GROUP WORK WITH WOMEN AND CHILDREN IMPACTED BY FAMILY VIOLENCE

BY

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A Practicum Report
Submitted to the Faculty of Graduate Studies
in Partial Fulfillment of the Requirements
for the Degree of

MASTER OF SOCIAL WORK

Faculty of Social Work
University of Manitoba
Winnipeg, Manitoba
April 2002

THE UNIVERSITY OF MANITOBA

FACULTY OF GRADUATE STUDIES

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DEDICATION AND ACKNOWLEDGEMENTS

This practicum is dedicated to my husband Mirek and our daughters Mila and Madan. Their ongoing love, support and patience encouraged and enabled me to complete this practicum. Thank you.

In addition to the support and encouragement of my immediate family, the completion of this practicum would not have been possible without the assistance of several individuals.

I would like to thank the members of my practicum committee: Dr. Diane-Hiebert Murphy, University of Manitoba, Ms. Linda Perry, Therapist at Elizabeth Hill Counseling Centre, and Ms. Linda Burnside, Assistant Program Manager at Winnipeg Child and Family Services. Special thank you to my advisor, Dr. Diane Hiebert – Murphy, who not only provided valuable insight and clinical skills that facilitated my learning process but also made the process feel manageable. Also a special thank you to Ms. Linda Perry for her extensive involvement in all phases of the intervention, as well for the educational and personal support she provided to me throughout the practicum. Thank you to Ms. Linda Burnside for her time and interest in my practicum and the encouragement that she provided to me.

I would like to express my thanks to the co-therapists and volunteers who assisted in the group's success. Thank you to Louise Pelltier who co-facilitated the mothers' group. Louise's contribution was immense in terms of practical assistance, peer support, and friendship. Thank you to Raul Dimaculangan who assisted with the facilitation of the children's group. Thank you also to Ian Larke and Julie de

Rocquigny who volunteered their time to provide childcare for the families who participated.

I would like to acknowledge and thank the Elizabeth Hill Counseling Centre and its staff. This practicum would not have been possible without the support and cooperation of the staff and the Centre itself. The Centre provided a wonderful learning environment and I am very appreciative of having had the opportunity to conduct my practicum at Elizabeth Hill.

I would also like to acknowledge my primary place of employment, Winnipeg Child and Family Services, and thank my colleagues in the Pandora Service Unit. The Agency provided a flexible working environment that permitted me to complete the curriculum requirements for the Masters program and the practicum itself. To my colleagues Debbie Bond, Katherine Currie, Marla Fellner, Cheryl Kubish, Christine Lichti, Cindy Murdoch, Eve Omar, and Colleen Wilson, thank you. Individually and collectively you provided me support and encouragement throughout the practicum process. You frequently lifted my spirits, helped adjust my perspective and eased my anxieties. A special thank you to Debbie for being my "smiling" audience.

Finally, I would like to thank the families who participated in this practicum. Not only did their commitment to the group contribute immensely to my professional and personal learning, but also to the enjoyment of the experience.

ABSTRACT

Empirical and clinical research suggests that women who have been battered may experience elevated levels of parenting stress and that their children may experience increased internalizing and externalizing behavioral problems. These combined variables may place the mother-child relationship at risk for strain even after the battering has stopped.

The purpose of this practicum was to develop, implement, and evaluate an intervention designed to strengthen the mother-child relationship for women and children who had experienced domestic violence. A time-limited, structured, and closed group work approach was used which included a support/parenting skills group for the mothers and a parent-child multi-family group for the mothers and children. The intervention incorporated Theraplay theory and activities as a means to strengthen the parent-child relationship.

The group intervention, implemented at Elizabeth Hill Counseling Centre, ran for twelve weeks and initially consisted of six women and their children, ranging in ages eight to ten years. A total of three mothers and three children completed the group program. The practicum findings indicate that the group was moderately beneficial to the group members. Clinical impressions suggest the most significant impact of the intervention for the mothers was their experience of commonality and mutual support.

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Introduction

The development of this practicum was based upon two salient themes found in the empirical and clinical literature on the subject of parental violence and its impact on mothers and their children. Research suggests that women who have been battered may experience elevated parenting stress (Holden & Ritchie, 1991; Holden, Ritchie, Harris, & Jouriles, 1998; Levendosky & Graham-Bermann, 1998) and that their children may experience increased internalizing and externalizing behavioral problems (Jouriles, Murphy, & O'Leary, 1989; Levendosky & Graham-Bermann, 1998; Levendosky, 2000a). These combined variables, maternal stress and child behavior problems, may possibly place the mother-child relationship at risk for strain (Erel & Burman, 1995; Wolfe, Jaffe, Wilson, & Zak, 1986). It is believed that an intervention designed to strengthen the mother-child relationship may contribute to reducing these presenting issues. This practicum, in addition to assisting the clients with their presenting problems, contributes to an expanding social work body of knowledge in the areas of domestic violence and its impact on the mother-child relationship. Ultimately, it is hoped that increased information regarding these topics will enhance the assessment and treatment of such families.

There were several personal learning and intervention objectives that I hoped to achieve through the implementation of a group approach with women and their children who have been impacted by domestic violence. These were:

Personal Learning Objectives

1. To increase personal knowledge and understanding of the issues facing women and their children who have been impacted by domestic violence.
2. To implement and evaluate a group intervention for women and their children who have been impacted by domestic violence.
3. To develop practice skills in short term group counseling and become more familiar with the application of multi-family group therapy and Theraplay in small group work practice.

Intervention Objectives

1. To provide an intervention for women and their children who have been impacted by domestic violence.
2. To reduce maternal parenting stress.
3. To reduce the level of emotional and behavioral problems experienced by the children.
4. To enhance the relationship between the mothers and their children.

CHAPTER II – LITERATURE REVIEW

Introduction

The impact that domestic violence has on the mother-child relationship has recently emerged as an area of study. Carrying out optimal parenting behaviors is particularly difficult for mothers dealing with domestic violence. Battering has been determined to be a major parental stressor that may affect the woman's ability to parent her children adequately (Holden et al., 1998; Levendosky & Graham-Bermann, 1998; Wolfe et al., 1996). In addition, research on battering has also established a link between a woman's experience of violence in a relationship and her child's emotional and behavioral adjustment (Jaffe, Wolfe, & Wilson, 1990; Levendosky & Graham-Bermann, 1998; Wolfe et al., 1996).

The lasting effects of domestic violence may carry over to the parent-child relationship even after women and children are no longer in their abusive environments (Holden at al., 1998). As such, an intervention may be helpful for these mothers and their children to enhance the quality of the mother-child relationship that may have been compromised by the domestic violence.

Definitions

No consensual definition of domestic abuse exists. For the purposes of this practicum report, domestic violence is defined as any intentional act or series of acts that causes injury to a spouse. These acts may be physical, emotional, or sexual. The term spouse includes those individuals who are married, cohabiting, or involved in an intimate relationship. It also encompasses individuals who are separated and living apart from their former spouse (Wallace, 1999).

When reference is made to children's exposure to the violence directed at their mothers, wide ranges of experiences are encompassed. Children may *observe* this violence directly by seeing their father (or another intimate partner of their mother) threaten or hit their mother. They may *overhear* this behavior from another part of the residence, such as their bedrooms. When investigators ask women who have been beaten where their children are while they have been assaulted, in 90% of the cases children are either in the same room, or in the next room (Hughes, 1988; Rosenberg & Rossman, 1990). Children may be exposed to the *results* of the violence without hearing or seeing the commission of any aggressive acts. For example, children may see the bruises or other injuries clearly visible on their mother or the emotional consequences of fear, hurt, and intimidation that may be apparent to them (Jaffe et al., 1990).

