THE USE OF THERAPLAY TO IMPROVE THE MOTHER AND CHILD RELATIONSHIP: A FAMILY GROUP INTERVENTION

by

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A Practicum Report

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The Use of Theraplay to Improve the Mother and Child Relationship:

A Family Group Intervention

BY

Heather I. Edinborough

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

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ABSTRACT

This report describes a twelve week group intervention to enhance the mother and child relationship for families who have experienced violence in the home. The group involved two main components; concurrent mothers' and children's groups, and a multi-family group, with *Theraplay* as an organizing framework. Four women and four of their children, whose ages ranged from six to nine years, completed the group. The intervention consisted of an educational and participatory component, wherein the mothers learned behaviours to actively strengthen their relationship with their child. Mothers and children together practiced what was being learned each week. A group format was chosen because the group setting is conducive to the growth of individuals, while encouraging trust in others. Findings indicated that the intervention was beneficial to the group members.

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CHAPTER I - THE PRACTICUM OVERVIEW

Introduction

The purpose of this practicum was to offer a particular group intervention to mothers and children who have experienced violence in the home. Four women and four of their children whose ages ranged from six to nine years, completed the group. The intervention consisted of an educational and participatory component and included two concurrent groups; a mother's group and a multi-family group. Theraplay was used as the organizing framework. The mothers would learn ways to actively strengthen their relationship with their child, and mothers and children together practiced what was being learned each week

The group was designed, implemented and evaluated as a social work intervention to assist in enhancing the mother and child relationship. The group was conducted for twelve weeks at Elizabeth Hill Counselling Centre, a program of the University of Manitoba. A group format was chosen because the group setting is conducive to the growth of individuals, while encouraging trust in others (Toseland & Rivas, 1984). A multi-family group, psycho-educational in nature, used Theraplay as the basis for the activities that comprised the mother-child segment of the group. At the conclusion of group, the group members indicated that they found the intervention helpful.

Rationale for Practicum

The practicum was developed based on the themes found in the clinical literature on the subject of domestic violence and its impact on mothers and their children. Research on violence in intimate relationships has focused largely on the direct emotional impact on women, the most common victims. Some clinical and empirical research has examined the emotional effect on women as parents (Holden et al., 1998; Levendosky & Graham-Bermann,1998), and also on the behaviour of their children (Jaffe,Wolfe, & Wilson, 1990; Levendosky & Graham-Bermann, 1998). As a result of the violence, women may experience increased stress in their parenting role, while their children may exhibit an escalation of behaviour problems of both an internalizing and externalizing nature. As the mother is usually the primary caretaker in families, she is expected to be available to attend to her children's emotional and physical needs. When the woman is under the strain of being a victim of violence and attempting to try to keep herself and her children safe, her ability to meet her children's demands may be, understandably, compromised. A distressed child, whether she is bored, or tired, or hungry, usually turns to mother for comfort. When mother needs to be hypervigilant about safety and survival issues, she may be unable to focus on what her child needs at that moment. The child may increase her efforts to get what she

requires from the mother, and engage in increasingly difficult behaviours. The resulting strain between the mother and child may continue even after the perpetrator of the violence is no longer part of the family unit.

Much of the research points to increased parenting stress for women who have been victims of battering by an intimate partner (Holden & Ritchie, 1991; Levendosky & Graham-Bermann, 1998). Furthermore, the research supports that their children experience increased behavioural problems (Jouriles, Murphy, & O'Leary, 1989; Levendosky & Graham-Bermann, 1998). The combination of increased maternal stress and difficult child behaviour may increase the strain on the mother-child relationship (Wolfe, Jaffe, Wilson, & Zak, 1986).

The group intervention, using Theraplay exercises and games, is implemented with the goal of strengthening the mother-child relationship. Both education and activities are used to address the mother's increased parenting stress, and her child's identified difficult behaviours. It is hoped that this practicum will reinforce the existing knowledge about the effects of domestic violence on women and their children, and will be able to offer another treatment option to address the compromised mother-child relationships.

Practicum Objectives and Learning Goals

As a result of facilitating the treatment group that made up the practicum, I hoped to achieve the following personal learning goals: (a) to gain increased knowledge about the issues facing women and children who have been affected by domestic violence, (b) to gain experience facilitating groups in social work to better serve the needs of clients, (c) to familiarize myself with the foundations, development, and treatment applications of *Theraplay*, and (d) to learn how to evaluate the efficacy of interventions, including the administration and scoring of standardized measures.

My objectives for determining the success of the intervention were: (a) to reduce the parenting stress reported by the mothers, (b) to effect a reduction in the behavioural problems exhibited by the children, and (c) to improve the relationship between the mother and the child. All of which would be evaluated by the mothers' self-reporting, and the observations of the group facilitators.

CHAPTER II - LITERATURE REVIEW

Introduction

The rationale for the treatment group, which is the subject of this practicum report, is predicated on a body of empirical and clinical research beginning with the area of domestic violence. The impact of violence in intimate relationships, mostly that of men against women, has been intensely researched since the 1960's and 1970's. Many studies have shown that women who are battered are affected psychologically, and that their functioning is compromised as a result of living with violence (Campbell & Lewandowski, 1997; Cascardi & O'Leary, 1992; Finklehor et al., 1983). This chapter will firstly review the literature on the impact of domestic violence on women

Secondly, the literature on the impact of domestic violence on women's parenting and the impact of domestic violence on children will be reviewed. Subsequent to studying the impact of violence on women and mothers, the research points to the serious effects on the children who witness violence in their homes (Graham-Bermann, 1996; Jouriles et al.,1989). It is postulated that children's psychological functioning is affected as well, and that their behaviours may deteriorate as a result (Davis &

Carlson, 1987; Jaffe et al.,1986; Saunders, 1994). The mother-child relationship is stressed as a result of the mother's reduced ability to attend to the many demands of life in a violence-ridden home. Behavioural problems exhibited by her children, who are having their own reactions to the violence, may also add to the strain in the relationship between mother and child.

There is research that seeks to explain the change in the behaviour of the children in a home where violence exists (Jaffe, Wolfe & Wilson, 1990). One way of understanding what is happening for such children is to look at the issue of the attachment between the mother and child. There is a theoretical explanation to substantiate the idea that this important attachment can be disrupted by the effects of living with violence (Perry, 1994). This chapter will therefore also review the literature on the importance of attachment, and the potential effects of violence as trauma to a child's developing brain will be explored. Finally, the use of Theraplay in a group setting will be discussed.

Impact of Domestic Violence on Women

According to Wallace, domestic violence is any intentional act or acts that cause injury to a spouse. It includes acts that are physical, emotional, or sexual

(Wallace, 1999). The word spouse describes those who may be married, cohabiting, or involved in an intimate relationship. It also includes those who are separated and living apart from their former partner. Since the early 1970's, considerable research has examined the phenomenon of violence against women (Walker, 1979; Seligman, 1975; Dobash & Dobash, 1979).

Several theories have gained prominence as a result of this research. Beginning in the 1970's, feminist theorists have advocated for the need to examine domestic violence in the context of the patriarchal system, specifically in patriarchal marriage (Dobash & Dobash, 1979). The position of these theorists was that the use of physical force in intimate relationships should be seen as an attempt on the part of the batterer to create an environment where his dominance was indisputable. Male dominance and female subordination have been accepted as the norm in Western society, and physical force was thus a means of enforcing male dominance (Nicarthy,1989). Until feminist theory offered alternate perspectives of male to female violence, it would have seemed hopeless for battered women to have help in shifting the responsibility for the violence. As noted by sociologist M. Pagelow (1981), women who find themselves trapped in a violent domestic situation could

not begin to be able to alter the situation in a vacuum. The success of their efforts would depend on the social and cultural environment within which they lived. While there are now laws and institutions that aim to protect women and children from violence, patriarchal influences and attitudes remain.

Walker (1979) used Seligman's (1975) model of "learned helplessness" to explain women's psychological reactions to continued domestic violence. Firstly, a woman subjected to repeated abuse finds that her motivation to respond is diminished, and the result is increased passivity. She then comes to believe that, no matter what response she may try, there will not be a favourable outcome. A sense of generalized hopelessness results, leading to the further belief that nothing she does will change what happens. She has learned to be afraid and is convinced that, no matter what she does, nothing will change. The Battered Women's Syndrome, also known as the Cycle of Violence, that was identified from Walker's work, has been divided into three categories: (a)the traumatic effects of victimization by violence, (b)learned helplessness deficits resulting from the violence and others' reactions to it, and (c)self-destructive coping responses to the violence (Douglas, 1987; Graham, 1994; Herman, 1992).

The Battered Women's Syndrome is described generally as a prolonged pattern of depressed affect, including a general sense of helplessness and fear, and social withdrawal. Cascardi and O'Leary (1992) found that, compared to non-battered women, battered women experienced increased levels of depression and lower self-esteem, and suffered higher levels of psychological distress. In addition, Campbell and Lewandoski (1999) reported that battered women who seek medical assistance present with mental health concerns as often as they do with physical injuries.

Impact of Domestic Violence on Women's Parenting

Parental functioning is determined by three general sources of influence (Belsky, 1984). These are:

1. Ontogenetic - includes the parent's own personality, developmental history and psychological well-being.
2. Microsystemic - refers to the immediate environment, such as the child's characteristics and the adult or spousal relationship.
3. Exosystemic - refers to the larger social system surrounding the family.

The quality of parenting exhibited by each parent is influenced by these three determinants. Belsky (1984) suggests that all three areas are affected. The mother's

psychological well-being is affected (ontogenetic), marital stress increases and children's ability to adjust is poor (microsystemic), and overall life stress is elevated as well (exosystemic).

Children are affected by domestic violence both directly and indirectly as a result of the impact the violence has on their parents (Jaffe, 1990). Direct effects may be actual physical danger to the child, and the learning of aggression as a means to control others. The mother-child interaction may include maternal physical and psychological illness due to the stress of being abused, and inconsistent or overly harsh disciplinary practices (Hughes, 1997).

When stressed, most children turn to their primary caregivers, who are usually mothers, for help with their problems. However, domestic violence, along with the resulting increased depression or stress, can negatively affect a woman's ability to parent, and to maintain close and positive mother-child relationships. Women living with domestic violence fear for their own safety as well as for that of their children. These mothers constantly need to focus their energy on assessing their partner's mood and the chance of further violence erupting at any time. As a result, their life may be so disrupted by the effects of

living with violence that they are unable to respond appropriately or consistently to their children's needs or fears.

When a parent is inconsistent in responding to a child's concerns, the child may act out her need in the form of behaviour designed to divert mother's attention. But, as Holden and Ritchie (1991) noted, parents who are coping with violence are often unable to provide consistent responses and guidance to their children.

Impact of Domestic Violence on Children

It is believed that exposure to violence has severe and damaging consequences on many aspects of a child's functioning: physical, developmental, cognitive, social, emotional, and behavioural (Kolko, 1996).A child's direct social interaction with others, such as the development of attachment, and social relationships, are significant in the child's social development (Ainsworth, 1991) They require the child's active involvement and participation. It has also been suggested that children are affected by events that occur in their presence, even though they do not participate in these events (Cummings et al., 1985). The emotional arousal that occurs in children as a function of witnessing strong emotions such as anger, is known as "transfer of excitation" (Hughes, 1987; p. 228) and appears

to lead to undercontrolled, aggressive behaviour. The child's anxiety levels appear to be related to the mother's anxiety levels in violent situations (Hughes et al.,1987).

Symptoms in such children can be remarkably similar to those observed in people suffering from Post Traumatic Stress Disorder (PTSD) (Jaffe, Wolfe, & Wilson, 1990). The American Psychiatric Association classifies PTSD as an anxiety disorder which may have an onset at any age, following exposure to a psychologically traumatic event (Perry and Marcellus, 1997). Generally, the event is outside the range of usual human experience. Many of the reactions of children to marital violence can be classified as trauma responses. Most notably, these are explosive bursts of anger and aggression, fixation on the trauma and subsequent reduction of activities, and somatic and emotional complaints.

