learning takes place in real life interactions and that is a lifelong process.

REFERENCES

Abidin, R. (1995). Parenting Stress Index. (3rd ed.): Professional manual. Odessa, Florida: Psychological Assessment Resources.

Achenbach, T. M., & Edelbrock, C. (1983). Manual for the child behaviour checklist and revised child behaviour checklist profile. Burlington, VT.: Queen City.

Aponte, H. (1976). Underorganization of the poor family. In P.J. Guerin, Jr. (Ed.), Family therapy: Theory and practice (pp. 432-448). New York: Gardner Press.

Aponte, H. (1985). The negotiation of values in therapy. Family Process 24, 323-338.

Aponte, H., Zarski, J., Bixenstine, C., & Cibik, P. (1991). Home/community-based services: A two-tiered approach. American Journal of Orthopsychiatry, 61, 403-408.

Aponte, H., & Van Deusen, J. (1981). Structural family therapy. In A. Gurman & D. Kniskern (Eds.), Handbook of Family Therapy (pp. 310-359). NewYork: Brunner and Mazel Publishers.

Ault-Riche, M. (1986). A feminist critique of five schools of family therapy. In J. C. Hanson (Series Ed.) & M. Ault-Riche (Vol. Ed.), Women and therapy. Maryland: An Aspen Publication.

Baines, C., Evans, P., & Neysmith, S., (Eds.). (1998). Women's caring: Feminist perspectives on social welfare. Toronto: Oxford University Press.

Barratt, M. S., Roach, M.A., Morgan, K.M., & Colbert, K.K. (1996). Adjustment to motherhood by single adolescents. Family Relations, 45 , 209-215.

Becvar, D., & Becvar, R. (1996). Family therapy: A systematic integration (3rd ed). Needham Heights, Mass: Allyn and Bacon.

Belsky, J. (1984). The determinants of parenting. Child Development, 55, 83-96.

Belsky, J., & Vondra, J. (1989). Lessons from child abuse: the determinants of parenting. In D. Cicchetti & V. Carlson (Eds), Child maltreatment: Theory and research on the causes and consequences of child abuse and neglect (pp. 153-202). New York: Cambridge University Press.

Bograd, M. (1992). Values in conflict: Challenges to family therapists' thinking. Journal of Marital and Family Therapy, 18, 245-256.

Brandt, J. (1989). Becoming parents: Families with young children. In B. Carter & M. McGoldrick (Eds.), The changing family life cycle: A framework for family therapy (pp. 235-254). Boston: Allyn and Bacon.

Breton, M. (1992). Reaching and engaging people: Issues and practice principles. Social Work with Groups, 8, 7-21.

Brown, F. (1989a). The postdivorce family. In B. Carter & M. McGoldrick (Eds.), The changing family life cycle. A framework for family therapy (pp. 371-398). Boston: Allyn and Bacon.

Brown, F. (1989b). The impact of death and serious illness on the family life cycle. In B. Carter & M. McGoldrick (Eds.), The changing family life cycle. A framework for family therapy (pp. 457-482). Boston: Allyn and Bacon.

Burt, S., Code, L., & Dorney, L. (Eds.), (1993). Changing patterns: Women in Canada. (Chapter Four). Toronto: McClelland & Stewart.

Canetto, S. (1996). What is a normal family? Common assumptions and current evidence. The Journal of Primary Prevention, 17, 31-46.

Caplan, P., & Hall-McCorquodale, I. (1985a). Mother-blaming in major clinical journals. American Journal of Orthopsychiatry, 55, 345-353.

Caplan, P., & Hall-McCorquodale, I. (1985b). The scapegoating of mothers: A call for change. American Journal of Orthopsychiatry, 55, 610-613.

Carter, B., & McGoldrick, M. (Eds.), (1989). Overview: The changing family life cycle. A framework for family therapy (pp. 3-25). Boston: Allyn and Bacon.

Christensen, O., & Thomas, C. (1980). Dreikers and the search for equality. In M. Fine (Ed.), Handbook of parent education (Chapter 3), New York: Academic Press.