Impact of Domestic Violence on Women

Women who are battered present a range of responses to their experience. Aside from physical injuries resulting from abuse, mental health sequalae to abuse are significant and prompt women to seek services as frequently as for their physical health problems (Campbell & Lewandowski, 1997). Research on the psychological effects of domestic violence on women has flourished in the past few years, concluding that survivors suffer increased adjustment problems (Finkelhor, Gelles, Hotaling, & Strauss, 1983; McCloskey, Figuerdo, & Koss, 1995; Sternberg et al., 1993). Battered women experience increased levels of depression, lower self esteem, and experience higher levels of psychological distress when compared with non-battered women (Cascardi & O'Leary, 1992; Sato & Heiby, 1992). High levels of violence and physical

abuse are positively correlated with the prevalence of posttraumatic stress symptoms with diagnoses ranging from 45% to 84% (Herman, 1992a; Houskamp & Foy, 1991; Saunders, 1994). Results of these studies are consistent in identifying patterns of symptoms appearing in this population, further suggesting that battered women as a population are at an elevated risk of developing pronounced mental health problems.

Theoretical Models of Psychological Impact of Domestic Violence on Women

Several theories have been proposed to explain how domestic violence contributes to the above-described mental health issues. Three primary theories referenced in the literature are the battered women's syndrome, traumatic bonding theory, and trauma response theory.

Battered Women's Syndrome

The battered women's syndrome has been described as a prolonged pattern of depressed affect and a general sense of helplessness, fear, and social withdrawal (Douglas, 1987). Walker (1978, 1984) applied the theory of learned helplessness and argues that a woman who is battered learns through repeated but failed attempts to stop the abuse that she cannot control the situation. As a woman recognizes her actions as ineffective in stopping the abuse, she stops taking overt actions to stop the violence. The syndrome has been subdivided into three major categories: the traumatic effects of victimization by violence, learned helplessness deficits resulting from the violence and others' reactions to it, and self-destructive coping responses to the violence (Douglas, 1987; Graham, Rawlings, & Rigsby, 1994; Herman, 1992a, 1992b; Walker, 1978, 1984).

Traumatic Bonding Theory

Hostage syndrome literature suggests that a woman views her batterer as her captor who is omnipotent and inescapable (Graham et al., 1994). Battered women are often isolated and living in an environment of threats and abuse that is alleviated only when the batterer shows some kindness. In time, women may focus on and try to elicit nurturance from their partners as a strategy of survival. Women may experience their batterers as simultaneously threatening their survival and as their only source of support or nurturance. This focus on the batterer can create distortions in a woman's ability to recognize that the batterer is the origin of the violence and in her ability to take overt action in response to the violence. The result is a traumatic bond between the woman and her abusive partner (Graham et al., 1994; Levendosky, 2000).

Trauma Response Framework

Many current mental health researchers and practitioners are conceptualizing the psychological effects of domestic violence within a trauma response framework. Trauma theory, proposed by Herman (1992a, 1992b), is focused on the traumatizing aspects of the violence and the trauma symptoms exhibited by battered women. The theory suggests that a batterer gains control over the woman's body through threats to a woman's safety as well as denying the woman the attainment of basic needs through actions such as deprivation of sleep, food, and shelter. The possible outcomes of chronic traumatic experiences include hyper-arousal, intrusion of memories of traumatic events, and constriction of emotions. A complex or chronic traumatic stress response, where the person is subjected to ongoing abuse, control, and terror, might be more adequate to explain the responses seen in battered women versus a single traumatic incident (Campbell, 1987; Dutton, 1993; Herman, 1992a, 1992b).

In summary these theories consistently reflect the ways in which domestic violence erode women's psychological health resulting in pronounced mental health issues. The results of domestic violence may contribute to diminished psychological health.

Impact of Domestic Violence on Children

The children who are exposed to the abuse of their mothers may also display harmful consequences. These children cannot be described by one particular pattern of response to their experience. Various studies report harm in several areas of functioning including behavioral, emotional, social, cognitive, and physical. Behavioral problems include aggression, tantrums, acting out, immaturity, truancy, and delinquency (Davies, 1991; Graham Bermann, 1996c; Hughes & Barad, 1983; Jouriles et al., 1989). Common emotional problems include anxiety, anger, depression, withdrawal, low self-esteem, and posttraumatic symptoms (Carlson, 1990; Davis & Carlson, 1987; Graham-Bermann, 1996; Graham-Bermann & Levendosky, 1998; Hughes, 1988; Jaffe et al., 1986; Sate & Heilby, 1992; Saunders, 1994). Social problems refer to poor social skills, peer rejection, and an inability to empathize with others (Graham-Bermann, 1996; Strassberg & Dodge, 1992). Cognitive difficulties generally include language lag, developmental delays, and poor school performance (Kerouac, Taggart, Lescop, & Fortin, 1986; Wildin, Wiliamson, & Wilson, 1991) and greater attention difficulties in school (Davis & Carlson, 1987; Figuero & Koss, 1995; Hughes & Barard, 1983; Jaffe et al., 1990; Sternberg et al., 1993). Physical problems include failure to thrive, problems sleeping and eating, regressive behaviors, poor motor skills, and somatic symptoms like eczema and bed-wetting (Goodson &

Delange, 1986; Jaffe et al., 1990). This greater level of harm is also manifested in medium and longer-term vulnerabilities. Subsequent research has found these children to be at risk for developing delinquent behavior during adolescence (Carlson, 1990; Koss et al., 1994; Wolfe, 1994) or for manifesting violence inside and outside of home during adulthood (Sugarman & Hotaling, 1989).

In summary, children who are exposed to family violence often display internalizing and externalizing behavioral problems resulting from the domestic violence. The behavior of these children may create additional parenting stress for their mothers who have been battered.

Understanding the Impact of Domestic Violence on Child Adjustment

Theory and research findings have been used to construct hypotheses regarding processes and mechanisms that contribute to the impact exposure to domestic violence has on children. When examining the effects of domestic violence on children three types of variables are thought to be responsible. These are: the type and extent of the violence, including the frequency and severity; the child's characteristics, including the child's age and gender; and the parenting received by the child, including the father's and the mother's response (Campbell, 1987).

Determinants of Parenting

To understand how parenting moderates child adjustment to domestic violence a brief review of an ecological model of parenting is useful. According to Belsky's (1984) process model of parenting, parental functioning is multiply determined by three general sources of influence: ontogenetic factors, microsystemic factors, and exosystemic factors. Ontogenetic factors include the parent's own developmental

history, personality, psychological well being, and personal psychological resources. Microsystemic factors refer to the immediate household, including the child's individual characteristics and the spousal relationship. Exosystemic factors refer to the larger social system surrounding the family including contextual sources of stress and support. Both the father's and the mother's quality of parenting are influenced by these ontogenetic, microsystemic, and exosystemic determinants.

Belsky (1984) suggests that parenting is a buffered system such that if there is a deficit in one determinant it can be buffered by a strength in another. Unfortunately, deficits in multiple areas, which can commonly occur in families affected by domestic violence, can further compound difficulties in parental functioning. Furthermore, the spousal relationship is of extreme importance, as it is the first order support system, with inherent potential for exerting the most positive or negative effect on parental functioning (Belsky, 1984). In families where there is domestic violence, all three determinants of parental influence are believed to be adversely affected. The personal psychological well-being of the mother is affected (ontogenetic factor), children's adjustment may be poor and marital stress is increased (microsystemic factors), and life stress may be elevated (exosystemic factor). This crucial link, between parenting and child adjustment, implies that the spousal relationship may exert an effect on children's development through its association with parenting (Erel & Burman, 1995). The reciprocal influence of these interrelated factors provides the context in understanding the impact of domestic violence on parenting and its influence on child adjustment.

Indirect Determinants

Jaffe and his colleagues (1990) theorize that children are affected by partner violence both directly and indirectly through the impact the violence has on their parents. Direct effects include physical danger to the child and the learning of aggressive behavior patterns. Many of these direct affects are thought to be mediated by the father, since he is often the abusive parent (Hughes, 1997). Indirect effects ensue from characteristics of father-child and mother-child interaction. With respect to father-child interaction, indirect effects may include exposure to paternal anger and irritability. Holden and Ritchie's (1991) study reflected battered women's reports that their husbands were highly irritable, were less involved in child-rearing, and used less induction and physical affection but more negative control techniques like physical punishment in their parenting practices. With respect to mother-child interaction, indirect effects may include maternal physical and psychological ill health from the stress of being abused and, similar to fathers, inconsistent or overly harsh parental disciplinary practices (Hughes, 1997). To date, evidence supporting these indirect, disruptive influences of family violence on children's adjustment has been difficult to gather because of the large number of factors that must be taken into consideration and the reliance upon correlational findings which cannot imply causality (Jaffe et al., 1990).