Children may experience symptoms of post traumatic stress disorder, such as re-experiencing the traumatic event, numbing of responsiveness, and hyperarousal (Zeanah & Scheering, 1996). Osofsky(P.14,1994) cites the following behaviours as common among young children exposed to violence):

- Memory impairment due to avoidance, and/or intrusive thoughts

- Development of anxious and disorganized attachment behaviours to the primary caregivers
- More aggressive play, imitating behaviours children have seen; trying to 'master the trauma'
- Acting "tough" to compensate for fear
- Appearing depressed or withdrawn
- Becoming constricted in activities, exploration, and thinking, for fear of re-experiencing the trauma
- Experiencing difficulty concentrating in school, due to intrusive imagery

There is a critical link between traumatic experiences, and the formation of personality (Crisci, 2001). Traumatic experiences can skew a child's expectations about the world, the safety and security of their personal relationships, and their sense of personal safety. This view of the world as a dangerous and unmanageable place has a profound influence on current and future behaviour. The healthy emotional development of a child is, in part, dependent on the safety and nurturing provided in the family environment. It is hoped and intended that being in a family will protect a child from traumatization so that the child can maintain a sense of order and continuity in their lives (Van der Kolk,1987). Having a familiar,

comforting adult available during or immediately following a traumatic event is of great help to a child in preventing future problems.

If however, the child is not calmed or comforted following trauma, or if the trauma is ongoing, the child may remain in a persistent state of fear. In such a state, the child may be "behaviourally impulsive, hypervigilant, hyperactive or withdrawn and depressed, have sleep difficulties and be anxious" (Perry,1994, p.6). Remaining in this persistent state of emotional arousal can result in alterations in the brain. Perry theorizes that the receptors that release brain chemicals during a child's growth period are altered as a result of the hyper-aroused emotional state, and subsequently the structural systems that regulate affect are impacted. The traumatized child's "template for brain organization is the stress response" (Perry, 1993, p.18). This stress can create intense feelings such as excitement, terror, shame, disgust and despair. The intense feelings get acted out as behaviours such as aggression, dissociation and hyperactivity. Caregivers then misinterpret the behaviours as conduct disorder, oppositional behaviour, lying and disrespect for adults.

Conversely, we may see children who have witnessed violence exhibiting behaviours that appear pre-occupied or withdrawn. Memories of trauma often are partly or fully out of conscious awareness (James, 1994). This withdrawing is a protective dissociating that serves to keep the frightening memory from intruding into the child's awareness. The use of this protective mechanism spares trauma survivors from being constantly bombarded by memory and emotions. The memories can be so strong that the child/victim feels as though the trauma is occurring over and over again in the present.

However, the ability to regulate one's affect is diminished in children who have experienced trauma. The emotional style of such children appears mercurial: calm and happy one moment, in an out of control rage the next. This inability to regulate affect leads to behaviours that present as oppositional, defiant, anxious, depressive and essentially unpredictable.

Freud's (1917) definition of trauma is still widely accepted as "an excessive magnitude of stimuli too powerful to be worked off in a normal way". Victims of trauma can experience fragmented images of the traumatic event (Schwartz, 1984). Immediate reactions include flight, and soon afterwards, emotional numbing. The next normal

psychological task for these victims is to come to understand and tolerate the traumatic event and its meaning for them, so that a manageable memory can be formed and the trauma can be experienced as being in the past. However, while intrusive reminders continue to occur, defenses are directed against experiencing repetition of the trauma. What can result is a psychological shutting down, which may manifest as depression, emotional numbing, disinterest in activities or relationships, and a disruption in memory or thinking (Suh & Abel, 1990).

Particularly difficult for caregivers can be the child who avoids intimacy (Levy & Orlans, 1998). Being close to someone can feel too vulnerable to a traumatized child who may feel loss of control, and therefore threatened rather than safe. The behavioural response to these threatening feelings may include avoiding eye contact, withdrawing, or engaging in personal habits that are disgusting to others, and which keep others at a distance. Such children also present as very guarded, controlling or psuedo-mature.

Whether children are active or passive victims of violence, the impact on their development and behaviour is significant. Children who are directly physically hurt by a violent family member experience significant fear and trauma. Both the passive and active child victim of

domestic violence can challenge even the most patient caregiver.

The Importance of Attachment

In order for children to develop in a healthy way, both physically and emotionally, they need to be in an ongoing reciprocal relationship with a caregiver who is attuned and responsive to the child's needs (Karen, 1994, p.4). The emotional bond that grows between the parent and child is a process known as attachment.

The term 'secure base' (1982) was coined by Ainsworth who used it to describe the environment created between the attachment figure and the child. The child who feels secure that the attachment figure will be available if needed, can negotiate his environment without anxiety. In order for the relationship between the child and caregiver to be secure and healthy, the attachment figure must be both accessible and responsive. In this way a secure attachment is built.

Attachment Theory identifies five types of attachment experience (Ainsworth, 1978,p.101-105). Each one requires a child to develop a particular way of adjusting psychologically. The five types are generally classified as:

1. secure
2. insecure: anxious and ambivalent

3. insecure: anxious and avoidant
4. insecure: anxious and disorganized
5. non-attachment.

The pattern of secure attachment is exemplified by care that is loving, responsive and consistent; caregivers are sensitive to the needs of the child. Within secure relationships, children see themselves as lovable, and others as responsive and trustworthy. This sense of self-worth helps the child develop a personality that is generally positive and socially competent.

Insecure, anxious and ambivalent attachment is the result of care that tends to be inconsistent, unreliable and unpredictable. The child's signals are read incorrectly or are not observed consistently. Because the behaviour of the child is not read accurately, the caregiver's response is unpredictable, and so the child feels unable to influence the relationship as needed. The child feels a continuous, fretful anxiety, and develops behaviours that may represent attempts to try and keep the parent involved.

Insecure, anxious and avoidant attachments occur when parents are indifferent towards, or even rejecting of their children. There is a lack of interest in the child's needs and emotional states. Such a child may ignore or avoid the

caregiver and does not seek comfort due to the history of rejection. The child has learned that at times of distress or anxiety, their behaviour does not bring comfort. These children are often watchful, showing little discrimination with whom they interact. Where ambivalent children fear that they will not get what they want, avoidant children fear what they want, so the preferred strategy is to be emotionally independent, or not emotional at all. They find it difficult to be part of close relationships. Conflict and upset are not handled well and often lead to emotional breakdown, violent outbursts or withdrawal.

Insecure, anxious and disorganized attachment is often indicative of a parent who is not necessarily consistently rejecting, but may occasionally be hostile or frightening. Displays of love and affection may occur along with times of aggression and violence. During times when the child becomes anxious, she may seek out the attachment figure for comfort. However, since the attachment figure was the cause of the initial anxiety, they are not a source of comfort or safety, and the child is faced with an unresolvable conflict. Such a child may become emotionally frozen and remain in a confused and distressed state, with little idea of what to do in relationships.

Non-attachment occurs when a child has not had an opportunity to develop any attachments at all. Such a child is indiscriminate in relationships, and people only seem to matter to them if they can meet the child's current need. Non-attached children have difficulty controlling their impulses and feelings of anger, and when relationships are sustained, they are often at a superficial level.

A secure attachment is built if the relationship between the child and the caretaker remains unbroken, secure, and healthy, and the child has found the primary attachment figure both accessible and responsive, The child develops an 'internal working model' in the early years (Bowlby, 1969). This model sets the stage for a human child to be able to successfully predict, control and manipulate their environment. The developing child builds the internal working model based on repeated patterns of interactions with others. A securely attached child will have an internal working model of a responsive caregiver, and of a self that is worthy of love and attention. In contrast, an insecurely attached child's internal working model may define the world as a dangerous place where other people are not to be trusted, and the self is ineffective and unlovable. Such assumptions are believed to be relatively enduring throughout the lifespan.

There are many conditions between the parent and the child, and between the child and the environment that can contribute to or disrupt the formation of a healthy attachment. A parent or caregiver can contribute negatively to attachment when their child is exposed to prolonged absences, insensitive care such as neglect or abuse, severe or chronic psychological disturbance of the caregiver, or substance abuse. The child's personality or physiology may also contribute to attachment disruption in the presence of such conditions as a difficult temperament that is not a "fit" with the caregiver, medical conditions requiring greater than normal care, and congenital and/or biological problems (such as attention deficit hyperactivity disorder, or fetal alcohol syndrome). Environmental contributions might include such things as violence (as a victim or a witness), lack of supports (no extended family, isolation), high stress (marital conflict or violent communities), and multiple out of home placements (moves in and out of the foster care system) (Levy & Orlans, 1998).

Theraplay

Theraplay is a form of play therapy that is gaining wide recognition as a treatment method for individuals with attachment problems (Myrow, 2000). There is increasing interest in, and use of Theraplay as social workers and

therapists discover its effectiveness. It is simple to do, action oriented, and appears to be able to readily engage those involved.

Theraplay is based on attachment theory, wherein we understand that the relationship formed between a child and her primary caregiver is the model for all other relationships. If that relationship is not a positive one, subsequent relationships may be characterized by difficulties in relating to others throughout the lifespan. Theraplay uses interactions that replicate positive feelings associated with that first relationship. The interactions are designed around interpersonal connectedness. Theraplay seeks to build up the child's and the parent's self-esteem, thereby creating increased feelings of being valued and important. It is postulated that once the participants start feeling better about themselves and their ability to have their emotional needs satisfied, they are more likely to be better attuned and more empathic toward others (Jernberg & Booth, 1999; Stern, 1995).

As discussed above, during a traumatic experience, a child's brain is in a state of fear-related activation (Perry, 1993). This activation of systems in the brain leads to adaptive changes in emotional, behavioural and

cognitive functioning. The resulting hypervigilance, tension, anxiety and impulsiveness which are useful during a threatening event become maladaptive when the threat has passed.

It has also been noted that the chronically traumatized child will develop symptoms which can make their lives, and those of their caregivers, difficult indeed. Therefore, interventions that restore a sense of safety and control are important for the traumatized child. Theraplay treatment involves replicating, as much as possible, the pleasurable, attachment enhancing interactions that are an essential part of the healthy parent-child relationship. Theraplay incorporates certain characteristics of this healthy relationship.

One such aspect is that of developing relatedness, which is believed to address the basic human need for connection with others. The early interaction between parent and child is the environment in which the need for relatedness is met, and the self develops. Theraplay sessions replicate activities which a parent may use that increase the child's awareness of and connection with others. The use of play in a Theraplay session is the means by which relatedness can be developed. Parents use play to entice their infants into a relationship. Such activities

foster attachment by positively affecting the child's view of self as someone who is special and pleasant to be with.

Having the caregiver remain in charge is a second important element of the Theraplay session. Many children who have been traumatized by adults seem to have learned that they can only rely on themselves. Having the adult be in charge relieves the child of that role, and provides the safety and security of limits and boundaries.

A third important aspect of Theraplay is the use of touch. Many traumatized children experience tactile defensiveness that makes it difficult to provide the soothing and nurturing that is essential to the attachment relationship. Theraplay gradually introduces touch in a way that allows these children to accept it in a way that reduces threat.

Through the use of Theraplay techniques, dramatic changes can be produced in the relationships between caregivers and their children, and thus in the lives of families. This is accomplished by addressing four problem areas in the lives of families that may be interfering with the development of the secure attachment relationship. They are: (a) inadequate structure in daily experience, (b) insufficient personal engagement, (c) a lack of empathic, nurturing touch, and (d) failure to provide the right kinds

of challenge to children. The creative and active interventions used in Theraplay can be used and modified to address the behavioural problems that traumatized children may exhibit. The techniques can help families understand and resolve issues related to the trauma experience. When a child has been a victim of, or witness to violence, Theraplay interventions can help. Carefully chosen activities from Theraplay can address the child's need to feel safe, to be comforted by a trusted caregiver, to re-establish trust, to develop a positive self-image, and finally, it can address the child's ability to modulate affect.

Group Work

Multiple family Theraplay can also be effective in helping families develop coping strategies. A social work intervention that includes several families simultaneously may benefit the intra-personal and inter-personal dynamics of each family involved in the group (Sherman, 2000). It offers the chance for treatment of individual problems and parent-child problems, as well as peer interactions.

A group has the potential to serve as a mutual aid system for its members (Schwartz, 1961). The expert, in the role of facilitator, has the task of helping group members create the conditions in which mutual aid can indeed take place (Shulman, 1984). Mutual aid can include the sharing of information (ideas about relationships and community services), mutual support (sharing of common concerns, the understanding of others' feelings leading to an acceptance of one's own feelings), and individual problem solving (where group members offer support and share similar problems and feelings).