Colapinto, J. (1991). Structural family therapy. In A. Gurman & D. Kniskern (Eds.), Handbook of family therapy volume 2 (pp. 417- 443). New York: Brunner/Mazel Inc.

Corey, M., & Corey, G. (1997). Groups: Process and practice. Pacific Grove: Brooks/Cole Publishing Co.

Davies, L., Avison, W., & McAlpine, D. (1997). Significant life experiences and depression among single and married mothers. Journal of Marriage and the Family, 59, 294-308.

Dubow, E., & Luster, T. (1990). Adjustment of children born to teenage mothers: The contribution of risk and protective factors. Journal of Marriage and the Family, 52, 393-404.

Edgeland, B., Jacobvitz, D., & Stroufe, L.A. (1988). Breaking the cycle of abuse. Child Development, 59,1080-1088.

Elliot P., & Mandell, N. (1998). Feminist theories. In N. Mandell (Ed), Feminist Issues: Race, class and sexuality (pp. 2-25). Scarbourough: Prentice, Hall and Bacon Canada.

Emery, R.E., & Tuer, M. (1993). Parenting and the marital relationship. In T. Luster & L. Okagaki (Eds.), Parenting: An ecological perspective (pp121-148). New Jersey: LawrenceErlbaum Associates Publishers.

Evans, P.M. (1998). Gender, poverty and women's caring. In C. Baines, P.Evans, & S. Neysmith (Eds.), Women's caring: Feminist perspectives on social welfare (pp.47-68). Toronto: Oxford University Press.

Ferguson, E. (1998). The child-care debate: Fading hopes and shifting sands. In C. Baines, P.Evans, & S. Neysmith (Eds.), Women's caring: Feminist perspectives on social welfare (pp.191-217). Toronto: Oxford University Press.

First, J., & Way, W. (1995). Parent education outcomes: Insights into transformative learning. Family Relations, 44, 104-109.

Friedlander, M. L. (1998). Family therapy research: Science into practice, practice into science. In M. Nichols & R. Schwartz (Eds.), Family therapy: Concepts and methods (pp. 503-533). Needham Heights: Allyn & Bacon.

Furstenberg, F., Brooks-Gunn, J., & Philip Morgan, S. (1987). Adolescent mothers in later life . New York; Cambridge University Press.

Garvin, C., & Reed, B. (1995). Sources and visions for feminist group work: Reflective processes, social justice, diversity and connection. In N. Van Den Burgh (Ed.), Feminist practice in the 21st century (pp. 41-69). Washington, D.C.: NASW Press.

Gaudin, J., Polansky, N., Kilpatrick, A., & Shilton, P. (1993). Loneliness, depression, stress and social supports in neglectful families. American Journal of Orthopsychiatry, 63, 597-605.

Gelles, R. (1992). Poverty and violence toward children. American Behavioural Scientist, 35, 258-274.

Gitterman, A. (1986). The reciprocal model: A change in paradigm. Social Work with Groups. Special Issue (pp. 29-37). New York: The Haworth Press.

Gitterman, A. (1989). Testing professional authority and boundaries. Social Casework: The Journal of Contemporary Social Work ,March, 165-171.

Glassman, U., & Kates, L. (1990). Group work: A humanistic approach. California: Sage Publications.

Green, R. G., & Crooks, P.D. (1988). Family member adjustment and family dynamics in established single-parent and two-parent families. Social Service Review, December, 600-613.

Halpern, R. (1990). Poverty and early childhood parenting: Toward a framework for intervention. American Journal of Orthopsychiatry, 60, 6-18.

Hanson, S.M. (1986). Healthy single parent families. Family Relations, 35, 125-132.

Hetherington, E. (1989). Coping with family transitions: Winners, losers and survivors. Child Development, 60, 1-14.

Hines, P. M. (1989). The family life cycle of poor black families. In B. Carter & M. McGoldrick (Eds.), The changing family life cycle: A framework for family therapy (513- 544). Boston: Allyn and Bacon.

Howing, P., Wodarski, J., Gaudin, J., & Kurtz, P. (1989). Effective interventions to ameliorate the incidence of child maltreatment: The empirical base. Social Work, July, 330-33.