Notwithstanding these methodological issues, it is important to examine the indirect mechanisms of the violence on the child in order to formulate an intervention approach. Given that the intervention that was developed for this practicum focused upon the mother as the child's primary caregiver, the indirect effects that are thought to be mediated by the mother require examination in greater detail. These characteristics

include the mother's physical and psychological health, as well as parenting practices, including inconsistency and harsh discipline.

Maternal Depression and Stress

For children, the risk of harm comes not only from exposure to frightening and emotional scenes involving parents, but also from the toll on the parents' abilities to maintain close and positive parent-child relationships. Most children turn to their mothers for help in coping with problems. Domestic violence may impact maternal parenting through increased maternal depression and stress. Depression has been reported as the primary mental health complaint of women who have been battered (Hamberger, Saunders, & Hovey, 1993). Depression is a prime example of a variable that has been shown to affect parenting (Patterson, 1990). In some cases, a depressed mother may not be consciously aware of the influence of the marital conflict on her parenting behavior (Holden et al., 1998). Living in a violent relationship also heightens stress (Jaffe et al., 1986). A mother's life may be so disrupted by the stress of her own victimization that she is unable to respond to her children's concerns and fears. Indeed, it is difficult to imagine that mothering is not affected in some way by living in such a hostile environment. Violence between parents is likely to be distracting at the very least; more likely it is consuming and debilitating. Attention and energy must be devoted to monitoring and assessing the partner's mood and propensity for violence, engaging in frequent verbal combat, and defending oneself and one's children against verbal and physical attacks. These mothers undoubtedly fear for their own safety (Hilton, 1992). Moreover, partner violence is often accompanied by additional burdens therefore mothers may be dealing with stresses from divorce,

money problems, unemployment, or homelessness, as well as assault (Jaffe et al., 1990). All of these factors may interfere with a mother's ability to help her children cope with their distress. For some domestically violent families, children who cannot count on their mother's psychological stability as a parent are more likely to develop internal paradigms of relationships that encourage withdrawal and depression (Wolak & Finkelhor, 2000).

Maternal Inconsistency and Discipline Style

Parental inconsistency in child rearing and harsh discipline practices can contribute to the development of child behavioral problems (Belsky, 1984; Holden & Ritchie, 1991; Holden et al., 1998). The Family Disruption Explanation (Emery, 1989) believes that the impact of stress on child adjustment is mediated by family management practices. If stressors disrupt parenting practices, then the child is placed at risk for adjustment problems (Patterson, DeBarysche, & Ramsey, 1992). The absence of consistent, effective child management may be a particular problem within domestically violent families for two reasons: parents may disagree more about child rearing and may communicate poorly, and mothers may respond differently to their children in the presence of the spouse (Holden & Ritchie, 1991). As previously reviewed, children in domestically violent homes may experience increased internalizing and externalizing behavioral problems resulting from the violence. In some circumstances, problematic child behavior, which evolved from the violence, may play a reciprocal role in the family's dysfunction, by placing counterstress upon the marital relationship and upon the mother's child rearing abilities (Belsky, 1994; Jaffe et al., 1990). Acknowledging this reciprocal relationship is not to suggest that the

child is responsible for the parenting they receive, rather it can assist in understanding the conditions under which certain people may be more or less likely to be poor parents (Herzberger, 1996). Parents who are coping with their own violent relationships may be unable to provide consistent supervision and guidance to their children (Holden & Ritchie, 1991; Jaffe et al., 1990). Parents may fail to teach their children to control aggression and may even unwittingly reinforce aggressive tendencies by ignoring them or backing down from confrontations over violent acts (Wolak & Finkelhor, 2000).

Increased reliance upon harsh discipline is another suspected cause of child behavior problems (Jaffe et al., 1990; Jouriles et al., 1987, McLoyd, 1990). For women who have been battered this aggression may develop in at least four ways. First, a violent marital interaction may spill over into child rearing behaviors, prompting mothers to interact in an aggressive manner with their children because of such processes as emotional contagion or behavioral momentum (Holden et al., 1998). Second, maternal stress is a mechanism that could account for the link between marital violence and mothers' child-directed aggression. Stressed parents are more likely to engage in punitive, excessively harsh, and negative child rearing behavior (Easterbrooks & Emde, 1988; Jaffe et al., 1990; Jouriles et al., 1987; McLoyd, 1990). The aggression towards the children can also perhaps be explained by the bi-directional determinants of behavior. Given the high rate of child misbehavior and externalizing problems in many of these children, at least some of the mother-to-child disciplinary actions undoubtedly escalate to the point of violence (Holden et al., 1998). Finally, related to a social learning explanation, mothers, who are victims of marital aggression,

may learn first hand that aggression can be used to get one's way and therefore use it with children (Holden et al., 1998).

In summary, children who are exposed to domestic violence may have increased emotional and behavioral problems. Women who have been battered may experience an elevation in their level of parenting stress. Even when a positive mother-child relationship can be maintained, it can be very difficult for mothers to buffer the impact of the marital violence on their children, due to the direct and indirect effects mediated by the fathers (Erel & Burman, 1995). Although many families are resilient, for some the combination of the children's needs and heightened parental stress consequently can contribute to a deterioration in the quality of maternal parenting (Holden et al., 1998; Jaffe et al., 1990).

Empirical Support – Linking Domestic Violence, Parenting and Child Adjustment

General research on parenting in stressful circumstances has demonstrated that parental functioning is quite vulnerable to environmental stress (Abidin, 1990, Belsky & Vondra, 1989; Conger et al., 1992; Conger et al., 1993; Erel & Burman, 1995; McLoyd, 1990; Pianta & Egelkand, 1990; Torturo, 1994). A few studies have examined the relationship between maternal parenting and children's adjustment in domestically violent homes (Holden & Ritchie, 1991; Holden et al., 1998; Jaffe, Wilson, & Zak, 1985; Levendosky, 2000; Levendosky & Graham-Bermann, 1998; McCloskey et al., 1995; O'Keefe, 1994a; Sullivan et al., 1997; Wolfe et al., 1986).

In general, researchers have reported that psychological and physical abuse of women by their partners creates high levels of maternal stress, particularly stress related to parenting, which negatively affects the quality of parenting provided to the

child (Holden & Ritchie, 1991; Holden et al., 1998; Levendosky & Graham-Bermann, 1998). Researchers have also reported that the stress in parenting is linked to increased internalizing and externalizing child behavior problems (Jouriles et al., 1989; Levendosky & Graham-Bermann, 1998; Levendosky, 2000a). It has been noted that increased maternal physical and emotional availability was related to better outcomes for children (Sullivan et al., 1997). The combined variables of maternal stress and child behavior problems place the mother-child relationship at risk for strain (Erel & Burman, 1995; Wolfe, Jaffe, Wilson, & Zak, 1986).

Most of the studies have focused on levels of aggression and violence directed by mothers towards their children. Very few other parenting variables have received attention. Only three studies reported information concerning maternal behavior beyond reports of mother to child aggression (Holden & Ritchie, 1991, McCloskey et al., 1995; O'Keefe, 1994a). Of these three studies, the majority used maternal self-report data on parenting, which is inherently limiting in that social desirability and low self-esteem may bias results. It is possible that mothers' perceptions of their children as deviant may be affected by their own negative feelings about themselves and their marriages (Bond & McMahon, 1984).