As well as offering mutual aid to group members, when used in a group setting, Theraplay reaches more children and families than an individual treatment approach would be able to do. The aim of a group setting is not only to enhance the individual's self-esteem, but also to increase

trust in others through concrete, personal, and positive experiences. Groups enable members to realize that they are not alone with their problems, to share concerns, and to hear that others have similar anxieties. They give members the opportunity to help others by being supportive, giving feedback, making helpful suggestions, and providing useful information. As group members are able to give and get help, they observe others attaining their goals. This provides hope to members who see that success is possible (Yalom, 1975). For those who are isolated, groups provide obvious benefits.

Multiple family therapy groups have particular benefits when there are common concerns and a desire to share information (McKay et al., 1995). Furthermore, research has shown that women's learning and development can be enhanced by participation in groups with other women (Berzoff, 1989). Groups designed for women who have been victims of domestic violence can offer support and understanding. Individually, women may feel isolated, stigmatized and powerless, but when put together in a group setting, they begin to benefit from sharing information and feelings with other women in similar situations. Many women unaccustomed to having any power are relieved by the presence of a group leader who provides structure and

guidance, thereby enhancing the sense of safety and permitting participation from each woman as she is able (Nicarthy, et al., 1984). By creating a safe place where the secret can be discussed, the group leader models an alternative that lessens feelings of guilt and self-blame.

CHAPTER III - THE PRACTICUM DESCRIPTION

Introduction

Elizabeth Hill Counselling Centre offers a treatment program for women and children who have been impacted by domestic violence. The group program, as it now exists, is a response to the perceived need for treatment to intervene in troubled mother-child relationships. Parents were reporting that they were experiencing considerable difficulty managing their children's behavioural problems. The use of *Theraplay* as the treatment modality to ameliorate these difficulties has become the predominant intervention. The focus of this practicum was the mothers' group and the multi-family group which were part of the whole group program. While the children's group was a significant and integral part of the overall program, it is not the focus of this practicum report.

Setting

The setting for this practicum was the Elizabeth Hill Counselling Centre. The Centre is operated by the University of Manitoba, and as part of that educational institution, is available as a training ground for students in social work and psychology. Elizabeth Hill Counselling Centre is located in the downtown area of Winnipeg, Manitoba, making it accessible to inner-city clients. The Centre provides free counselling services to individuals, couples, and families. Clients are

often referred by other professionals or agencies, but they can self refer as well.

Supervision

Supervision and assistance were provided by the committee members for this practicum: Eveline Milliken, assistant professor in the Faculty of Social Work at the University of Manitoba, Linda Perry, therapist at the Elizabeth Hill Counselling Centre and a member of the Faculty of Social Work at the University of Manitoba, and Valerie Barnby, who was Quality Assurance Co-ordinator at Winnipeg Child and Family Services at the time this practicum was completed.

Linda Perry provided assistance in the planning of session content, as well as weekly post-group supervision. Eveline Milliken provided extensive assistance in helping me to understand and meet the academic requirements of a practicum for the Faculty of Social Work.

Referral Process

Referrals were sought from a number of collateral social service agencies. They most often came from school social workers (Child Guidance Clinic), and from Child and Family Service Agencies. Some clients were self-referred and were gleaned from Elizabeth Hill Counselling Centre's wait list.

Preparation for the Start of Group

Planning began in August 2002, with the group starting in September 2002. Because the Counselling Centre maintains a wait list of clients, the facilitators of the group undertook to identify potential group members from this list. An informational poster advertising the group went out to various collateral agencies which were identified as having potential referees to the parent-child group. All these potential clients were then contacted and interviewed as to their suitability for group participation. Criteria included: the child was living with the caregiver, the violent partner was no longer residing in the home, and the child was between the ages of six and nine years. As we finalized the list of group members, consideration was given to ensuring that the families were able to attend each week. This was facilitated by making arrangements for necessary childcare, and for transportation to and from the group meetings.

Because the parent-child group had been conducted at Elizabeth Hill Counselling Centre in previous years, a session outline was already in place. Having learned some history from our potential group members via intake interviews conducted prior to the start of group, the facilitators were able to structure the first session in a way that would be most meaningful for the members. For example, most of the women had

been away from the violent partner for a long enough period of time to allow them to settle in housing which they felt was safe for themselves and their children. Attending a Theraplay workshop and reviewing pertinent literature were also helpful steps in preparing for the sessions and for determining the best way to create a fit between the intervention and the needs of the group members.

Criteria for Participation in Group

The group was advertised as a program for mothers who, along with their children, had been exposed to violence in their homes. The children could be male or female, between the ages of six and nine years, and presently living with their mother. It was required that both mother and child were living in a situation where domestic violence was no longer occurring. The mothers were seeking assistance on behalf of their children whom they identified as having emotional or behavioural difficulties.

Selection of Group Members

Ideally, mothers and children were seen for a two-part intake/assessment interview. First, the mothers met with facilitators for the purpose of discussing family history, specifically the history of family violence. The structure and purpose of the group was explained to the mothers, and their readiness/suitability for optimum use of the group style of intervention was assessed. The mothers were then asked to

return for a subsequent visit with their children. During this visit each woman completed two standardized measurement questionnaires: the Parenting Stress Index (Abidin, 1983) and the Child Behaviour Checklist (Achenbach, 1991).

Personnel

I facilitated the mothers' group, along with Joanne, a Bachelor of Social Work student. Jennifer,a Master of Social Work student, and Julie, a Bachelor of Social Work student, led the children's group. While all four facilitators participated in the multi-family group, I was responsible for preparing the activities for the multi-family group, and for leading these sessions.

Recording

Elizabeth Hill Counselling Centre keeps files on each client seen at the Centre. For the parent-child group, the files included consent forms signed by the mother, an intake summary, contact/process notes, and a treatment summary. I found it helpful to also keep my own notes regarding the significant issues that arose in the mothers' group.

Group Goals

The mothers' group was designed to assist the women in understanding the issue of family violence, and its impact on themselves and their children. It was hoped that by sharing their experiences, the mothers would discover issues in common,

both as women and as parents. The multi-family part of group, with the women and their children together, focused on the use of Theraplay activities to strengthen the parent-child relationship through the use of play. The women's willingness and ability to participate in these activities was observed over the course of twelve weeks. The children's responses to the activities were also monitored, and any observed or reported changes in the children's behaviour either at home or in the group setting were noted.

Overview of the Group and the Intervention

The women's group was a psycho-educational support group, and the multi-family group was an activity based therapy group for the mothers and their children. The twelve weeks of group sessions followed a program that had been created by previous facilitators. The following topics were covered: family violence, the importance of play, understanding and problem solving children's behaviours, and the use of Theraplay activities to strengthen the parent-child relationship.

The general format for each evening of the mothers' group was: check-in, housekeeping issues, introduction of the theme for the session (for both the mothers' and the family groups), a warm-up game, discussion of the theme, and check-out.

Because the group had been conducted previously at Elizabeth Hill Counselling Centre, a program had been printed, outlining

the areas to be covered in each week's session. While the facilitators felt that it was important to cover the subject matter for each week as closely as possible, on occasion the needs of the group members did dictate the content. For the mothers' group, which is the subject of this report, the weekly themes were as follows:

Week 1	Why we are here, and the importance of play
Week 2	The impact of family violence on women
Week 3	The impact of family violence on parenting
Week 4	The impact of family violence on children
Week 5	Family violence and the cycle of child misbehaviour
Week 6	Introduction to Theraplay: importance of Nurture
Week 7	Theraplay continued: importance of Structure
Week 8	Theraplay continued: importance of Engagement
Week 9	Theraplay continued: importance of Challenge
Week 10	Problem-Solving children's behaviours
Week 11	Unfinished business
Week 12	Goodbye party

The important areas to be covered over the course of the twelve weeks were: family violence, its impact on the women, on their ability to parent, and on children and on their behaviour; the importance of play; and the use of play to strengthen the relationship between mother and child.

The multi-family group occurred at the end of each session of the mother's group for approximately forty-five minutes. The focus was on using an activity from Theraplay which would support the education and ideas that were introduced in the mothers' group discussion. The intent was to bring the mothers

and children together to play, thereby strengthening the parent-child relationship.

The general format of the multi-family group began with having a prepared snack together, at which time one of the mothers would share with the children what they had done during their time in group. One of the children would then follow suit, telling the mothers what activities the children had participated in during their group. The whole group then sang the 'hello song', followed by everyone playing Theraplay based games. Each evening closed with the 'farewell song'.

In weeks six through eleven, puppet play was introduced in the multi-family group. This medium was used to tell a story of fighting in a family from the perspective of a little boy, "Max", the puppet. The use of puppetry can facilitate the discussion of topics which are difficult or painful for children. According to Webb (1991), children may identify with the puppets and be able to projects their feelings or conflicts onto the play figure.

Evaluation Plan

The goal of the social work intervention is to improve and enhance the functioning of individuals, families and groups (National Association of Social Workers, Code of Ethics, 1984). Determining the success of an intervention involves being able to evaluate its efficacy through accepted and objective methods

of research (Bloom & Fisher, 1982). An important consideration in the design of this group intervention was a clear definition of the purpose.

One of the defining criteria for inclusion in the group was the behaviour problems of the children as identified by their mothers. It was seen as significant that the behaviours of the children were perceived as problems that the mothers wished for help in managing or changing. Therefore, a standardized measurement was introduced that would measure some identifiable problematic behaviours, as rated by the mothers. The measuring would occur before and after the social work intervention - at the beginning of the group and again at the group's conclusion. The measure chosen was the Achenbach Child Behaviour Checklist (CBCL) (Achenbach, 1991).

Women who have been in violent relationships may experience elevated stress in parenting, as well as in general functioning (Holden & Ritchie, 1991; Jouriles et al.,1989). The Parenting Stress Index (PSI)(Abidin,1983), again with the parent doing the rating, measures a number of categories within the Child Domain and within the Parent Domain. The scores are totalled to determine the degree of Total Stress and Life Stress that the parent and child are experiencing. Jennifer, the other Master of Social Work candidate, and I administered both the Child Behaviour Checklist and the Parenting Stress Index to each woman

at the intake meeting, and again after the group intervention was completed. It is hypothesized that an intervention which targeted both the child behaviour problems and the parenting stress, would decrease the incidence of both these variables.

Achenbach Child Behaviour Checklist

The Achenbach CBCL is a parent rating scale consisting of two sections: social competence assessment and assessment of behaviour problems. The behaviour problems section consists of 113 items. Two major syndromes, or broad-band factors, are Externalizing and Internalizing, and scores are obtained for both of these. Scoring can also be obtained for more specific syndromes or narrow-band factors. Examples of the Externalizing group are behaviours such as aggression, delinquency and hyperactivity. Examples of the Internalizing group are somatic complaints, depression and anxiety. Scores are plotted on a profile sheet that provides percentile and T-score equivalents. T scores above 64, and therefore greater than the 98th percentile, are considered to be clinically significant. T scores between 60 and 63, and between the 95th and 98th percentile are considered to be borderline clinically significant. Test-retest reliability is high, ranging from .81 to .87, and the CBCL Manual reports that the validity of the scores is also high. The CBCL has been widely used in numerous studies as the measure for the classification of abnormal behaviour.

Parenting Stress Index

The PSI is a parent self-report questionnaire, designed to identify potentially dysfunctional parent-child systems. The four broad-band scales include the Child Domain Stress, Parent Domain Stress, Total Stress and Life Stress. Within the Child Domain is scoring for such areas as *distractibility, mood,* and *demandingness*. Within the Parent Domain, areas such as *competence, isolation, health,* and *role restriction* are measured. A Total Stress score is derived from adding the Child Domain and Parent Domain scores, while the Life Stress scale provides some indication of the amount of stress the parent may be experiencing outside of the parent-child relationship (Abidin, 1983). The reliability of these scales are reported to be .90 and .93 (Abidin, 1983). The PSI Manual also reports on the construct and predictive validity of the measure that also correlate to other studies (Abidin, 1983).

Total Stress scores that are at or above 260, which is above the 85th percentile, are considered high. The normal range for scores is within the 15th to 80th percentiles.

Client Satisfaction Questionnaire and Post Group Interview

Following the completion of the group, the mothers were asked to evaluate the intervention by completing the questionnaires and participating in a post-group interview. The questionnaires were filled out by the women independently. The

women were given the choice of providing feedback by participating in the interview on the final night of the group or in their homes at a future date. All four mothers chose to have the feedback interview done at their homes.