Johnson, H. (1996). Dangerous domains. Scarborough: Nelson Publishing.

Johnston, J., Campbell, L., & Mayes, S. (1985). Latency children in post-separation and divorce disputes. Journal of the Academy of Child Psychiatry, 24, 563-574.

Jung, M. (1984). Structural family therapy: Its application to Chinese families. Family Process, 23, 365-374.

Kaplan, L., & Girard, J. (1994). Strengthening high-risk families: A handbook for practitioners. New York: Lexington Books.

Kissman, K. (1991). Feminist-based social work with single-parent families. Families in Society: The Journal of Contemporary Human Services, 23-28.

Kurland, R. (1978). Planning: The neglected component of group development. Social Work with Groups, 1, 173-178.

Land, H. (1995). Feminist clinical social work in the 21st century. In N. Van Den Burgh (Ed.), Feminist practice in the 21st century (Chapter 2), Washington: NASW Press.

Lindner, M. S., Hagan, M. S., & Brown, J. C. (1992). The adjustment of children in non-divorced, single-mother and remarried families. In E. Mavis Hetherington & W.G. Clingempeel (Eds.), Coping with marital transitions (pp. 35-72). Monographs of the society for research in child development No. 227, Vol. 57, Nos. 2-3.

Luster, T., & Mittelstaedt, M. (1993). Adolescent mothers. In T. Luster & L. Okagaki (Eds.), Parenting: An ecological perspective (pp. 69-99). New Jersey: Lawrence Erlbaum Associates Publishers.

Luster, T., & Okagaki, L. (Eds.), (1993). Parenting: An ecological perspective. New Jersey: Lawrence Erlbaum Associates Publishers.

Macoby, E. (1992). The role of parents in the socialization of children: An historical review. Developmental Psychology, 28, 1006-1017.

Macoby, E., Depner, C., & Mnookin, R. (1990). Coparenting in the second year after divorce. Journal of Marriage and the Family, 52, 141-155.

McLanahan, S. (1983). Family structure and stress: A longitudinal comparison of two-parent and female-headed families. Journal of Marriage and the Family, May, 347-357.

McKie, C. (1993). An overview of lone parenthood in Canada. In P. Hudson & B. Galaway (Eds.), Single parent families: Perspectives on research and policy (pp.53-71). Toronto: Thompson Educational Publishing.

Minuchin, P. (1985). Families and individual development: Provocations from the field of family therapy. Child Development, 56, 289-302.

Minuchin, S. (1974). Families and family therapy. Cambridge, Mass.: Harvard University Press.

Minuchin, S., & Fishman, H.C. (1981). Family therapy techniques. Massachusetts: Harvard University Press.

Minuchin, S., & Nichols, M. (1993). Family healing: Tales of hope and renewal from family therapy. New York: The Free Press.

Mooney, K. (1984). Child behaviour checklist. In D.J. Keyser & R. C. Sweetland (Eds.), Test Critiques. Kansas City: Westport Publishers.

Morawetz, A. (1984). The single-parent family: An author's reflection. Family Process, 23, 571-576.

Nichols, M., & Schwartz, R. (Eds.), (1998). Family therapy: Concepts and methods. Needham Hights: Allyn & Bacon.

Napoliello, A., & Smith Sweet, E. (1992). Salvador Minuchin's structural family therapy and its application to Native Americans. Family Relations, 19, 155-165.

Olds, D. L., & Henderson, C. R. (1989). The prevention of maltreatment. In D. Cicchetti & V. Carlson (Eds.), Child maltreatment: Theory and research on the causes and consequences of child abuse and neglect (pp. 722-763). New York: Cambridge University Press.

Papell, C., & Rothman, B. (1966). Social group work models: Possession and heritage. Education for Social Work, Fall , 66-77.

Papell, C., & Rothman, B. (1980). Relating the mainstream model of social group work with groups to group psychotherapy and the structured group approach. Social Work with Groups, 3, 5-23.

Patterson, G. (1982). Coercive family process. Eugene, Oregon: Castalia.

Patterson, G., Chamberlain, P., & Reid, J. (1982). A comparative evaluation of a parent-training program. Behaviour Therapy, 13, 638-650.