Three recent studies have focused on maternal parenting and utilized qualitative narrative analysis or quantitative observational measurement (Levendosky & Graham-Bermann, 1998; Levendosky & Graham-Bermann, 2000; Levendosky 2000a; Levendosky, Lynch, & Graham-Bermann, in press). The results of these studies have confirmed the findings mentioned above. Levendosky (2000a) implemented a qualitative study consistent with feminist theory that examined women's narratives

about parenting in domestic violence situations. The study was an initial exploration of maternal perception of the impact of partner violence on parenting. Thematic analysis of these narratives revealed that most women believed that their parenting was affected by their partner's violence. Interestingly women reported not only negative effects of the violence on their parenting, but also some positive effects indicating that woman frequently mobilized their resources to respond to the violence on behalf of their children. These findings are in contrast to theoretical conceptualizations of women who have experienced domestic violence as helpless or as focused solely on their batterer's needs (Levendosky, 2000a).

Levendosky, Lynch, and Graham-Bermann (in press) also conducted a similar qualitative study. The women's narratives revealed that the abuse was seen as interfering with their ability to give love and time to their children. Overall, it appeared that the psychological abuse was a more significant aspect of the abuse in damaging women's parenting. It was also more strongly related to women's trauma symptoms, supporting the traumatic bonding effects theory observed in domestic violent relationships (Graham & Rawlings, 1991; Levendosky & Graham-Bermann, in press b).

Finally, Levendosky and Graham-Bermann's (2000) study was unique in using behavioral observation of battered women and their children in dyadic interactions in order to obtain a third party report of the quality of parenting by these women. The reliance upon third party reports confirms the findings of studies that have used only mother's reports. The validity of using only mother's reports in studies of children of battered women has been questioned since the high levels of distress, depression, or

anxiety the mothers are experiencing may lead them to have less tolerance for and be less aware of the needs and responses of their children (Campbell, 1987).

The results of this study demonstrate partial support for three hypotheses. First, domestic violence appeared to play a significant role in predicting a decrease in parenting warmth, suggesting that the experience of abuse depletes one's ability to give emotional support to others, including one's children. Second, psychological abuse to the mother was shown to predict antisocial behaviors within the children, suggesting that in families where mothers are abused, children begin to take on characteristics of the abuser in their interactions with their mother. Third, and finally, maternal authority-control was significantly affected by psychological abuse, not physical abuse, suggesting that the psychological abuse was more damaging to women's parenting (Levendosky & Graham-Bermann, 2000).

This study provides further evidence that the experience of domestic violence affects women's parenting behaviors, not only as a reflected in self-report data, as had previously been shown, but also in observed behaviors. The study controlled for maternal reports of depression, demonstrating that the results are not purely mediated through maternal psychological functioning. The study also noted that there was a significant relationship between maternal self-reports and observer reports of children's behaviors suggesting that both observational and maternal reports are valid means of assessing child behavior. In sum, abuse of the woman by her partner was a significant predictor of maternal parenting behavior. The findings lend support to the notion that multiple stressors are related to parenting style and that battering is one experience that may negatively impact the woman's ability to parent her children adequately. The

most important finding in this study is that battering has a direct negative impact on women's parenting, which in turn is related to children's behaviors (Levendosky & Graham-Bermann, 2000).

In summary, domestic violence can have a significant impact on the women who are battered and on the children who are exposed to the violence. Both clinical and empirical evidence indicates that women who are battered are at risk of experiencing elevated levels of parenting stress and that the children in these homes may experience increased emotional and behavioral problems. The link between parenting stress and child adjustment suggests that an intervention, which can address the parent-child relationship, may be beneficial for both mothers and children.

Theories Utilized for Intervention

The models of intervention chosen for this practicum include a mothers support group and a parent-child multi-family group utilizing Theraplay activities. The literature will therefore focus upon group work theory, support group work with women who are battered, parenting group work with women who are battered, parent-child multi-family group work, as well as Theraplay.

Group Work

The practice of group work is used by a wide variety of helping professionals including social workers (Toseland & Rivas, 1995). Group work incorporates the values of social work and social work practice, with importance placed upon three values in particular. These include the group member's ability to help one another, the group's ability to empower people and the group's ability to promote understanding among people from diverse backgrounds (Toseland & Rivas, 1995).

Types of Groups

Groups generally fall into two main categories: Task and Treatment Groups. Treatment groups as outlined by Toseland and Rivas (1995) can be further classified by their primary purposes, which are (a) support, (b) education, (c) growth, (d) therapy, and (e) socialization. In practice settings, there are innumerable variations of treatment groups that combine these five primary purposes. The primary purpose of the group for this practicum was comprised of support and therapy. Support groups are designed to help members cope with stressful life events and revitalize and enhance their coping abilities to more effectively adapt to and cope with future stressful life events (Toseland & Rivas, 1995). Therapy groups are designed to help members change their behavior, cope with and ameliorate personal problems, or rehabilitate themselves after a social or health trauma (Toseland & Rivas, 1995).

Composing the Treatment Group

Many factors need to be considered when composing a therapy group. Choices in regards to homogeneous or heterogeneous member selection, group size, open and

closed membership and time limits need to be determined. Group leadership is another important element to be considered.

Homogeneous and Heterogeneous Groups.

Homogeneity refers to selection of group members based upon similarities which may include their purpose for being in the group or personal characteristics which they have in common with other group members (Corey & Corey, 1997, Toseland & Rivas, 1995). Homogeneity helps facilitate communication and helps members identify with each other's concerns, problems, and tasks. Additionally, commonalties assist members in building relationships with each other (Toseland & Rivas, 1995). Heterogeneity refers to selection of group members based upon differences and it is thought that there should be some diversity of member coping skills, life experiences, and levels of expertise (Toseland & Rivas, 1995). Differences within these areas provide multiple opportunities for support, validation, mutual aid, and learning among members (Toseland & Rivas, 1995).

Group Size.

The size of the group should be determined by criteria including the purpose of the group and the needs of the members. Toseland and Rivas (1995) suggest that the group should be small enough to allow it to accomplish its purpose, yet large enough to permit members to have a satisfying experience. In general, a treatment group should have about six to eight persons, with an outer limit of ten (Wickham, 1993).

Open or Closed Membership.

The choice between an open or closed group membership is affected by the purpose of the group. Open groups maintain a constant size through the replacement of members

as they leave, whereas closed groups ideally begin with and end with the same membership (Toseland & Rivas, 1995). The closed group usually meets for a predetermined number of sessions and is thought to have several benefits, including a greater sense of cohesion and cooperation amongst members; increased stability of roles and norms; and higher group morale (Toseland & Rivas, 1995; Wickham, 1993).

Time Limits.

A time limited treatment group, which has a closed membership, offers several advantages. These include cost effectiveness, establishment of firm and clear boundaries from the outset, promotion of goal oriented work, facilitation of bonding to help members focus on the future, and allowance for more clients to have access to the program (Brown, 1991).

Group Leadership.

Group leadership refers to the process of guiding the development of the group and its members to achieve goals that are consistent with the value base of social work practice (Toseland & Rivas, 1995). The interactional model of group leadership, described by Toseland and Rivas (1995) acknowledges that leadership is shared between the worker and the group members. The model clearly shows that leadership emerges from a variety of interacting factors as the group develops, including the purpose of the group, the type of problem being confronted, the environment; the groups as a whole, and the group members.

While the interactional model of leadership contributes to the achievement of goals, certain leadership skills are also thought to be helpful. Toseland and Rivas (1995) describe a functional classification of group leadership skills that have been

divided into three areas: a) facilitating group processes skills, b) data gathering and assessment skills, and c) action skills. In general, skills used in one area commonly are combined with another area. Combinations of these skills are helpful to facilitate the group process, bridge process to action, and to achieve the group goals (Toseland & Rivas, 1995).