CHAPTER IV - THE GROUP EXPERIENCE AND ANALYSIS

The group began on September 25, 2002 and ran for twelve weeks, finishing on December 11, 2002. The size of the group remained consistent, with four mothers and their children at the outset, and all four pairs completing the group. Attendance varied, and the participants did miss between one and three sessions each.

Group Member Profiles

Jane

Jane is a twenty-six year old Metis woman. At the time of the group, she was living with her three sons and her third common-law partner, Rob. Rob is not the father of any of Jane's sons. Jane self-referred to the group at Elizabeth Hill. She identified her eldest son as the one who had been most exposed to the violence perpetrated by her two previous common-law partners. She expressed her belief that some individual therapeutic work for her and nine-year-old Joseph would be beneficial to their somewhat troubled relationship.

Jane's two previous common-law relationships had been characterized by episodes of verbal and physical assault of Jane and her son Joseph. She felt that Joseph was too young to remember the incidents perpetrated by her first partner (Joseph's biological father), but that he did recall the numerous physical altercations between Jane and her second

partner. Jane recognized that her relationship with Joseph was often difficult. His frequent tantrums and extreme emotional lability were challenging for her. Jane's two eldest boys had been in the care of Child and Family Services for several years, but had been returned to her care within the past year. The boys had been seeing a private play therapist, and Jane had worked with a Reunification Social Worker through Child and Family Services. While she described herself as almost "finished" with helpers, she was looking forward to the group for her and Joseph. Jane missed three of the twelve sessions mostly due to child care difficulties.

Ann

Ann is a Metis woman in her mid-thirties. She had been separated from her husband of eleven years for just over one year at the time of group. She had maintained occasional telephone contact with him, but he had had no contact with the children since their separation. Ann was involved with Child and Family Services, as her adolescent daughter was in agency care due to parent-teen conflict. Ann's two sons, ages ten and eight, were in her care, and she wished for services for both of them.

Ann's social worker recommended the group to Ann, and she was interested in attending despite her trepidation about speaking up in group situations. Ann described a number of

violent episodes in the home wherein her husband did substantial property damage, struck her and the boys, and had ultimately been removed from the home by police. She was not sure that the boys had witnessed all of these episodes, but did acknowledge that they would have overheard them. Because Alex was acting out more than his older brother, Ann hoped that the group would be more beneficial for him. Ann and Alex missed only one of the twelve sessions.

Sue

Sue is Metis, and a twenty-eight year old single mother of three children. She has been separated from her husband for just over a year, and recently was granted sole custody of the children. Sue and her children are receiving services through Child and Family. These services are mostly respite and other supportive efforts to maintain the family in the home. Sue referred herself and her eldest child, seven year old Dora, to the group.

Sue reported numerous extremely violent episodes of physical abuse and death threats against her and her children while she lived with her husband. Dora had been witness to many of them, and had made attempts to call police during these assaults. The family had had no contact with the children's father since the separation. Sue had taken steps to move to a shelter and then to a new town to avoid contact with him.

Sue presented at the initial interview in an agitated state, and Dora was hyperactive and difficult to contain. When questioned about her and her daughter's readiness to engage in a group process, Sue appeared to become angry, insisting she needed the assistance and that she be allowed to participate with her daughter. Sue could barely manage Dora's angry outbursts and tantrums, and was considering placing her in foster care. Having described her current situation, it was clear that this family was in crisis. They were admitted to the group in the hope that change could be effected at this critical time. The decision to admit Sue and her daughter to the group was discussed among the group facilitators and with Linda Perry. It was a source of concern that the child's behaviour might be too disruptive for group to be beneficial for her. Also, Sue admitted that she was at the point of considering foster care for Dora. I believed that Sue was determined to get some immediate help for her and her child and would be motivated to use the group process to their mutual benefit. Sue and her daughter attended ten out of twelve sessions.

Cara

Cara is a Caucasian woman in her mid-thirties, and single parent to three children. Cara referred herself and her daughter Shannon to the group at the encouragement of her private therapist. Cara felt that Shannon's fear at having witnessed her

father's violence and death threats toward her mother, had made her an anxious child who would hopefully benefit from a group therapy approach.

Cara described a frightening series of escalating violent episodes toward her during her marriage to her ex-husband. She had had to move from her home and the children's schools in order to avoid being found by him. At the time of group, her ex-husband was in jail for the assaults against her. They had been separated for some time and the family had had no contact with him. She was aware that he was to be released from jail shortly. Cara presented as still very much afraid of him, and feared that she was passing her fear on to her children. She was the highest functioning member of the group, with a good job and considerably greater personal and material resources at her disposal. Cara and Shannon missed three of the twelve sessions.

Summary of Client Profiles

Similarities and Differences

A review of the client profiles reveals some similarities among the four women and their situations. These similarities, as well as any obvious differences among the women, have significance in achieving cohesion within the group.

Three of the four women were involved with Child and Family Services. At the time of the group, all three described that

involvement as helpful at this stage. Only one woman had had her children removed against her wishes, and now that they were back in her care, she regarded her Child and Family social workers as helpful and supportive.

Three of the four women were in varying stages of crisis for the duration of the group. It was difficult for them to consistently maintain their equilibrium in the face of crisis, and from week to week, these women described incidents and situations which seemed to be compromising their coping skills. On occasion, symptoms of depression were evident among these three women. Both their descriptions of their own behaviours, as well as the facilitators' observations, suggested that these same three were experiencing various depressive symptoms. They cited irritability and difficulty sleeping, experienced frequent crying, and were unable to experience enjoyment.

Three of the four women were living as single parents with their children. Only one of the women had sought individual therapy for herself; she was continuing to attend therapy sessions at the time of group. Two of the women worked outside the home at the start of group, and a third had obtained part-time employment by the end of the sessions. Other differences existed in the racial backgrounds and socio-economic status of the women, with only one of the four not claiming aboriginal status. Because one woman (Jane) was living with a man who had a

well-paid job, she claimed that finances were not a problem in their family. All of the other women were struggling financially, with one of them being on full social assistance and another needing partial financial assistance in addition to her full time job. Cara complained of her significantly reduced income and lower standard of living for her and her children now that she was separated.

Treatment Groups

Classification of groups by type is common. The group which is the focus of this report was a treatment group. There are four primary purposes for treatment groups: (a) education, (b) growth, (c) remediation, and (d) socialization. (Toseland and Rivas, 1984). Both education and growth were goals of the group. The initial purpose of the group was to educate the mothers through presentation and discussions about the importance of play, to demonstrate the use of Theraplay, and the pervasiveness of the impact of domestic violence on both the women and their children. An additional purpose was to develop the women's insight and awareness through the experience of the group. By the facilitator presenting information (about the effects of violence, the importance of play, etc.), education, as a group purpose, was addressed. But the structure of the group, and the style of communication during the women's group, also served to address the purpose of growth, wherein the

members participated in discussions and did a great deal of self-disclosing.

Using treatment groups has advantages over individual therapy. Groups can help members to realize that they are not alone with their problems, allowing each member to share her concerns and hear that others have similar concerns. They give members the opportunity to help others by being supportive, giving feedback, making helpful suggestions, and providing useful information. As members are able to give and get help, they observe others achieving their goals. Groups can also be beneficial for those facing problems of isolation. They can provide members with opportunities to test new skills learned in the group.

Multiple family therapy groups have particular benefits when there are common concerns and a desire to share information (McKay, 1995). Women's learning and development can be enhanced by participation in treatment groups with other women. Groups specifically designed for women who have been victims of domestic violence offer support and understanding. Individually, women may feel isolated, stigmatized and powerless, but they benefit from exchanging information and expressing feelings with others who have been in similar situations. Women who are unaccustomed to having any power and have little experience in a non-authoritarian structure, can be comfortable with the

presence of a group leader who models structure, information and guidance. This can enhance a sense of safety and allow women to participate as they are able (Nicarthy et al., 1984).

Garland's Theory Of Groups

Garland's theory of groups (Garland, 1973) holds that there are phases through which groups pass. These phases have implications for understanding the behaviour of the members of the group, and what the facilitator needs to do to manage the behaviours for the success of the group. An awareness of the phases helps the facilitator decide when action may be required.

Garland's work was based in part on Bernstein's (1952) description of a set of criteria for measuring the progress made by the group as an entity. These criteria included members' attendance, their ability to plan, cohesiveness, and their ability to handle conflict within the group.

The central theme of Garland's theory of group work is that of closeness. This theme, wherein the members are continually making decisions about how close they will come to one another, is evident throughout the life of the group. From the time the members make their first tentative moves to become acquainted and comfortable with one another, through the times when they share intense feelings, and ultimately how they deal with endings at the dissolution of the group, we see that closeness is central to the process, and to the development of the group.

Some of the ways facilitators observe the closeness are: proximity, such as who sits next to whom; the willingness of each person to be governed by the rules of the group; the choice of activities; and the degree to which members participate (solitary or gregarious).

The five stages that constitute Garland's group development are: (a) Pre-affiliation, (b) Power and control, (c) Intimacy, (d) Differentiation, and (e) Separation. Each stage will be described briefly, followed by a more detailed account of the process of the practicum group's development and how Garland's theory describes this process.

The first stage is pre-affiliation, with the task being approach-avoidance. The members are just becoming familiar with one another and with the situation. They may utilize simple activities, such as small talk, to get acquainted, while at the same time maintaining distance. Members may be experiencing some anxiety about becoming involved and taking risks, yet are attempting to find ways to accomplish this exploration and affiliation. They may exhibit some ambivalence toward involvement and have an "on again, off again" attitude toward activities. There exists the desire to become involved in the group and make use of what the group and the facilitator have to offer, and thus there is the tendency to approach. However, there is also the desire to avoid, in order to escape the

demands and possible disappointments. Members exhibit avoidance by not participating, coming late and even dropping out of the group. It is important to remember that there may be a set of behaviours that exemplify both approach and avoidance simultaneously. This should be expected, and a facilitator's handling of this stage can help ensure the group's success. By gently inviting trust through allowing distance, giving clear information about the group's operation and structure, and ensuring initial success through activities, a facilitator can assist each member to work through the task of the pre-affiliation stage.

The second stage is power and control. Once each member solves the problem of whether the group is safe and rewarding, and therefore worth an investment of time and emotion, issues of power and control may begin to surface. These may present as issues of status and influence, communication patterns and making choices as a group. There may be some "testing" of the facilitator, and an attempt to create a status hierarchy. The relationship between the facilitator and the group can have a significant impact on the intra-group dynamics. The facilitator has the ability to give or withhold either material or emotional rewards, such as craft materials or food, or personal attention for individual members. The influence of the facilitator can be comforting for some, and overwhelming for others. The challenge

for the group leader is to avoid repressing the members into conforming, but also to avoid a full-blown takeover by one or more group members. Successful resolution of this stage enables member to trust - both one another, and the social worker.

Stage three is intimacy. It is characterized by an intensification of personal involvement and an increasing willingness to bring feelings into the open regarding other members and the program. A system of relationships develops that is more personal, and affiliations are formed. There is clearly a desire to know others and have others know them, and to share the emotions that arise from common experiences. The leader's attention is focused on: (a) support for members' needs for dependency, (b) encouraging the crises that occur which signify growth, and (c) recognition and clarification of the growth.

Stage four, the stage of differentiation, is one where members begin to accept one another as distinct individuals. They begin to see the group experience as a unique one from which they can gain something to assist each of them individually. Having achieved varying degrees of autonomy and intimacy, each member becomes more able to differentiate. Members begin to compare this group experience to other groups and social situations. It is suggested that as the differentiation occurs, there is increased flexibility for role re-definitions within the group, and even for shared leadership.

Members may become comfortable enough to experiment with different behaviour modes that are not the norm for them. The issue of cohesion and its importance in the intimacy stage (stage three)continues to be significant. However, it is not a goal that needs to be attained at the expense of personal autonomy. Members' individual needs for autonomy and growth can hopefully be met through the social contract that is the continued attendance and participation in the group.