Portes, P., Howell, S., Brown, J., Eichenberger, S., & Mas, C. (1992). Family functions and children's postdivorce adjustment. American Journal of Orthopsychiatry, 62, 613-617.

Richards, M. (1993). Children and parents and divorce. In J. Eekelaar & P. Sarcevic (Eds.), Parenthood in modern society: Legal and social issues for the twenty-first century (pp. 307-315). The Netherlands: Martinus Nijhoff Publishers.

Rose, S. (1989). Working with adults in groups. San Fransisco: Jossey-Bass.

Roy, R., & Frankel, H. (1995). How good is family therapy? Toronto: University of Toronto Press.

Russell, M. (1989). Feminist social work skills. Canadian Social Work Review, 6, 69-81.

Rutter, M. (1981). The city and the child. American Journal of Orthopsychiatry, 51, 610-65.

Schwartz W. (1961). The social worker in the group. In The Social Welfare Forum Official Proceedings. National Conference on Social Welfare (pp. 146-171). Ohio: Columbus University Press.

Sheeber, L., & Johnson, J. (1992). Child temperament, maternal adjustment and changes in family life style. American Journal of Orthopsychiatry, 62, 179-185.

Sidel, R. (1992). Women and children last. New York: Penguin Books.

Simon, G. (1995). A revisionist rendering of structural family therapy. Journal of Marital and Family Therapy, 21, 17-26.

Smith, J., Berthelsen, D., & O'Connor, I. (1997). Child adjustment in high conflict families. Child: care, health and development, 23, 113-133.

Stack, C. (1997). All Our Kin. New York: Basic Books.

Stevens, J. (1988). Social support, locus of control, and parenting in three low-income groups of mothers: Black teenagers, black adults and white adults. Child Development, 59, 632-642.

Swift, K. (1995). Manufacturing bad mothers: A critical perspective on child neglect. Toronto: University of Toronto Press.

Telleen, S., Herzog, A., & Kilbane, T. (1989). Impact of a family support program on mothers' social support and parenting stress. American Journal of Orthopsychiatry, 59, 410-419.

Tolan, P., & McKay, M. (1996). Preventing serious antisocial behaviour in inner city children: An empirically based family intervention program. Family Relations, 45, 148-155.

Toseland, R., & Rivas, R. (1995). An introduction to group work practice. Needham Heights: Allyn & Bacon.

Tuckman, B. (1963). Developmental sequence in small groups. Psychological Bulletin, 63, 384-399.

Vosler, N., & Proctor, E. (1991). Family structure and stressors in a child guidance clinic population. Families in Society: The Journal of Contemporary Human Services, March, 164-173.

Wahler, R., Cartor, P., Fleischman, J., & Lambert, W. (1993). The impact of synthesis teaching and parent training with mothers of conduct-disordered children. Journal of Abnormal Child Psychology, 21, 425-440.

Wallerstein, J. (1991). The long-term effects of divorce on children: A review. Journal of the American Academy of Child and Adolescent Psychiatry, 30, 349-360.

Walsh, F. (Ed.), (1982). Normal family processes. New York: The Guilford Press.

Walsh, J., Hewitt, H., & Londeree, A, (1996). The role of the facilitator in support group development. Social Work with Groups, 19, 83-91.

Walters, M., Carter, B., Papp, P., & Silverstein, O. (Eds.), (1988). The invisible web: Gender patterns in family relations. New York: The Guilford Press.

Wayne, J. (1979). A group work model to reach isolated mothers: Preventing child abuse. Social Work with Groups, 2, 7-18.

Webster-Stratton, C. (1997). From parent training to community building. Families in Society: The Journal of Contemporary Human Services, March/April, 156-171.

Webster-Stratton, C., & Hammond, M. (1988). Maternal depression and its relationship to life stress, perceptions of child behaviour problems, parenting behaviours and child conduct problems. Journal of Abnormal Child Psychology, 16, 299- 315.

Wetchler, J. (1995). A conservative response to Simon's revision of structural family therapy. Journal of Marriage and the Family, 21, 27-31.