Another issue related to leadership is whether groups are more effective when offered by one leader compared to two. Literature suggests that co-leadership has many advantages both to the worker and for the group members (Brown, 1991; Toseland & Rivas, 1995). With respect to group work with women who have been battered, NiCarthy et al. (1984), as well as Butler and Wintram (1991), have similarly recommended the use of coleaders because it fits with the feminist philosophy of mutual support. Benefits for the workers include the sharing of responsibility, the receiving and giving of emotional support, and the opportunity to debrief after the sessions, which lessens the probability of burn out, always high in work with this population, as studies have shown (e.g., Horton & Johnson, 1993). Benefits for group members include modeling a relationship based on equality, respect, and caring, and demonstration that two people can be different and yet accept their differences, work together, and accommodate and adapt to each other (Toseland & Rivas, 1995; Wickham 1993). It has also been suggested that two leaders are advantageous in group Theraplay. Theraplay, which relies upon an interpreting therapist and incorporates a high degree of physical activities in sessions, proves two leaders to be preferred (Jernberg & Booth, 1999).

Group Stages

The premise that groups move through a developmental sequence is a core concept in group work. Generally, groups are viewed within a developmental framework although slight variations exist within the titles of the stages (Brown, 1991; Garland, Jones, & Kolodny, 1973; Shiller, 1997; Toseland & Rivas, 1995; Wickham, 1993).

This practicum utilized the Relational Model of group work proposed by Shiller (1997). The Relational Model of group work is based upon women's development called "self in relation" theory proposed by Gilligan (1982). The five main components of this theory are:

1) Relationship is seen as a basic goal of women's development.

2) Empathy is a crucial feature.

3) The parent-child relationship is seen as the paradigm or model for other relationships.

4) The basic developmental task is relationship-differentiation, which takes place within, rather than after, instead of, or outside of, the context of the relationship itself.

5) Relational authenticity, feeling connected, clear and vital in relationships, is valued, including risk, conflict, and expression of the full range of affect (Gilligan, 1982; Schiller, 1997).

The Relational Model understands that women go through stages of group development differently than men and children and thus do not fit the common stages of group process developed by many theorists. The model, derived from feminist scholarship, takes into account the centrality of connection and affiliation for women in defining and ordering stages of group development. Compared to many models of

group development while the first and last stages, pre-affiliation and termination remain the same, the three middle stages are better seen as establishing a relational base, mutuality and interpersonal empathy, and challenge and change (Schiller, 1997).

Stage One - Pre-Affiliation

Pre-affiliation as the beginning stage of group development involves members becoming oriented towards each other, being accepted and learning more about the group (Johnson & Johnson, 1997). For the members, the central issues in this first stage are that of trust and commitment (Corey & Corey, 1997). For the worker, tasks include identifying common needs and interests of members and the establishment of a safe and comfortable working environment for the treatment process (Glassman & Kates, 1990; Wickham, 1993).

Stage Two -Establishing a Relational Base

Establishing a Relational Base, as the second stage of group development, is in contrast to mainstream group models which view this stage as a time when conflict is high (Garland et al., 1973). Overall, this stage is a time when women come together to form bonds of affiliation and connection and to establish the felt sense of safety in the group. Establishing this relational base will enable them to later move into more challenging activities, including difficult topic exploration and dealing with conflict in the group (Schiller, 1997). For the worker, tasks include tuning into issues of affiliation, similarity and safety, and highlighting these commonalties amongst the women to be valued and healthy. The establishment of affiliation and commonality are crucial in this stage of the group (Schiller, 1997).

Stage Three - Establishing Mutuality and Interpersonal Empathy

Establishing Mutuality and Interpersonal Empathy, as the third stage of group development, can be characterized by intimacy and differentiation, trust and disclosure, mutuality in therapeutic/member relationships, and modeling the sharing of power. This third stage of group development incorporates both elements of intimacy and differentiation, moving beyond simple connection and recognition of sameness to a stage of mutuality that allows for both empathetic connection and for differences. Here trust and disclosure are paired with recognition and respect for differences. While not engaged in overt conflict or challenges at this stage, members are able to allow and appreciate each other's differences within the framework of their affiliation and connection. A key difference in the Relational Model is the recognition of the mutuality in the therapeutic relationship between worker and members, as well as the mutual aid among members. This means that the worker acknowledges to herself and to the group how she is impacted or touched emotionally by what is happening in the group. The central perspective of therapy is movement and change. Change happens because the client can be moved by the worker, and the worker can be moved by the client. This movement occurs through empathy. Feedback that honors and acknowledges a person's ability to connect and have an impact is crucial. Another area of practice where mutuality is significant is in the area of co-leadership. Workers here can model mutual respect in spite of differences, and members are able to witness a sharing of power. A Relational Model of co-facilitation provides an example of cooperation within power and authority and an appreciation of both similarity and differences (Schiller 1997).

Stage Four – Challenge and Change

The Relational Model contrasts previous theory on group development by asserting that conflict typically occurs much later in women's groups. Challenge and Change, as the fourth stage of group development, can be characterized by high potential for growth, building upon earlier stages of development to process issues of power, authority and conflict, managing conflict while maintaining affiliative bonds, expression in range of emotion, and risk taking. This is potentially the most growth producing stage of group development, hence the most difficult. This stage poses a challenge that is often at the heart of growth for women: how to engage in and negotiate conflict without sacrificing the bonds of empathy. The idea of managing conflict in stage four nicely summarizes the ideal outcome of work done in stages two and three, during which the tools are built that can then be used to negotiate this fourth stage. In this regard conflict for women is not a stage of group development that must be worked around, rather conflict itself is an area which requires working on. The role of the worker at this stage is to help women maintain their connection through the expression of the full range of emotions, including anger and conflict. Members should be encouraged by the worker to take risks in confronting themselves, other members, the facilitator, or someone or idea outside of the group. By the time the group reaches this fourth stage, workers traditionally have seen this as a time when the group can pretty much run itself, needing little input from the workers. If however, in women's groups the challenge to embrace power and not shy away from conflict occurs at this stage, it is possible that the worker's role needs to be different as well. The group may need additional support and guidance to successfully negotiate this

stage. In other words there may be a call for increased rather than decreased worker activity at critical moments in this stage (Schiller, 1997).

Stage Five- Termination

Termination, which is the final stage of the group's development, can be characterized by withdrawal of commitment by group members with a reemphasis on the individual. Observable patterns of behavior are fairly consistent when describing the reactions of members regarding termination. Separation, as described by Garland et al. (1973), can include reactions of flight, denial, regression, a need to continue, recapitulation, review, and evaluation. While the worker will continue many tasks of the beginning and middle phases, the primary effort is directed towards helping members perceive the termination as a symbol of their growth, stabilize the gains which they have made, and to prepare for ending.

Group Dynamics

Group dynamics refer to the forces that result from the interactions and behaviors of the individual members and the group as a whole (Toseland & Rivas, 1985). Understanding group dynamics is essential for working effectively with groups in order to promote positive outcomes for the group members. Toseland and Rivas (1995) suggest four group dynamics to be central it understanding and working effectively with groups. These are a) communication and interaction patterns, b) group cohesion, c) social control exerted in groups, and d) the group culture that develops.

Communication and Interaction Patterns

As members of a group communicate to one another, a reciprocal pattern of interaction emerges. These interactional patterns that develop can be beneficial or

harmful to the group. Open group-centered communications are often the preferred pattern of communication. A group worker who is knowledgeable about helpful communications and resulting interactions can intervene in the patterns that are established in order to help the group achieve desired goals and to ensure the socio-emotional satisfaction of members (Toseland & Rivas, 1995).

Cohesion

Members initially attend groups for a variety of reasons. Cohesion refers to the evolving dynamic that promotes members to remain in the group. Many factors contribute to the development of cohesion. These include a high level of open communication, cooperation amongst members, reasonable group size, identification of members' expectations and needs, and achievement of group goals (Toseland & Rivas, 1995). The benefits of cohesion can include maintenance of membership, higher attendance rates, and increased personal satisfaction for members (Toseland & Rivas, 1995; Yalom, 1985).

Social Control

Social control is the term used to describe the process by which the group as a whole gains sufficient compliance and conformity from its members to enable it to function in an orderly manner. Social control results from forces generated by several interrelated factors including norms, roles, and status of members (Toseland & Rivas, 1995).