The fifth stage is separation. As the group nears its conclusion, the members begin to move apart and find new resources for meeting social needs. If the group has been significant for the members, it now may become a frame of reference for approaching new social, group, or familial situations. There may arise some anxiety over termination, and group members may employ several methods of either avoiding or putting off the reality of termination, or facing and accomplishing it. These methods may include (a) denial, (b) regression, (c) recapitulation, (d) evaluation, (e) flight.

Denial may take the form of either simple denial wherein the members act as though they've simply 'forgotten' that the group is disbanding, or clustering, where a banding together of the members takes place. Regression can be a simple regression that looks like disorganization, when members seem less able to cope with the very tasks that they have been addressing

throughout group. However, it may also take a more extreme form when members behave as they did at the beginning of group, reflecting a desire to start over again. They believe that if the facilitator sees that they still need the service that the group has provided, the group will continue. A third device is recapitulation, which can take the form of either wanting to re-enact what was done earlier in group, or to conduct a review of the group, much like reminiscing. This review can include evaluation, which reflects a more rational approach to the termination of the group experience. Finally, members may choose to react to termination by using one of two types of flight. Nihilistic flight is the destructive reaction to separation where there is denial of the positive aspects of the group experience. This is an attempt to control the grief of separation by behaving in a rejecting manner. Members may miss meetings or behave in ways that seek to provoke rejection by others. Conversely, positive flight is a constructive method of weaning one's self from the group. Members start to seek new groups, activities or interests outside the group while still continuing as a member. These new contacts serve to substitute for the gratification that will end when group ends. The facilitator's focus is to assist in the process of moving apart, both by making resources and opportunities available for post group assistance, and by focusing on evaluation. It is important

to tie the group experience to subsequent life situations for the members.

Although Garland's theory of groups did not inform the design of the intervention which is the subject of this practicum report, I believe that this theory does describe the stages of this group as I observed it. The following section will describe an analysis of the actual group intervention, using Garland's model of five stages of development in social work groups (Garland et al.,1993).

Group Analysis

Stage One: Pre-affiliation

Jane had always had the most difficult time parenting the eldest of her boys, Joseph. She described him as not able to "believe" that she loved him. His difficult behaviours reflected his constant attempts to test her commitment to him. Jane had had the assistance of a reunification social worker from Child and Family Services who had taught her about Theraplay, and she was often able to incorporate some Theraplay activities into her daily routine with all her children. She felt that the group would afford her an opportunity to have some one to one time doing something special with and for Joseph. This previous knowledge gave Jane an advantage coming into group, helping her to approach it with confidence, thereby diminishing any tendency to avoid at this initial stage. Jane spoke very confidently in

the first few groups. Proudly she told her story of her children having been in care, and then being reunited with her. She and another member discovered that they knew each other, and had been neighbours several years earlier. In the first stage then, Jane was approaching the group with enthusiasm. She had closeness to another group member and confidence in her advance knowledge about the treatment modality the group would be using.

During the multi family part of group, Jane was obviously able to gain cooperation from her son. Joseph appeared to seek out his mother for the activities and responded well to her direction. Jane seemed to be comfortable in believing that this would be a positive experience for her and Joseph, and she was participating fully.

Ann was more reluctant, and during this first stage her tendency to avoid the group seemed strong. At the first meeting she was able to tell both the facilitators and the group that she found it extremely difficult to speak up in a group situation. However, her desire to help her younger son was strong enough to encourage her to commit to attending. She presented as somewhat hopeless about her ability to effect change, and her behaviour at the first few groups was only minimally participatory. During the break between the women's group and the multi-family group, Ann did not approach the other participants; instead, she waited in the women's group room

until the break was over, or offered to help the facilitators with taking the snack to the family group room.

During the multi-family part of group, Ann made only perfunctory attempts to engage her son. Alex kept himself quite separate from both his mother and the other children. He was uncooperative during the activities, and Ann seemed unable to gain his attention or cooperation. Her efforts were minimal, and she gave up immediately when she encountered resistance from Alex. This pattern continued for the first few weeks, and I was concerned that her lack of success, and avoidance of the other women may lead to her dropping out of group. Four individual sessions were held with Ann, by phone and at her home, with the intent of helping her to develop the assertiveness to be more insistent with Alex. The hope was that if she could experience a success with him, she would be able to stay motivated and continue attending.

Cara presented as high functioning in terms of what she already knew about the impact of violence for both herself and her children. She had had some personal counselling, and wanted something for her daughter as well. Cara hoped that the group would help Shannon to be less fearful and clingy, and she was eager to try Theraplay. Cara's tendency to approach the group did not seem particularly strong, and in fact, she did not attend the first group session. When a phone call was made to

her after the first group, she claimed to have forgotten which evening was the first session. Cara had two major crises in the first few weeks of group; she had to find new housing, and she learned that her ex-husband was being released from jail. In these early weeks, Cara did very little interacting with the other women in the group. When she spoke in group, it was to the facilitators. She seldom responded directly to what the other women said. In the third group session, during the discussion of the lingering impact of violence on the women and their children, Cara used the term 'post traumatic stress'. I asked the other women if they had heard of it, and they had not. I asked Cara if she could explain the syndrome to the others. She did so in such a way that the others were able to incorporate it into their own experiences. I had hoped that this might have started some dialogue between Cara and the others. Unfortunately it did not. The tendency to avoid was significant in Cara's behaviours - missing the first meeting and not engaging with the other women - and I was concerned that she was not getting what she had hoped for in the women's group.

During multi-family group, Cara and Shannon remained physically close to one another, and while Cara was able to participate in the activities with some degree of enthusiasm, Shannon did not. In spite of complaining that her daughter was clingy, Cara never did encourage her to participate more with

the others during the activities. No amount of gentle cajoling by the facilitators could bring Shannon into more full participation either.

Sue and her daughter Dora came to the intake meeting with a clear agenda. Sue was adamant that she and Dora be admitted to group, and that their need for assistance was extreme. There was trepidation on the part of the facilitators about being able to manage Dora's behaviours and whether Sue's many stated needs could possibly be addressed in this group. Sue's insistence won out however, and her intense desire to be part of the group resulted in no avoiding behaviours with regard to the women's group. She was extremely open in her conversations in the group, and tried to create an immediate rapport with Jane whom she had known several years earlier. She spoke to the other women directly during group, offering suggestions and support. Sue was easily the most talkative of the group, often monopolizing the conversations in the early weeks. To her credit, however, she was able to sense that she was talking too much and reduced her speaking time in order to give others the chance to contribute. Sue stopped short during one of her monologues and acknowledged that she had "a big mouth," turned to Ann, a much quieter member, and gave her the opportunity to speak. Sue was keen to participate in the best way she could, and showed no avoidance of the women's group.

In the multi-family group, Sue was quite competitive. Both Sue and Dora engaged energetically in the games and activities that were chosen from Theraplay. Unfortunately, Sue was also competitive with her daughter, and Dora would respond with tantrums and extreme acting out behaviours. Dora would swear, scream, and hit and kick her mother. Sue would then physically and emotionally withdraw her attention from her child and stop participating. Clearly, additional individual meetings were needed for Sue, and several occurred in her home over the course of group. Without these, I feared that Sue's lack of success with her daughter in the multi-family group may have deterred her from continued attendance. It was necessary for each of the participants to experience some initial success so that this first stage of group could be completed.

Stage Two: Power and Control

The second stage of group according to Garland's model is power and control, wherein issues of status and influence surface, and patterns of communication are established. As noted, the successful resolution of this stage enables the members to begin to trust one another. The approaching and avoiding activities of stage one seemed to occur from time to time throughout the first few weeks of group. However, the issues of control began to surface quite early, thereby having the first and second stages sometimes occurring simultaneously.

Communication patterns among the members of the group had been set by the second group session, and remained fairly consistent throughout. During group discussions, Jane and Cara and Sue were able to direct the topics of conversation for the most part. However, on two occasions, Cara had issues that she needed to discuss, and it was clear that Jane did not like having the attention focused away from herself. Jane would roll her eyes and yawn loudly when Cara spoke at any length. In order to address Jane's apparent discomfort, it was suggested that I drive her and Joseph home after several of the group sessions. (This enabled Jane's child care provider to remain at home with her two younger children, rather than having to take them out late at night to pick up Jane and Joseph.) I was able to confront Jane on her reactions to Cara's disclosing in group.

Jane claimed to be unaware that she was being so blatantly disrespectful of Cara's dilemmas, and said she would be careful not to do so in the future. She did admit that she did not care for Cara, and that she felt that Cara tried to be "better than" the other women in the group. We explored the reasons for Jane's feelings in this area, and she appeared to gain some insight about her own self-esteem and her subsequent reactions to Cara.

For three or four weeks in the second half of group, Ann did an uncharacteristic amount of disclosing, but members were more tolerant of her need to speak out in group. Sue was actively

supportive of Ann, both in and out of the group setting. She was sympathetic to Ann's emotions and problems, and offered suggestions that were intended to be supportive. Sue and Ann once met by chance at a doctor's office, and Sue assisted Ann with her child, and took her to a pharmacy where she could get a prescription filled. Both women reported on this contact the next time they were at group and both seemed pleased to have encountered one another.

From my observations, there did not appear to be a time when the women were testing me or the other facilitators. In spite of the clear domination of Jane and Cara and Sue in the communication patterns among the women, it was not difficult for me to get back to the business of each group. This was likely because I had initially taken the role of expert, and the women seemed willing to accept that.

Communication patterns in the multi-family group were clearly in the hands of the facilitators. The children knew that Jennifer was in charge of their group, and seemed to accept that. My taking charge of the multi-family group activities was also accepted, except when one or two of the more recalcitrant children flatly refused to cooperate due to other factors that were troubling them. When Dora would tantrum, or one of the boys refused to participate, the group would carry on without them, thereby establishing that the child could not take control.

There were occasions, however, when I allowed another of the facilitators to direct the activities, or choose an activity. I believe that I should have been more assertive about being in charge, thereby making it clearer to the children what the expectations and consequences were.

Stage Three: Intimacy

During stage three, intimacy was characterized by the women's ability to bring their struggles into the open. A particularly good example of this was their disdain for the film "The Crown Prince" shown during group four. None of the women felt the film had any relevance for them and they were candid in their negative review of the film. I was encouraged by their candor and their ability to eschew that which was meaningless for their particular situations. The women's desire and ability to relate to one another was more evident by the fourth and fifth week. Not only had they formed alliances within their small group, but they had become more emotionally generous with one another. There was increased ability and desire to relate to one another and echo the common expressions of their struggles with men, and with their children. By group five we were discussing the cycle of child misbehaviour and how the women's responses to their children's behaviour contributed to it. Initially, the women were quite subdued as they watched the cycle being drawn on the flip chart. A brief comment by Cara,

wherein she recognized her contribution to maintaining the cycle, was enough to spur the other women into acknowledging their own mistakes and poor responses to their children. Soon all the women were eagerly offering alternatives they could have used to deal better with misbehaviour. Through this sharing of common experiences and emotions the women moved toward increased intimacy. It was easy enough to clarify what these women were recognizing at this stage. While they admitted to feeling guilty that they had responded inadequately to their children, I was able to assist them to recognize the growth that all of them were clearly experiencing at that moment, by identifying what they now knew they could do better next time.

I remain unsure if there was ever any significant degree of intimacy achieved in the multi-family group. The children's behaviour was mercurial from child to child. While Dora was able to moderate her behaviour significantly and was increasingly able to relate to the other children, Joseph and Alex became more insular in their approach to others in the group. Shannon remained at the periphery, instead preferring her mother's closeness to that of the other children. It took perhaps the involvement of Max the puppet to effect any intimacy among some of the children. This occurred over the sixth and seventh groups, when the children were able to direct their comments to Max rather than interact with real children. Talking to Max

allowed the children to say things they may not have said otherwise. For example, Joseph repeatedly told Max that a foster parent was the only safe person to talk to about a problem. Dora was most solicitous of Max and clearly showed her concern for his plight. This was clearly an opportunity for these children to express their thoughts and feelings in a way that was more comfortable, because the scenario concerned Max's experiences and feelings rather than their own.