Whipple, E., & Wilson, S. (1996). Evaluation of a parent education and support program for families at risk of physical child abuse. Families in Society: The Journal of Contemporary Human Services, April, 227-239.

Wiehe, V. (1996). Working with child abuse and neglect. Thousand Oakes, California: Sage Publishing.

APPENDIX A

SESSION OUTLINE

Week #1

Group Development Stage: Beginning/Affiliation, trust, power and authority

Process Goals:

- begin to build trust between members and in the group process; express belief in group as a place where members can get their needs for support, information and to try out their ideas
- lessen anxiety by acknowledging and normalizing anxiety and apprehension about joining a group
- provide format to promote safety (ground rules for discussion, session format and establish goals for the group)
- encourage member involvement; provide structured exercise to exchange personal information and let each member speak at least once in group; invite responses to discussion content; promote expression of hope, concerns, intentions and fears
- begin to build commitment to the group; accentuate similarities between members

Content

- welcome members
- weekly theme; Why are you here? Why am I here?
- clarify purpose and expectations about group membership and the role of the worker through group discussion

- getting to know you exercise; write answers to two questions: 1) what do you think is your greatest strength as a mother?, and 2) what do you find most challenging about being a mother? Members meet in pairs and read what they have written, rotating until all members have spoken to each other
- brainstorm group rules
- identify individual goals for group within context of group goals
- summary of session and find a volunteer to tell children what we did in session
- snack and journal writing

WEEK #2

Group Development Stage (same as week #1)

Process Goals (same as week #1)

Content

- welcome members and acknowledge change in membership
- assist members in exchanging information about each other in structured exercise
- explain and do feelings checkin using forms filled out during parent-child checkin
- explain group rules discussed previous week and ask for member input and consensus
- review group goals and ask members to state their goals for joining the group

- Weekly theme: What is a Mother? : Mothers asked to give images of mothers they have seen on TV; discuss their own experiences and answer questions: 1) what did you think it was going to be like?, and 2) what is it like for you?
- Summarize session and ask for mother volunteer to speak to children's group
- Snack and journal writing

Week #3

Group Development Stage: Beginning

Process Goals:

- continue to build trust in group and between members; encourage everyone to speak at least once; normalize anxious feelings
- as members self disclose feelings, concerns or other information acknowledge and thank member for being open with the group, ask about feelings when information shared and ask other members to share their reactions and feelings as information was being shared
- identify and amplify similarities between members
- acknowledge differences and frame as resource for others and unique nature of individuals

Content

- checkin with feelings chart and ask members to comment on their week
- recap content and theme of previous week/ mothering role, self expectations, societal expectations, importance of the role, need for patience, perseverance and beginning of discussion about multiple stresses that interfere with the role

- Weekly theme: Mothers' Stresses and how they cope; Continuation of discussion of mothering role in relation to their children
- Mothers responses to their children's negative behaviours and sharing of coping strategies
- Summarize discussion during snack and find mother volunteer
- Journal writing

Week # 4

Group Development Stage: Beginning; expectation of emergence of power/authority issues

Process Goals:

- recognition of changes in group attendance and impact on development of trust between members; include all members in activities
- continue to build group cohesion and affective bonds, expression of feelings and group norms of behaviour (attendance, listening and responding to others)
- talk about group goals and ask members to identify and state their individual goals
- Facilitator activities; provide opportunities for shared participation in activities; engage group as a whole; process what's going on in the group in the here and now; acknowledge sharing information and differences in individual circumstances

Content

- Feelings checkin

- Recap last week's theme using list of stresses and coping strategies members identified previous week; ask if mothers used any of the strategies during the week
- Introduce this week's theme: What do mothers want to help their children do? Child development information discussed
- Summarize session during snack; introduce flowers as gift to mother volunteer who speaks to children's group; acknowledge the feelings associated with the task; reinforce this activity as modeling for their children and practice for talking about adult subject in ways children can understand
- Journal writing

Week # 5

Group Development Stage: moving into middle stage/ member request for work

Process Goals:

- continue to build cohesion and facilitate communication between members
- Respond to member's request for 'work' by doing role plays
- Acknowledge and praise any reported efforts to try out new behaviours, positive comments about children and activities together

Content

- feelings checkin and welcome member returned after planned absence
- recap of previous week's group; ask members to recall session activities, discussions about cultural and family differences, their impact on parenting and expressed desire to parent without physical punishment
- Introduce weekly theme: How can you respond when your child misbehaves?