Norms refer to shared expectations and beliefs about appropriate ways to act in the group and they generally develop as the group evolves. Norms are helpful because they provide clear guidelines for acceptable behavior, and therefore increase

predictability and security for members. In some instances, deviation from norms is helpful as it allows the introduction of new behaviors that can be beneficial for the group. Norms are very powerful and are not easily modified; therefore the worker should try to ensure that developing norms are beneficial for the group (Toseland & Rivas, 1995).

Roles are shared expectations about the functions of individuals in the group and are important for the group because they allow for the division of labor and appropriate use of power within the group. A role not only prescribes certain behavior but also prohibits deviation from expected behavior (Toseland & Rivas, 1995).

Status refers to an evaluation and ranking of each member's position in the group relative to all other members. A person's status is multiply determined. How well a person is liked, his/her level of expertise, and his/her level of responsibility in relation to others in the group may determine status. A member's status level may influence his/her conformity to group norms, as s/he may have a vested interest in maintaining or changing his/her level (Toseland & Rivas, 1995).

Group Culture

Group culture refers to values, beliefs, customs, and traditions held in common by group members. The culture that a group develops has a powerful influence on its ability to achieve its goals while satisfying members' socio-emotional needs. A culture that emphasizes values of self-determination, openness, fairness, and diversity of opinion can do much to facilitate the achievement of group and individual goals (Toseland & Rivas, 1995).

Group Work with Women Impacted by Domestic Violence

Many possible intervention formats exist that can address the issues presented by women who have been impacted by domestic violence. Group work, as one modality, can be introduced to assist women with their emotional recovery from the battering experience, with unique parenting issues, as well as parent-child relationship issues.

Support Group Work

Many authors recommend a support group format when working with women who have been battered (Campbell, 1986; Holiman & Schilit, 1991; NiCarthy et al., 1984; Seskin, 1988; Trimpey, 1989). According to Schopler and Galinsky (1993), support groups fall on a continuum between self-help groups and therapy groups. They differ from therapy groups in that although professionals may be present as leaders, an essential aspect is the use of group members in supporting and teaching each other. Boyd (1985), Breton and Nosko (1997), Harris (1985), and Saunders (1993) all recommend the support group as the most beneficial treatment modality with woman who have been battered. According to these authors, compared to other approaches, support group intervention:

1. Offers a warm, accepting, and caring milieu in which women can feel secure and appreciated.
2. Reduces feelings of isolation and stigmatization.
3. Provides an atmosphere of mutual encouragement and support.
4. Provides the ideal structure for consciousness raising, that is, for dispelling a number of false perceptions, as well as for instilling new perceptions.
5. Provides an efficient venue for accessing information on how other women handle their situations and on what they have done or are doing to change these situations.

Generally, support groups for women who have been battered appear to be working towards achieving common objectives that are well founded in the literature, including increasing self esteem, locus of control, and social support, and decreasing stress levels and levels of family violence (Tutty, Bidgood, & Rothery, 1996).

Treating women in a support group format is supported by outcome research conducted on group programs. Of four published studies, three (Cox & Stoltenberg, 1991; Holiman & Schilit, 1991; Tutty, Bidgood, & Rothery, 1993) found statistically significant pretest/posttest improvements in areas such as self-esteem, anger levels, attitudes toward marriage and the family, and depression (Tutty et al., 1996). Although the research in this area is minimal, these results can be interpreted as providing initial evidence of the efficacy of group intervention with these women.

Parenting Group Work

The literature demonstrates that quality of parenting is vulnerable to the influences of family violence. For women who have been battered, offering parenting instruction that specifically addresses issues relevant to how their experiences of violence has affected their parenting, rather than general parenting classes, would likely better meet their needs (Levendosky, 2000). An example of a specific parenting issue common for this population is the need for mothers to develop parental authority and control over their children. Women may benefit from assistance in seeing the ways in which both psychological violence, such as ridicule, and physical violence, such as being pushed, may undermine their authority with their children. It may be that many of these women, because of their own experience of battering, have a difficult time using their authority with their children, which then serves to put their children at

risk for antisocial behaviors (Levendosky 2000; Levendosky & Graham-Bermann, 2000). Although the literature highlights unique parenting issues for women who have been battered there remains limited information suggesting the ideal format to provide such specialized parent education and skills development.

Within the literature, two interventions were mentioned that did rely upon a group work component to address parenting issues for this population. Hughes (1982) described one such program where a group work approach was utilized to provide parent education and training to mothers who were battered. The mothers group component was one part of a brief intervention with children in a battered women's shelter. The interventions which were used with the mothers were essentially child focused and consisted of an educative approach directed toward both the improvement of parenting skills, and the enhancement of knowledge of the children's emotional needs. The women were introduced to these basic ideas in a weekly group parenting meeting. The educative approach consisted of talking with the mothers regarding their individual parenting styles, giving them support for their efforts, and providing suggestions related to alternative forms of interaction or discipline. Lecklitner et al. (1999) also described the use of a group work format to address parenting issues for women who had been battered. The mothers group component was one part of an intervention for children who had been neglected and/or abused and for their mothers where co-occurring domestic violence had been identified. The program consisted of twelve weeks of concurrent groups for mothers and their school aged children. The mothers group provided support and encouragement of existing maternal strengths and coping skills. Clinical efforts were directed towards improving parenting skills,

increasing safety planing, identifying emotions, reducing trauma symptoms, and establishing positive coping strategies to practice at home.

Neither of these interventions, which utilized a group work component, evaluated the effectiveness of the intervention for the mothers or children. Although the merits of these group work interventions, as a means to provide parent skills and training cannot be supported by outcome research, other interventions which focused upon parent skills training suggest positive outcomes. Holden et al. (1998) provided individual parent education and skills training to women who had been battered. The intervention that Holden described focused upon similar objectives to those who utilized a group work component, including parent education, support, and enhancing the understanding of children's needs. Positive benefits of the intervention were noted for mothers and children. Mothers became less distressed and improved their parenting, becoming both better managers of their children's behaviors and increasing their display of warmth and involvement with their children. In response, children's behavior improved remarkably. These results suggest that incorporating parenting skills training as an intervention for women who have been battered can simultaneously enhance their parenting and address the damaging effects of spousal violence on children (Holden et al. 1998).

Multi-Family Group Work

O'Shea and Phelps (1985) define Multi-family therapy groups as:

> A deliberate, planful, psychosocial intervention with two or more families present in the same room with a trained therapist for all or most of the sessions. Each participating family should have two or more members that represent at least two

> generations in the family and are present for all or most of the sessions. Sessions should have an explicit focus on problems or concerns shared by all family members in attendance. These focal problems should pertain directly or indirectly to cross-generation family interactions. Sessions should implicitly or explicitly emphasize patterns of interfamilial interaction, as well as utilize actual or potential alliances amongst members of different families based upon similarities of age sex, focal problem or family role (p. 573).

In summary, multi-family therapy groups include children, parents, and a facilitator; are problem focused; and are explicitly interactionally oriented both within the family unit and between family units (McKay et al., 1995).

Treating families in multiple groups has proven effective in a number of settings, suggesting that a family simultaneously benefit from the intra-personal and inter-personal dynamics of each family involved in treatment (Sherman, 2000). Rhodes and Zelman (1986) utilized multi-family group therapy specifically with women who had been battered and their children. Their clinical impression following intervention suggested a strengthened parent-child relationship with enhanced cohesion and mental health support occurring within families. Meezan and O'Keefe (1998) compared the effectiveness of multi-family group therapy with traditional family therapy with abusive and neglectful caregivers and their children. The study found that multi-family group therapy appeared to be more successful not only in fostering improvements in family functioning, but also fostering improvements in child behavior. Greenfield and Senecal (1995) introduced recreation based multi-family groups as a modality for treating children and families where the children had been

diagnosed with a variety of externalizing behavioral disorders and the families had a documented history of aggression, either between parents or between the parents and the children. The study noted that the pleasurable recreational approach led to different and richer ways of relating between the children and members of their families; these approaches were then viewed as a medium to repair interpersonal family conflicts.