Stage Four: Differentiation

Differentiation is the fourth stage in Garland's model. There was evidence of some differentiation occurring in the women's group. During the earlier stages of group, the tendency to approach (or avoid) was evident between Jane and Sue by their choice to align with one another based on their previous contact. As the group continued, Jane's alignment with Sue seemed to weaken. Jane had often had the attention of the group members during check-in at the start of each session when she spoke proudly, with humour and enthusiasm, of her family and their accomplishments over each previous week. She took on a role that was almost that of an entertainer, engaging the other women's attention and appreciation for her good-natured style of relating. As she netted approval from the others, she seemed less inclined to limit herself to being close to only Sue. In multi-family group Jane continued to be the most successful at

directing her child's participation and cooperation in the activities. This was no doubt due to her previous knowledge of some Theraplay techniques, and she appeared legitimately proud of her successes with Joseph.

As Jane became more confident, so too did Sue. Several individual meetings with Sue, and her own efforts to seek out other groups and situations that were rewarding for her, seemed to give her the confidence to try different approaches with Dora. One of the hallmarks of the differentiation stage is seeking out other social situations where one can practice other roles. Sue had joined a self-help group at a women's shelter, become involved in a musical group at church, and was volunteering at a day care. She had increased patience with Dora, and seemed able to incorporate much of what she was learning in the group. Sue had begun group while she was in crisis, and expressed these crises both verbally and behaviourally. Late in the second half of group, Sue had visibly re-defined her role from that of an angry victim to a capable adult and calmer parent.

Unfortunately, Ann appeared to be regressing and expressed a good deal of hopelessness. She was now requiring medication for depression. Her financial situation was dire, her extended family was causing problems for her, and she stated that she was

less able to attend to her son's behaviour problems than she had been at the beginning of group.

I was unable to see any evidence of Cara addressing the tasks of differentiation. Her presentation at the end was essentially the same as at the beginning of the group. Her disclosures in group were primarily about her child's progress or struggles. Cara had her own individual therapist and, other than disclosing when she was in crisis on two occasions, Cara was not disposed to sharing her own insights or thoughts. Perhaps if I had suggested individual meetings with Cara, I could have discovered a way to make the women's group more significant for her.

Stage Five: Separation

Separation is the fifth and final stage of a group. Ideally, the members are beginning to move apart and find new resources for meeting their social or growth needs. I believe that all the women used healthy devices to deal with the termination. One of these devices is evaluation, which is an important task for a post-group meeting and is formally built in to the group itself. All four women willingly participated in the evaluation with me. They also accepted the termination using positive flight, wherein they had begun to make new or additional contacts, and were seeking resources for ongoing assistance.

In the multi-family group, there was evidence of the children having a more difficult time with terminating. A device known as recapitulation was taking place, with the children wanting to repeat the activities that were done in the beginning. However, it may have been that the children simply wanted to play favourite games. There was also some regression among the children, almost to the point where they were behaving as they did at the beginning of group. This was true of Alex and Dora in particular. Dora had made good, albeit scattered, progress, but during the final evenings of group she seemed less able to maintain those gains. Alex had been perhaps mirroring some of his mother's regression for some weeks, but it did appear as though Alex wanted us to see that he still needed our help. The post-group evaluation confirmed that Alex still wanted to have a group to attend and his mother was trying to find an appropriate venue for him.

Group Analysis Summary

The concept of group cohesion is not specifically addressed in Garland's model. Group cohesion can be defined as the result of the action of all the factors that cause members to remain in a group (Toseland & Rivas, 1984). Group cohesion can affect the functioning of a group by helping to maintain its membership (Cartwright, 1968). Furthermore, cohesiveness in treatment groups can lead to increased self esteem, a greater willingness

to listen to others, and freer expression of feelings (Yalom, 1975). Even though the four women in the group moved through the intimacy and differentiation stages in ways that did not always reflect cohesiveness, none of the members left the group. Cohesion does not need to be attained at the expense of personal autonomy and growth.

The women's group appeared to provide an opportunity for each of the women to develop new skills and experience individual growth. In observing each woman's progression through the stages of the group I was able to see them accomplishing, in varying degrees, the tasks that were particular to each stage. Certainly, some appeared to make greater progress than others.

Evaluation of Standardized Measurement Results

The following section will present and analyze the information obtained from the pre- and post-test measurements, including the Child Behaviour Checklist (CBCL), and the Parenting Stress Index (PSI). Tables at the end of the section depict the results. The results of the Consumer Satisfaction Questionnaires and the post-group interviews will be discussed as well.

Jane and Joseph

Jane's scoring of Joseph at the pre-test CBCL showed his Internalizing score at 52 which was not in the clinically significant range. His Externalizing score was 63. Scoring at the post-test in January indicated his Internalizing behaviours score had risen to 60, just into the clinically significant range, with his Externalizing behaviours score falling to 58. Jane reported that Joseph had had an increase in somatic complaints, as well as increased anxiety. She noted that he was worrying more, expressing nervousness, and feeling like he was not allowed to make mistakes. These behaviours were not specifically observable in Joseph during the times he was seen in group. However, it was noted that in the multi-family group, Joseph was occasionally less participatory than he had been earlier, and would remove himself from group activities for brief periods. However, there was very little blatant opposition from Joseph, making him appear to be a more manageable child for his mother.

The PSI scoring showed decreases in both the Child Domain from 138 to 128 and the Parent Domain from 167 to 163, from the pre-test in September to the post-test in January. The changes were only slight and did coincide with my observations that Jane retained the skill to intervene effectively with Joseph. She was consistently able to do so over the life of the group. Her Life

Stress showed an increase from 10 to 14 from pre-test to post-test. This moved her from the normative range into the more clinically significant area, and could have been a result of some expressed problems with extended family.

Ann and Alex

When scoring the CBCL for Alex, Ann identified increases in every area from pre-test to post-test. His Internalizing score went from 60 to 70, and the Externalizing score from 70 to 74. All of his scores, except for anxiety and withdrawn/depressed, were now into the clinically significant range. His Total Problem score rose from 65 to 72, also clinically significant.

The PSI showed significant increases as well, with the Child Domain score going from 131 to 144 from September to January. All but one of the areas were now above the 95th percentile. For herself, Ann scored 137 in the Parent Domain at pre-test, and 154 at post-test. Four out of the seven areas were now above the 85th percentile where only one had been at pre-test.

This is a concerning trend for this family. I believe that what Ann was scoring was her perception of how she and Alex were coping, and it was obvious that her sensitivity to that was increasing. Ann started group with a reluctance to talk about her situation, and considerable minimization of how her ex-husband's violence had affected their lives. As time went on, she talked more about her problems with her children, money,

loneliness, her job and extended family. Ann was expressing fear and hopelessness that she had not previously acknowledged. The impact of this was apparent in her demeanor and in the fact that she was trying prescribed anti-depressant medication. Ann was overwhelmed with her day to day problems, and Alex's behaviour, while probably not much worse in reality, was far more difficult for Ann to manage in her diminished emotional state. In several meetings during the life of the group and in two meetings afterward, it was apparent that Ann's functioning was regressing, and Alex was responding to her decreased ability to help him control his behaviour.

Sue and Dora

In September 2002, the pre-test CBCL showed Dora's scores for Internalizing Problems at 73, and the post-test CBCL done in January 2003 indicated a decrease, at a score of 64. The scores for Externalizing Problems dropped from 87 to 83. The Total Problems score dropped from 81 to 72 between September and January. At pre-test, Sue scored her daughter as being clearly in the clinical range in every area except *somatic complaints* and *thought problems*. At post-test, the scores had all decreased. Sue's scoring of her daughter's problems now indicated that of the eight areas, only three were in the clinically significant range. These included the externalizing problems of *delinquent* and *aggressive* behaviours. The scores

would indicate that Sue saw improvement in her daughter's behaviours. This would certainly coincide with my observations of Dora's progress. Dora was increasingly able to participate in the activities without tantrums or acts of anger directed at her mother.

The PSI identifies parent child systems that are under stress. The scores are a reflection of the parent's view of problems in the Child Domain, and in the Parent Domain. In September, Sue identified Dora as being off the scale in every area of the Child Domain, with her scores being extremely high. This was absolutely a crisis profile. Interestingly, Sue scored herself in the normal range of the Parent Domain in every area except *competence*. Her scores were not in the clinical or concerning range. By January, Sue scored Dora considerably lower in the child domain in all areas except *demandingness* and *acceptability*. All were still above the 80th percentile which exceeds the normative range. Sue's own scores remained much the same, except for a significant improvement in 'competence'. Her Total Stress and Life Stress scores remained very high from beginning to end. This would fit with my observations that both Sue and Dora had made obvious progress during group. The improved scores were not surprising, given Sue's increased patience and tolerance for her daughter's behaviours, along with her own increased satisfaction with elements in her adult life.

In spite of the consistently high Total Stress and Life Stress scores, Sue described being happier and feeling more hopeful. Dora was still a high-energy child who required repeated reminders to manage her behaviours, but those behaviours were now more often joyful than antagonistic.

Cara and Shannon

At the time of the pre-test of the CBCL, Cara was scoring her daughter in the normal range for both internalizing and externalizing behaviours. Her internalizing score was 63, with the highest score being in the anxious/depressed category. Shannon's score for externalizing behaviours was 62. Her score in the aggressive behaviour category was at the 93rd percentile. By the time the post-test was done in January 2003, Cara was scoring Shannon much lower in all areas. Her internalizing behaviours had fallen to a score of 39, and externalizing behaviours to 52. The aggressive behaviour category was now at the 60th percentile.

The scoring for the PSI took a similar direction. At the pre-test in September, Shannon's score in the Child Domain was 151, with *adaptability, demandingness,* and *mood* being above the 99th percentile. Only one category registered in the normative range. Cara scored herself at 142 in the Parent Domain, with two of the seven categories in the clinically significant range. At post-test, the scores in the Child Domain were down to 130, with

demandingness and *mood* still scoring high, but now under the 99th percentile. Cara's scores in the Parent Domain were all in the normative range with the score having decreased to 117.

The fact that Cara perceived a positive change in both herself and her daughter is gratifying when one is considering the efficacy of the group. The evidence of this positive change was not immediately observable to myself, as Shannon never presented as a behavioural challenge in the multi-family group. Although Shannon often refused to participate in some of the more energetic activities, even then she did not present as oppositional. Cara felt that Shannon wouldn't participate because she was self-conscious about being overweight.

Summary of Post-Group Analysis

At the post-group interviews, the women stated they were glad they had been part of the group. They felt the group had helped their children, and that they had learned some new things about parenting. They enjoyed being part of the women's group, although they claimed to be disappointed or embarrassed when their children were uncooperative during the multi-family part of group.

The results of the CBCL at the beginning of group reflected a range of scores for the four children. Many variables could account for this, such as the frequency of the violence, how recent the last violent episode was, the particular

characteristics (such as resiliency) of each child, and the quality of the child's attachment to the mother. Particularly high scores do support the various studies that have found domestic violence being harmful to children's emotional and behavioural areas of functioning (Carlson, 1990; Davies, 1991; Graham-Bermann, 1996; Hughes, 1988; Hughes & Barad, 1983; Jouriles, Murphy, & O'Leary, 1989).

Changes were noted between the scores of the pre-tests and post-tests. One must be careful however, not to interpret the changes as only a result of the intervention, when other personal, familial, and environmental changes were occurring simultaneously.

The PSI scores for the women in the Parent Domain moved in a positive direction for three out of four of the women from pre-test to post-test, indicating improved functioning. One of the women's scores decreased from pre-test to post-test and it is possible that the intervention did affect this result. The high scores in the Parent Domain and in Life Stress are certainly not a surprise in view of the various studies that report women's elevated stress in parenting in an environment where there is domestic violence (Holden & Ritchie, 1991; Holden et al.,1998; Levendosky & Graham-Bermann, 1998).

At the beginning of group, one of the women was in personal counselling and two continued to have supportive services from

Child and Family Services. It was the intention of these three women to continue to avail themselves of the services they were getting. Ann intended to re-enroll in the group if possible, with her other son. Only one of the four women felt she was now able to be "finished" with helpers and therapeutic services.

CHAPTER V - EVALUATION

This chapter will evaluate the group intervention which is the subject of this report. In particular, it will evaluate the success of the intervention by determining how well the intervention met the practicum objectives, and what the implications may be for social work practice.