- facilitate members' awareness of thoughts and feelings when in stressful situations with child; facilitate awareness in members of their behavioural choices; integrate coping strategies
- Explain role play procedure as a way of exploring theme, identify problem situation all members have encountered, discuss possible responses; role play, debrief.
- summarize session, snack, journals

BREAK

Week # 6

Group Development Stage: Beginning with Power/authority theme prominent

Process Goals:

- address group members' previous challenge to developing group norms of finding alternatives to using physical punishment when responding to children
- summarize previous session and label members' feelings associated with expressed desire to change children's negative behaviours by using physical punishment
- acknowledge positive impulses and feelings expressed in statements about disciplining children, spread the feeling to the whole group and validate the difficult challenges of parenting
- continue to build cohesion and promote open communication between members and between members and group worker

Content

- feelings checkin with comments from members about how the previous two weeks have been spent; celebrate positive feelings, activities with children or coping strategies tried or used successfully
- recap previous session and open discussion about power and control issue in group and between parents and children (see above)
- reinforce purpose of group as a place to explore ways to strengthen their relationships with child and get support from others
- Introduce weekly theme: Parent's rights/ children's rights; this theme was introduced to promote discussion of the need for balance between the needs of mothers and the needs of their children within the context of a relationship. Promoting respect and equality as it relates to the relationship between mothers and children while validating members' need for adult relationships, support and individual differences could be part of the discussions
- Summarize session, snack and journals

Week # 7

Group Development Stage: Beginning; affiliation

Process Goals:

- Encourage and support members' communication with each other and support of each others' goals

- provide opportunities to discuss differences openly through provision of theme materials and activities

Content

- feelings checkin and comments about weekly events and specific feeling word to describe relationship with their child that week
- request feedback, thoughts about previous week's session
- introduce theme: Discipline vs. Punishment; mini lecture on discipline as part of strong parent child relationship, definitions provided with positive aspect of each noted ; open discussion or use problem-solving model to integrate use of discipline in to strategies with children
- relate theme to age appropriate child behaviour expectations
- summary, snack and journals

Week # 8

Group Development Stage: beginning ending stage and transition into second half of program

Process Goals:

- continue to promote communication between members as they work toward their goals
- remind members of their goals and the purpose of the group
- continue to support their efforts to change or try out new behaviours
- begin to discuss the end of the mothers' group and the transition to the parent-child group

Content

- checkin with reminder that group will meet for 3 more sessions
- review goals for the group and get ideas about how members want to use the last three sessions
- introduce theme: Who and what is in my child's world?
- Have members draw and discuss an ecomap for their child; identify multiple influences and possible stresses and supports (seeing child in social context)
- Emphasize the important role mothers play in mediating those influences and the importance of the parent-child relationship
- Summarize session, snack and journals

Week # 9

Group Development Stage: ending stage

Process Goals:

- continue preparing members for end of group
- externalize members thinking about where they might get support or ideas about parenting
- begin review of themes discussed in previous sessions and things they have learned, benefits they have noticed, things they wish had happened
- continue to support and encourage member communications and support change efforts or attempts to meet their goals

Content

- feelings checkin
- remind members there are 2 sessions left in group

- handout summary of group sessions
- ask members to recall the purpose of the group and their goals for the group and link with session summary
- continue to stress the importance of the mother-child relationship at the same time validating the challenges it presents
- ask members to identify feelings or thoughts about ending the mothers' group and beginning the parent-child group
- introduce session theme: Where do mothers get their ideas about mothering?
- Members each provided with a 'parenting shield' with sections drawn on it and places to write ideas; members engage in an activity where they identify sources for positive ideas about parenting and write them inside the shield; negative ideas or negative influences are recorded outside the shield outline. After discussing their shield with each other they are invited to cut away the negative ideas
- Summarize session, snack, journals