Multi-family therapy groups have strengths similar to all therapy groups. Benefits include providing a supportive environment, validation of personal experiences, and reduction in social isolation. In addition, multi-family therapy groups provide exposure to new parenting skills and multiple sources of feedback. The multi-family approach provides an alternate context for parents to listen to their children, promotes intense focus between family members, and provides an opportunity to practice new behaviors and skills as a family in a protective supportive environment (Cassano, 1989; McKay et al., 1995). Multi-family therapy is contraindicated for chaotic families, preschool children with families and for families in which an important pertinent fact is kept as a secret from other family members (Cassano, 1989). Multi-family group therapy is especially useful for situations where treatment requires a didactic component. Families which demonstrate social isolation and families in which parental authority, responsibility and role performance have broken down also benefit from this modality (Cassano, 1989; O'Shea & Phelps, 1985).

Theraplay Intervention

Research suggests that mother-child interactions do not necessarily improve as a result of the mother's moving away from the batterer (Holden et al., 1998). In circumstances such as these, Theraplay may be an appropriate intervention to target

parent-child relationships that may have been adversely affected by the exposure to the domestic violence.

Theraplay can offer a positive, strength focused approach, which relies upon enhancing the parent-child relationship. The Theraplay approach assumes that change is possible and that the essential ingredient of change lies in the creation of a more positive relationship between the child and the parents (Koller & Booth, 1997). Theraplay is modeled on the natural, healthy parent-infant relationship and involves replicating as much as possible the pleasurable interactions that are an essential part of the healthy parent-infant relationship; therefore treatment actively involves parents. The goal of treatment is to enhance attachment, self-esteem, trust, and joyful engagement to empower parents to continue on the health-promoting interactions learned during treatment sessions (Jernberg & Booth, 1998). The goal for Theraplay treatment for all children is three-fold: to help the child replace inappropriate solutions and behaviors with healthy, creative, and age appropriate ones; to increase the child's self-esteem; and to enhance the relationship between the child and his/her caretakers (Jernberg & Booth, 1998). Parents are essential to the process of changing the relationship between themselves and their child. Parents are their child's primary caregiver; therefore they are the ones whom the child should turn to for security and comfort. The goals for parents include: teaching them how to respond more empathetically to their child's needs; helping them interact in new ways that promote their child's healthy development; and providing them with the skills that will enhance their relationship with their child (Jernberg & Booth, 1999).

Theraplay was developed by Ann Jernberg (1979), based upon the work of Des Lauriers (1962), Des Lauriers and Carlson (1969), and Brody (1978, 1993) (Koller & Booth, 1997). Theraplay has four major assumptions that are understood in the context of attachment and bonding theories of development.

1. The Theraplay approach assumes that the primary motivating force in human behavior is a drive toward relatedness. Personality development is essentially interpersonal. The interaction between parent and child is the crucible in which the self and personality develop (Ainsworth, 1969; Bowlby, 1969; Stern, 1985).
2. The playful (Stern, 1969), joyful empathic (Kohut, 1984), attuned responsive caretaker (Winnicott, 1958) is essential to the development of a strong sense of self, feelings of self worth, and secure attachment.
3. The capacity to soothe and nurture oneself in later life depends on early experiences of being soothed and nurtured (Kohut, 1984; Winnicott, 1958).
4. When things go well in a relationship, the infant develops an inner representation of himself or herself as lovable, special, competent, and able to make an impact on the world; of others as loving, caring, responsive, and trustworthy, that is, as being readily available; and sees the world as a safe, exciting place to explore. In other words, within a secure attachment, the infant begins a process of learning about himself or herself and the world that is positive and hopeful and which will have a powerful influence throughout his or her life (Bowlby, 1973)

In summary, these premises suggest that difficulties result when positive early experiences are missed which can contribute to problem behaviors and attachment relationship problems (Koller & Booth, 1997).

Theraplay targets four problem areas: engagement; nurturing; structure; and challenge (Jernberg & Booth, 1999). Each problem is manifested in many forms, but the success of Theraplay springs from how attachment-based play is used to meet the treatment needs of children whose relationships with their parents suffer from problems in the four dimensions (Jernberg & Booth, 1999; Munns, 2000).

While the reliance upon attachment and bonding theories can assist in the structuring of treatment, it should be noted that much of the early research in attachment was biased towards mother blaming when identifying the origins of parent-child problems. The early pioneers of attachment research, including Bowlby (1950), Harlow (1958), Ainsworth (1969), and Lorenz (1979), are considered to provide critical research confirming various theories of child development and parent-child relationship formations. What these studies actually amount to in terms of useful information is uncertain, since they all began with the unvarnished assumption that mothers are the prime architects of their children's lives, rather than one of many influences (Eyer, 1996). Furthermore, the research on bonding and attachment remains a patchwork of varied and non-matching studies that do not research the same variables. Social science research on attachment is limited by the number of factors that can be accounted for in any one study and also by the likelihood that researchers will actually study the same consistent phenomena. Therefore many studies of attachment cannot corroborate one another (Eyer, 1996). Critics of attachment theory suggest it is simply an inadequate framework to capture the range of socio-emotional influences that compromise the foundation of children's developing capacity for trusting relationships and for understanding the developmental significance of parent-

child relationship (Eyer, 1996). Essentially, the trend of attachment theory has been to focus on the mothering or lack of mothering/maternal deprivation as the source of many problems in childhood and therefore has ultimately led to mother blaming.

Furthermore, some attachment and bonding theories are deterministic in their suggestions of critical periods or "windows of opportunity" for attachment to occur (e.g., Lorenz, 1979). This assumption would therefore suggest that creating or enhancing attachments in later life is difficult, and therefore hope for change is slim. Contrary to this underlying assumption, not every parent-child relational problem occurs within the early formative parent child years. As with mothers and their children who are impacted by domestic violence, relational strain can result from the context of living in an abusive environment. Despite the limitations of the theories of attachment and bonding, which are the basis for Theraplay, the framework remains useful for understanding therapeutic assessment and intervention of families who are experiencing relational problems.

Currently Theraplay intervention cannot be supported by research, however the benefits of using the Theraplay model with women who have been battered and their children can be surmised from the outcome research on mothers and children in other clinical populations. Generally, having parents and their children meet together to share information, address common concerns, or develop supportive networks can be an efficient and effective means of providing child and family mental health services (McKay et al, 1995). Theraplay provides a mode of intervention that can focus on the relationship between mother and child. Unless the parent can be helped to understand the impact of the traumatic event on the child and on the parent–child relationship,

difficulties in the mother-child interaction may persist, with potentially serious consequences for the child's development as a result (Davies, 1991). Studies consistently show that the most effective interventions for children take the form of clinical intervention with both the mother and child. Holden et al.'s (1998) intervention which emphasized mother-child dyad therapy demonstrated that mothers became less distressed and improved their parenting, becoming both better managers of their children's behaviors and increasing their display of warmth and involvement with their children. In response, children's behaviors improved remarkably.

Theraplay has similar elements to other forms of treatment, such as filial therapy and client centered play therapy. The evident similarity between Theraplay and filial therapy is the parents' involvement as active agents for change. The major differences in the approaches are in the activity level of the parents in sessions and the different goals of the two approaches (Jernberg & Booth, 1999; Johnson, 1995). In contrast to client centered play therapy, Theraplay encourages parents to take the initiative in engaging the child in playful interactions. For Theraplay the goal is an immediate change in the way the parent and the child interact. The belief is that the best way to improve the relationship is to start over, thus Theraplay focuses on the pre-symbolic interactive play typical of very young children (Jernberg & Booth, 1999). In specifically distinguishing Theraplay from other treatment methods, Jernberg (1993) lists the following characteristics: it is playful, uses no toys and few props, asks no questions, focuses on health, is structured by the adult, encourages physical contact with the therapist, has an agenda designed to meet the child's needs, encourages regression, and is geared to enhancing parent-child attachment (Koller & Booth, 1997).