Achieving the Practicum Objectives and Learning Goals

In Chapter I (page 5) of this report, my personal learning goals were to (a) gain increased knowledge about the issues facing women and children who have been affected by domestic violence, (b) to gain experience in conducting groups to better serve the needs of clients in social work practice, (c) to familiarize myself with the foundations, development and treatment applications of Theraplay, and (d) to learn how to evaluate the efficacy of interventions, including the administration and scoring of standardized measures. My objectives for determining the success of the intervention were: (a) to reduce the parenting stress, as reported by the mothers, (b) to effect a reduction in the behavioural problems exhibited by the children, as observed by the group facilitators and as reported by the mothers, and (c) to improve the relationship between mother and

child as observed by the group facilitators, and as reported by the mothers.

The Effects of Domestic Violence On Families and the Implications for Social Work Practice

The issue of domestic violence is not always consistently responded to in social work practice. Social work practitioners, the police, and the courts now have a greater understanding of the problems faced by women who are battered, but the services available are not always consistently delivered. Shelters and safe houses for women and their children in this province are providing services as well as they can, but the issue of domestic violence and its effect on children who witness the violence, is not necessarily widely understood or thoroughly assessed by some social work practitioners. Having worked fifteen years in the field of child protection, both as a protection worker and as a supervisor of protection workers, I am aware of the inconsistency of services provided, when domestic violence is one of the presenting problems. In child welfare practice for example, there is often considerable variation in how social workers respond to incidents of violence in clients' homes. The physical safety of children is always a consideration when determining what the child welfare social worker's actions

will be, but the emotional difficulties created for child witnesses of violence are not always addressed. Shelters and safe houses make physical safety their first priority as well, and are advocates for the women who may require legal assistance, as well as support in re-establishing themselves in alternate housing and with financial assistance for themselves and their children. The work done by social workers for this population is based on addressing the immediate needs for safety. As a child welfare social work practitioner, I have learned from this practicum that the needs of these mothers and their children extend far beyond meeting that immediate need. From the women who were the participants in this practicum, I learned that they struggle daily with their new status as single parents. Their difficulties included both practical day to day matters such as having reduced incomes, and emotional matters that included loneliness and guilt, and the exhaustion that comes from having to manage their children's problems by themselves. The four participants and I learned together how their children may have thought about the violence and how it affected them. We learned that the violence may continue to be experienced emotionally by their children even if they had not witnessed it directly. I was able to help myself and the

women identify when their children's behaviours may be reflecting their fears and anxiety, and what they can do to address those behaviours. It was often surprising to the women that their children had been as affected as they were by the violence in the home. The most difficult part of that revelation was the guilt that the mothers experienced when their children had had to live with the violence over an extended period. My task then became to put their actions, or inaction, in context. Sharing the information of how the violence in their lives affected all areas of their lives, was valuable in helping them move past the feelings of guilt, and on to acting to improve their children's functioning. My increased understanding of the emotional effects of domestic violence on women and children will serve to better inform social work practice as I supervise and share my increased knowledge with other child welfare practitioners.

Benefits of Group Work for Social Work Practice

Groups are a preferred treatment modality for women who have been battered. Not only does being with others who have had similar experiences benefit women, the group serves as a venue for parent education (Breton & Nosko, 1997; Levendosky, 2000; Levendosky & Graham-Bermann, 2000). Most of the women in our group stated that the group was a

positive experience for them in that they were assured that they were not alone in dealing with their problems. Indeed, they stated that they were relieved to find that it was not only their children who were misbehaving, but that other mothers had the same issues in managing negative behaviours. In observing one another, the women were able to informally assess and compare whether or not they were progressing over the course of the group. For example, in the earliest weeks of the group, it was apparent that all the participants were aware of the difficulties between Sue and her daughter Dora. Dora was unable to get through any group sessions without major behaviour problems including inattention, non-compliance, and rather severe acting-out. Sue's responses were equally distressing with her refusing to talk to her daughter and withdrawing from her completely for the duration of the group session. The other participants observed these episodes with obvious discomfort. As the weeks progressed, and Sue and Dora had a number of successes with each other, the other participants shared in their obvious pleasure. To be able to see such an improvement was surely gratifying for everyone involved. All the mothers showed pride in their children's accomplishments during group activities, and these successes were noted by the other group members. The

cohesion that the women attained with one another, and the compassion that they came to show for one another seemed to enhance their experience in a way that would not have been possible in individual counseling.

The four women were not a homogeneous group. There were certainly some similarities but there were differences among them as well. In observing the patterns of communication in the mothers' group, there were usually obvious differences in the style and amount of communicating. Only one of the four (Cara) was what might be termed as having been in a middle class of the socio-economic strata. She did not participate as consistently as the other women, and when she did speak, had a style of communicating that evidenced her education and different circumstances. I was made aware that at least one of the other participants did not care for her due to her perception that Cara was acting in a superior manner to the rest of the group. Cara was also the only one of the group who had not had Child and Family Services involved in her life. In spite of the fact that the women identified Child and Family Services as either a positive or at least benign presence in their lives, the fact that Cara had not may have put her in a rather different category than the other women. I believe that this is one element of homogeneity

that perhaps should be observed when choosing participants for this group. Receiving involuntary services from Child and Family Services may well be a stigmatizing factor that separates group members from one another.

The treatment group ran for a total of twelve weeks. This time frame was helpful in terms of planning the sessions and assisting the women to work toward meeting goals for themselves and their children. One of the women (Ann) expressed a need to continue with a similar service through Elizabeth Hill Counselling Centre. The others had developed their own supports which they felt would be sufficient for them and their children. I believe the group clarified for each woman what additional help they wanted, if any. Those that experienced successes, even if sporadic, seemed buoyed by these successes and ready to search for other sources of help when required.

Both a mothers' support group and a parent-child multi-family group were used for this group intervention. The literature suggests that support groups for women who have been victims of domestic violence may help to increase self-esteem and provide social support (Tutty et al.,1996). Support groups that focus upon parenting education where a common set of problems has been identified, can also be helpful when the participants get to practice new skills

learned in the safe environment of a group. There were occasional examples of the women offering emotional or social support to one another but generally it did not extend past the group setting. Being able to experience successes in changing some of their children's negative behaviours, and having the other group members witness each others' successes did help to boost self-esteem. It is my belief that the women did learn a considerable amount from the education component of the mother's group. Using diagrams on the flip chart provided a concrete way of looking at some of the information provided, and definitely seemed to help the women comprehend the more complex concepts (such as Belsky's three sources of influence on parenting).

I believe that the group was able to meet the identified needs of the women in the group better than individual counseling would have. My learning goal of developing experience in using groups was achieved, and I was encouraged to observe the positive effects the group experience had for the women week to week.

Benefits of Theraplay for Social Work Practice

The use of Theraplay both in the mothers' group and the multi-family group met with varied successes. In the mothers' group, the women certainly seemed to enjoy the

play aspect. They engaged in the games enthusiastically and generally brought that enthusiasm to the multi-family group. When they played the games with their children, the responses of the children would either dampen or heighten the mothers' enjoyment of the games. For example, every child enjoyed the game wherein they would hide treats on their person (in their socks, pockets, etc.) ,and mother would search them for the treat which the child could then eat. The order was then reversed and mother would hide the treats on herself. The element of gentle, playful touch made this a game that all seemed to enjoy. The mothers learned that many of the games could easily be played at home with their child, and provided both of them with delightful one to one time together.

The group provided learning opportunities. The women became less self-critical about their responses to their children at the times when they had been dealing with the violence in their lives. They learned about their children's responses to the violence and how that affected their behaviour. Most importantly, the women learned ways to understand and address those behaviours. Theraplay activities are fun, easy to learn and easy to practice. The foundational aspect of Theraplay which included the importance of the four elements of nurture, structure,

engagement and challenge, were introduced to the participants. From weeks six through ten, the mothers were provided with examples of how each of these can be used to remedy undesirable behaviours. Having a repertoire of simple, fun activities which can ameliorate negative behaviours can help to improve the parent child relationship.

An introductory course in Theraplay was offered which I attended prior to beginning the practicum. Through the use of lectures, films, and exercises which practiced the activities, I was able to gain an understanding of how Theraplay is used in an intervention where there is an identified family member with behavioural problems. For the purposes of this group, activities and games were the primary methods used which were drawn from Theraplay. The design of the group also incorporated the use of feeding to provide additional aspects of nurturing between the mothers and their children. Theraplay's simple games that provide nurture, structure, challenge and engagement are easy to teach and easy for most parents to do at home. The use of Theraplay for social work practitioners could be quite significant in working with families. All of the children in the group enjoyed the game that consisted of the mother 'drawing' letters on the child's back with her finger, and

the child having to guess the letter she had drawn. It was most interesting how even the most fractious children in the group would sit quietly and attend to what their mother was drawing on their back. It was a soothing activity that brought pleasure and closeness to both mother and child. Social workers who work with families struggling to cope with children with difficult behaviours could show parents the effectiveness of Theraplay games. The small improvements that occur are the beginnings of change for the better.

Evaluating the Success of a Group Intervention and Implications for Social Work Practice

Social workers are encouraged to evaluate their practice. Measuring the success of an intervention can take several forms, but other demands of social work often seem to preclude getting to the task of evaluation. One of the common methods used to evaluate interventions in social work is writing progress notes. By keeping ongoing records of the social worker's contacts with clients, her observations of the client's progress form the basis for evaluating the success of her interventions. Self-reporting from the clients and the social workers, as well as questionnaires, provide information that assists in evaluating one's work. Standardized measurements and

scales, when used before and following an intervention, can also provide one measure of the success of an intervention.

In evaluating the group which is the subject of this report, all of the above methods were used. I kept my own progress notes, and each of the women completed a series of pre and post intervention interviews and standardized measurement tools. All of the women, when interviewed after the group was completed, indicated they had found the group helpful. Looking at the standardized measurements used, and comparing the change from pre-test to post-test, the results were mostly positive for three out of four of the women (and their children, as reported by the mothers).

My own perception of the success of the intervention is that it was generally a useful experience for each of the women for different reasons. The experience of being in the group benefited them all in various ways. Jane was able to reinforce the skills she already had and spend some valuable one to one time with her child. Cara learned more about the pervasive effects of violence on her and her child and was thus better able to understand, tolerate, and address some of her daughter's less desirable behaviours. Ann, in spite of the fact that she experienced greater difficulties in her life during her time in the group, seemed to benefit from speaking out in a supportive group

setting. I believe she came to feel emotional support from the other women in the group and was therefore encouraged to talk about her problems in a way that was helpful for her. Sue, who came to the group in an obvious crisis state, showed the greatest improvement, in my opinion. Sue was a resourceful, somewhat fearless woman who did not hesitate to try new things for her own satisfaction. She had already accomplished a number of things in order to ensure safety for herself and her children, such as moving to a new town, finding alternate housing, obtaining protection orders through the courts, enrolling her children in school and daycare, and beginning to engage in community activities. Being in the group enhanced her sense of competence as she was able to have more successful interactions with her daughter. Sue's initial crisis presentation did create some concern among the facilitators that she and her daughter were not ready to manage the structure of a group. I believe that one of the significant factors that caused her to be successful was the fact that she had already done a number of necessary tasks in leaving her violent partner, that the group became a secondary or supplementary intervention for her. In Ann's case, even though she presented completely differently, her crisis came during the life of the group and continued throughout. For Ann

then, the group was really her first, primary intervention and she seemed overwhelmed by the enormity of the tasks she had to complete, both instrumentally and expressively.

The women's progress can be said to be related in part to where they are in the process of having separated from the violence. This element might be considered in choosing participants for the group. The fact that Ann was, in some ways, not ready to accept that her violent partner should no longer be part of her life, meant that she had not achieved the same emotional understanding of her new status as the other women had. The fact that Ann had so much to do to improve her own functioning, meant that she did not have the same energy to expend on her children. Her need to solve her own very real adult issues precluded her need and ability to address her children's needs at the time of the group. More thorough assessment of the mothers' current functioning and attitudes should be a significant component of the intake process in determining who the participants will be.

In summary, the experience of the group was generally positive for all four women, in my opinion. A positive therapeutic experience will encourage them to seek assistance again if required. They benefited in different ways and to different degrees, based on their needs at the

time. The new information that the women received, and the exposure to Theraplay activities will always be theirs to access when they need it.

EVALUATING MY OWN LEARNING

I feel fortunate to have had the opportunity to complete the practicum which is the subject of this report, and to have witnessed what I feel to be the 'success' of the intervention. I have learned a great deal about topics relevant to social work practice which I am convinced will enable me to provide better service to clients and better supervision to other social workers.