Week # 10

Group Development Stage: Ending (final session)

Process Goals:

- end the group
- celebrate the relationship that brought them to the group and their efforts to meet their goals
- review learning during the group program
- explore and support any activities members have tried outside of group

- ask members how they have used the group experience, how they view themselves in the group and positive and negative feelings about the group
- ask members about their feelings about meeting in a group with their child

Content

- feelings checkin and reminder that this is the last time members will meet in mothers' group
- ask members to identify a feeling about the end of the group
- introduce theme: What I like about being my child's mother.
- Activity: after identifying positive aspects of their mothering role and/or aspects of their child they enjoy members make a card with a variety of craft supplies provided. Members will present their card to their child during the parent-child group checkout
- Connect positive feelings and concerns about their child to the reasons for attending the group
- Name and support members positive feelings for children and continue encouragement of their strengthening their relationships with their children
- Frame parent-child group as a way of continuing to work toward this goal
- Summarize session and snack and join children to present them with cards.

Client Satisfaction Questionnaire

Please help us to improve our program by answering these questions. We are interested in your honest opinion, whether it is positive or negative. We are also interested in any thoughts you have about what might improve the program. We appreciate your participation in this evaluation.

PLEASE CIRCLE YOUR RESPONSE TO QUESTIONS OR WRITE YOUR COMMENTS IN THE SPACE PROVIDED.

1. Generally, how satisfied are you with the service you received?

1	2	3	4
Quite dissatisfied	Sort of dissatisfied	Mostly satisfied	Very satisfied

2. Was the program helpful in providing you with what you felt you needed?

1	2	3	4
Not helpful at all	Occasionally helpful	Often helpful	Very helpful

3. If you required counselling services for similar problems in the future, would you return to our program?

1	2	3	4
Definitely not	I don't think so	Possibly, yes	Definitely, yes

4. Would you recommend this program to friends?

1	2	3	4
Definitely not	I don't think so	Possibly, yes	Definitely, yes

5. Additional Comments or Suggestions:

PARENT-CHILD GROUP PROGRAM

Elizabeth Hill Counselling Centre is offering a special group program for single mothers who have a child (7 to 10 years old) experiencing behavioural and/or emotional problems.

To be eligible, mothers must currently be living with the child and likely to remain the custodial parent. Mothers must have some motivation to improve their parenting and the children must be prepared to attend the treatment group.

Mothers must have no current substance abuse problems or psychiatric problem which would interfere with their ability to engage in treatment. Children with developmental delays in emotional or behavioural functioning, or who exhibit behaviours which would place other children in the intervention at risk of harm, would not be eligible for this program. This intervention is not suitable for those living in a family situation in which there is violence or a risk of violence or where the parent or child have specific trauma issues which need to be addressed before the individual could benefit from the proposed group program.

The program consists of a 14 week mothers' group which runs concurrently with a group for their children. Sessions will take place Wednesday afternoons, most likely from 1-2:30. Following the completion of the seperate parents' and children's groups, the mother-child dyads will be brought together in a multi-family group for 8 sessions.

PROGRAM GOALS
The overall goal of the program is to help the mothers and children improve the quality of their relationship by:
: helping the children develop social skills and strengthen their abilities to interact with peers in a positive manner
: helping the children learn to identify their feelings and to express them using words rather than behaviour
: helping the mothers be more effective parents by strengthening their parenting skills and by increasing the mothers' empathy for their children
: helping the mothers to identify personal issues which impact on their abilities to be effective parents and to help them seperate their own difficulties from the behaviours and needs of their children
: providing the mothers with an opportunity to increase social support

INTERESTED INDIVIDUALS may contact Anne Sippell or Cara Grondin through the Elizabeth Hill Counselling Centre (EHCC) at 956-6560, for more information or to make referrals.
ASSESSMENT INTERVIEWS will be held through January 1998 with groups to follow.
LOCATION : All sessions will be held at EHCC, 321 McDermott Ave, 3rd Floor.

This program is part of a research study being undertaken by the EHCC and the University of Manitoba Faculty of Social Work.