It is true that social workers have many demands on their time in the workplace, and that some activities seem to be less important than providing service. Such things as keeping one's knowledge current, and finding ways to evaluate the efficacy of interventions sometimes get ignored. One of the most valuable lessons I have learned while completing this course of study is that social workers must evaluate the work they do with their clients. Measuring progress can be done in a variety of ways, but it should be done in order to provide effective service. If a client's functioning does not seem to be improving as a result of our efforts, it seems obvious that the social worker should stop to evaluate, along with the client, the

efforts that have been made, and decide if something different should be tried. In order to try something different, social workers have to review current literature, journals and articles that offer new information and ideas.

My own practice and supervision direction have been influenced by the learning I have done during the group intervention. In particular, I am moved by the plight of children who witness domestic violence. It has often been the practice that as long as we have ensured the physical safety of children, we feel we have done our job. This practicum has taught me that the effects for the children are often longer lasting than they have been for the woman who is the direct victim of the violence. Children need and deserve some particular assistance working through their experiences and the fears and anxieties that remain.

Using groups in social work can be a particularly effective way of providing therapeutic service to clients. I have learned in this practicum that a trained group facilitator can provide a more effective group experience. A social worker who has learned about group stages, potential problems, and how to remedy them, is more likely to ensure a positive and helpful group experience for the participants.

Finally, it is my opinion that the use of Theraplay activities can be helpful to many families struggling with their children's behaviours. The basics of Theraplay, and the activities that serve to resolve attachment problems, are simple to learn and apply. I look forward to continuing to share my learning experiences with other social workers who strive to help the families with whom they work.

Appendix I

Table 1: T Scores for the Child Behavior Check List at Pre- and Post-Test

Table 2: Raw Scores and Percentile Ranks of the Pre- and Post-Test Measurements for the Parenting Stress Index

Table 1

T Scores for the Child Behavior Check List at Pre- and Post-Test

GROUP MEMBER		Internalizing	Externalizing	Total Problem
Dora	Pre-Test	73	87	81**
	Post-Test	64	83	72**
Joseph	Pre-Test	53	63	55
	Post-Test	60	58	58
Alex	Pre-Test	60	69	65**
	Post-Test	70	74	72**
Shannon	Pre-Test	63	62	62*
	Post-Test	39	52	45

NOTE:

* Indicates a borderline, clinically significant score on the Total Problem Scale (between 60-63).

** Indicates a clinically significant score on the Total Problem Scale (above 63).

Table 2

Raw Scores and Percentile Ranks of the Pre- and Post-Test Measurements for the Parenting Stress Index

GROUP MEMBER		Child Domain	Parent Domain	Total Stress	Life Stress
Sue	Pre-Test	199	138	337	19
		>99%	75%	>99%	95%
	Post-Test	156	137	293	35
		>99%	75%	95%	>99%
Jane	Pre-Test	138	167	305	10
		95%	95%	95%	70%
	Post-Test	128	163	291	14
		95%	95%	95%	85%
Ann	Pre-Test	131	137	268	28
		95%	75%	90%	>99%
	Post-Test	144	154	298	39
		99%	90%	95%	>99%
Cara	Pre-Test	151	142	293	16
		>99%	80%	95%	90%
	Post-Test	130	117	247	12
		95%	45%	75%	80%

NOTE: The normative range for score is within the 15th to 80th percentile.

REFERENCES

Abidin, R. (1990). Introduction to the special issue: The stresses of parenting. Journal of Clinical Child Psychology, 19, 298-301.

Abidin, R. (1992). The determinants of parenting. Journal of Clinical Child Psychology, 21, 407-412.

Abidin, R. (1983). Parenting Stress Index Clinical Manual. Charlottesville, VA: Pediatric Psychology Press.

Achenbach, T. (1991). Manual for the Child Behavior Checklist/4-18 and 1991 Profile. Burlington, VT: University of Vermont.

Ainsworth, M., Blehar, M., Waters, E., & Walls, S. (1978). Patterns of Attachment. Hillsdale, NJ: Erlbaum.

Ainsworth, M. (1972). Attachment and Dependency: A Comparison. In J. Gerwitz (Ed.). *Attachment and Dependency*, (pp. 97-136). Washington: V.H. Winston & Sons.

Ainsworth, M. (1991). Attachments and other affectional bonds across the life cycle. In C. Parkes, and J. Stevenson-Hinde, and P. Marris, (Eds.). *Attachment across the life cycle,* (pp.33-51). London, England: Tavistock/Routledge.

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

Bowlby, J. (1969) Attachment and loss. Vol. 1: Attachment. London, England: Hogarth Press.

Bowlby, J. (1973). Attachment and loss. Vol. 2: Separation. New York, NY: Basic Books.

Campbell, J., & Lewandowski, L. (1999). Mental and physical health effects of intimate partner violence on women and children. The Psychiatric Clinics of North America, 20, 353-374.

Cascardi, M., & O'Leary, K.D. (1992) Depressive symptomology, self esteem, and self blame in battered women. Journal of Family Violence, 7, 249-259.

Crisci, G. (2001). Attachment & Trauma Assessment Strategies for Children and Adolescents. Workshop, Winnipeg, MB.

Cummings, M. (1990). Classification of attachment on a continuum of felt security: Illustrations from the study of children of depresssed parents. In M. Greenberg, D. Cicchetti, & M. Cummings, (Eds.). *Attachment in the Preschool years,* 311-335. Chicago, IL: University of Chicago Press.

Davis, L., & Carlson, B. (1987). Observation of spouse abuse. What happened to the children? Journal of Interpersonal Violence, 2, 278-291.

Delaney, R.J. (1998). Fostering changes: treating attachment disordered foster children. Oklahoma City, OK: Wood 'N' Barnes.

Finklehor, D., Gelles, R., Hotaling, G., & Strauss, M. (1983) The dark side of families. Beverly Hills, CA: Sage.

Garland, J., (1973). A Model for stages of development in social work groups. In Bernstein, S. (Ed.), *Explorations in group work: Essays in theory and practice.* Boston, MA: Milford House.

Gilligan, C. (1982). In a different voice: Psychological theory and women's development. Boston: Cambridge University Press.

Graham, D., Rawlings, E., & Rigsby, R. (1994). Loving to survive: Sexual Terror, men's violence, and women's lives. New York, NY: New York University Press.

Graham-Bermann, S. (1996). Family worries: Assessment of interpersonal anxiety in children from violent and nonviolent families. Journal of Clinical Child Psychology, 25, 280-287.

Graham- Bermann, S., & Hughes, H. (1998). The Impact of domestic violence and emotional abuse on children: The intersection of research, theory, and clinical intervention. Journal of Emotional Abuse, 1,1-21.

Graham-Bermann, S., & Levendosky, A. (1998). Traumatic stress symptoms in children of battered women. Journal of Interpersonal Violence, 13, 113-119.

Herman, J. (1992). Complex PTSD. A syndrome in survivors of prolonged and repeated trauma. Journal of Traumatic Stress, 5, 377-391.

Herman, J. (1992). Trauma and recovery. New York, NY: Basic Books.

Holden, G., & Ritchie, K. (1991). Linking extreme marital discord, child rearing and child behavior problems: Evidence from battered women. Child Development, 62, 311-327.

Holden, G., Geffner, R., & Jouriles, E. (1998). Children exposed to domestic violence. Theory, research, and applied issues. Washington, DC: American Psychological Association.

Hughes, H. (1998). Psychological and behavioral correlates of family violence in child witnesses and victims. American Journal of Orthopsychiatry, 58, 77-90.

Hughes, H. (1997). Research concerning children of battered women: Clinical implications. Journal of Aggression, Maltreatment & Trauma, 1,225-244.

Hughes, H., & Graham-Bermann, S. (1998). Children of battered women: Impact of emotional abuse on adjustment and development. Journal of Emotional Abuse,I, 23-50.

Jaffe, P., Wolfe, D., Wilson, S., & Zak, L. (1986). Emotional and physical health problems of battered women. Canadian Journal of Psychiatry, 31, 625-629.

Jaffe, P., Wilson, S., & Wolfe, D. (1998). Specific assessment and intervention strategies for children exposed to wife battering: Preliminary empirical investigations. Canadian Journal of Community Mental Health, 7, 157-163.

Jaffe, P., Wolfe, D., & Wilson, S. (1990). Children of battered women. London, England: Sage Publications.

James, B. (1994). Handbook for treatment of attachment-trauma problems in children. New York, NY: Lexington.

Jernberg, M. & Booth, P. (1999). Theraplay: Helping parents and children build better relationships through attachment based play. San Francisco, CA: Jossey-Bass Publishers.

Jouriles, E., Barling, J., & O'Leary, K. (1987). Predicting child behavior problems in maritally violent families. Journal of Abnormal Child Psychology, 15, 165-173.

Jouriles, E., Murphy, C., & O'Leary, K. (1989). Interspousal aggression, marital discord, and child conduct problems. Journal of Consulting and Clinical Psychology, 57, 453-455.

Karen, R. (1990). Becoming attached. The Atlantic monthly, February, 35-70.

Kolko, D., & Kazdin, A. (1996). Children's perspectives in the assessment of family violence: Psychometric characteristics and comparison to parent reports. Child Maltreatment, 1, 156-168.

Levendosky, A., & Graham-Bermann, S. (1998). The moderating effects of parenting stress on children's adjustment in woman abusing families. Journal of Interpersonal Violence, 13, 383-398.

Levy, T.M., & Orlans M. (1998). Attachment, Trauma, and Healing. Washington, DC: CWLA Press.

Munns, E. (2000). Theraplay. Innovations in attachment-enhancing play therapy. Northvale, NJ: Jason Aronson Inc.

Nicarthy, G., Merriam, K., & Coffman, S. (1984) Talking it out: A guide for Groups for abused women. Seattle, WA: Seal.

O'Keefe, M. (1994a). Linking marital violence, mother-child/father-child aggression, and child behavior problems. Journal of Family Violence, 9, 63-78.

Osofsky, J. (1994). Introduction: Caring for infants and toddlers in violent environments. Arlington, VA: Zero to Three.

Perry, B.D. (1993) Medicine and psychotherapy: Neurodevelopment and the neurophysiology of terror. The Advisor,6, 1-18.

Perry, B.D. (1994a). The effects of traumatic events on children: Material for parents. Houston, TX: CIVITAS Child Trauma Programs, Baylor College of Medicine.

Schiller, L. (1997). Rethinking stages of group development in women's groups: Implications for practice. Social Work with Groups, 20, 3-19.

Schwartz, H. J. (1984). An overview of the psychoanalytic approach to the war neuroses. In H.J. Schwartz (Ed.). Psychotherapy of the Combat Veteran. New York, NY: Spectrum.

Shulman, L. (1984). The skills of helping individuals and groups. Itasca, IL: F.E. Peacock Publishers.

Suh, E. & Abel, E. (1990). The impact of spousal violence on the children of the abused. Journal of Independent Social Work,4, 27-34.

Toseland, R., & Rivas, R. (1995). An introduction to group work practice. (2nd ed.). Massachusetts, WI: Paramount Publishing.

Walker, L. (1978). Battered woman and learned helplessness. Victimology, 2, 525-534.

Walker, L. (1984). The Battered woman syndrome. New York, NY: Springer.

Weider, S. (1997). Creating connections: Intervention guidelines for increasing interaction with children with multi system developmental disorder (MSDD). Zero to three, 19-27.

Westra, B., & Martin, H. (1981). Children of battered women. Maternal-child nursing Journal, 10, 41-54.

Winnicott, D.W. (1971). Playing and reality. London, England: Havistock.

Wolfe, D., Jaffe, P., Wilson, S., & Zak, L. (1986). Children of battered women: The relation of child behavior to family violence and maternal stress. Journal of Consulting and Clinical Psychology, 53, 657-665.

Wolfe, D., Zak, L., Wilson, S., & Jaffe, P. (1986). Journal of Abnormal Child Psychology, 14(1), 95-104.

Van der Kolk, B. (1987). The psychological consequences of overwhelming life experiences. In B.A. Van der Kolk (Ed.), Psychological trauma. Washington, DC: American Psychiatric Presss.

Zeanah, C., & Scheering, M. (1996). Evaluation of post traumatic symptomology in infants and young children exposed to violence. In J.Osofsky & E. Fenichel (Eds.), Islands of Safety, 9-14. Arlington, VA: Zero to three.