Theraplay can be incorporated into both individual and group approaches with clients. Using Theraplay within groups allows the approach of relationship building to reach more of those who need it. Group Theraplay aims to enhance self-esteem and to increase trust in others through concrete, personal, and positive experiences. It also strives to increase the sense of family and belonging among group members. Theraplay groups are primarily organized around four group rules (no hurts, stick together, have fun, and the adult is in charge) and two group rituals (check up and food share). These rules and rituals frame the sessions and communicate the Theraplay message of nurture, engagement, structure, and challenge (Jernberg & Booth, 1999; O'Conner, 1991).

Summary

Many interventions exist which one can choose from for women who have been battered and for these women and their children. The literature suggests, and research supports, that group intervention is well suited for both. With respect to women who have been battered, a support group format is thought to be the most beneficial treatment modality (Breton and Nosko, 1997; Boyd, 1985; Campbell, 1986; Cox & Stoltenberg, 1991; Harris, 1985; Holiman & Schilit, 1991; NiCarthy et al., 1984; Saunders, 1993; Seskin, 1988; Trimpey, 1989; Tutty et al., 1993). Women who have been battered also present with unique parenting dilemmas that may benefit from parent education and skills development designed with the population's unique issues in mind (Hughes, 1992; Levendosky 2000; Levendosky and Graham-Bermann, 2000). In terms of addressing the parent-child relationship difficulties that may arise from family violence, there is clinical support and research that supports the use of parent-

child multi-family group work (Cassano, 1989; Greenfield & Senecal, 1995; Sherman, 2000; and Zelman, 1986). The introduction of Theraplay activity within the group is an appropriate intervention to target parent-child relationships that may have been adversely affected by the exposure to the domestic violence. The Theraplay approach assumes that change is possible and that the essential ingredient of change lies in the creation of a more positive relationship between the child and the parents (Koller & Booth, 1997). It is with this information in mind that a combined group work approach was chosen for this practicum.

CHAPTER III – THE PRACTICUM DESCRIPTION

Introduction

This practicum intervention was continuation of a treatment program based out of the Elizabeth Hill Counselling Centre. The existing program targeted women and their children who have been impacted by domestic violence. The primary focus of the intervention was to improve the parent-child relationship. Previously, the structure of the program had included three components: a mothers' group, a childrens' group and a joint parent-child multi-family group. The continuous evolution of the program began to reflect two trends in service delivery. First, the mothers' and the childrens' groups, as originally designed, began to be increasingly replaced by multi-family group work sessions. Secondly, while the mothers' and childrens' groups continued to have elements of psycho-education and support, a shift towards Theraplay intervention predominated in the joint parent-child multi-family group. For the purposes of this practicum, the focus is upon the mothers' group and the parent-child multi-family group. The children's group was an important piece of the overall therapy, however it will not be thoroughly discussed.

Setting

The practicum was carried out at the Elizabeth Hill Counselling Centre, which is located within the downtown area of Winnipeg, Manitoba. The Centre is operated by the University of Manitoba and provides supervised training to students in social work and psychology. The Elizabeth Hill Counseling Centre provides counseling services to individuals, couples and families. Clients are self-referred, or referred from other professionals or agencies. There are no fees charged to the clients.

Supervision

The committee members for this practicum included Dr. Diane Hiebert-Murphy, a professor in the Faculty of Social Work at the University of Manitoba, Linda Perry, a therapist at Elizabeth Hill Counselling Centre and a member of the Faculty of Social Work at the University of Manitoba, and Linda Burnside, an Assistant Program Manager at Winnipeg Child and Family Services and a sessional instructor in the Continuing Education Department at the University of Manitoba.

Linda Perry provided extensive assistance is session planning. Dr. Diane Hiebert-Murphy provided supervision, which included videotaping of group sessions and weekly supervision meetings.

Pre-Group Preparation

Planning for the group began several months in advance. Preparing and circulating advertisement for the group was the foremost activity. Contacting families from the existing waiting list, as well as newly referred families, was a major task. Several meetings were held with the other facilitators to discuss the group and to divide tasks. The initial interviews and screening of potential members occurred over the course of several weeks. In addition to screening members for the group during the intake phase, efforts were made to assist the families in accessing appropriate supports to ensure success in participating and completing the group; issues such as transportation and childcare arrangements were addressed.

A tentative plan for the group structure and session content was completed prior to the first session. The structure and content was partially determined by past group outlines, in conjunction with insights from the literature review completed on this

population group. Efforts to compliment themes between the mothers' group and the childrens' groups were attempted.

Referral Process

Requests for referrals were made to various social service agencies. Informational newsletters and posters outlining the general criteria for the group, the type of therapy being offered, weekly themes, and the goals of the groups were circulated. Referrals were received from a variety of sources, with the majority being referred from Child and Family Services Agencies, Child Guidance Clinics and self-referrals. Many of the families had received or continued to receive services from external support agencies.

Participation Criteria

Involvement with the group required the primary identified issue to be exposure to family violence. Mothers had to have a history of abuse by partners and be requesting help with and/or help for their children who may have been presenting with emotional and behavioral concerns. Children could be of either gender, between the ages of 7 and 10 years. Participation was voluntary although families were expected to commit to attending all group sessions. Potential members were excluded if the mother and child were not living together, if the mother was not a single parent, and if the mother and child continued to live in a home where domestic violence was occurring.

Client Selection

The mothers and their children were seen for a two-part screening and assessment interview. The first part of the screening interview included the mother

meeting with the facilitators to discuss the family history, specifically in terms of family violence. The second part of the interview included the child and provided an opportunity for the mother to discuss an incident of family violence to which her child had been exposed. The purpose of this discussion was to provide an atmosphere of permission for the child to acknowledge and discuss the violence. Mothers and children were provided with a tour of EHCC, and were provided with information about the group process and the group objectives. Mothers and children were also given an opportunity to ask questions throughout this process. Following this screening interview, the mother and child were requested to complete pre-test clinical measures. Mothers were asked to complete the Parenting Stress Index (Abidin, 1983) and the Child Behavior Checklist (Achenbach, 1991).

Personnel

Four therapists in total facilitated the group program. A pre-master's social work student, Louise, and myself facilitated the mother's group. Linda Perry, supervising therapist and another master's student, Raul, facilitated the children's group. Although all the therapists participated in the joint parent-child multi-family group, I was responsible for the planning and facilitation.

Recording

Procedural and recording requirements of Elizabeth Hill Counseling Centre were adhered to. This included the documentation of consent, pre-group interviews and screening assessments, process notes and contact summaries, and termination reports. Each group session was documented and analyzed for member process and group dynamics. Also documented were family members' reactions to content and

Theraplay activities. Each session was videotaped. A learning log was also maintained for personal reflection of educational objectives.

Group Goals

The group program was designed to provide both mothers and children an opportunity to explore the issue of family violence and its impact on their family. The mothers were given an opportunity to share their experiences and to gain an understanding of the impact that the violence has had for themselves as women and mothers, for their children, and also on their parent-child relationship. In the joint parent-child multi-family group, Theraplay activities were used as a means to facilitate positive parent-child interaction and as a means to understand the importance of play in strengthening parent-child relationships.

Overview of Group Intervention

The methods of intervention utilized were a psycho-educational support group for women and a multi-family therapy group for mothers and children. Both group components included discussion of traditional family violence themes and incorporated Theraplay activities. The discussion topics that were selected were based upon existing knowledge about women who have been battered and their children. The program was a closed, structured, and time limited group. The group ran for twelve weeks from mid-September to mid-December 2001. Each group session was held once a week with sessions being two hours in duration. Generally the time was divided equally between the mothers' group and the parent-child multi-family group. A snack was provided to the families and this was incorporated into the multi-family portion of group.

Following is a summary of weekly themes for the mothers' group:

Week 1	Why are we here and the importance of play
Week 2	Effects of family violence on women and on parenting
Week 3	Effects of family violence on children
Week 4	Healthy parent-child interaction – Nurture
Week 5	Healthy parent-child interaction – Engagement
Week 6	Addressing a member in crisis
Week 7	Healthy parent-child interaction – Structure
Week 8	Healthy parent-child interaction – Challenge
Week 9	Problem solving child behavior – Part 1
Week 10	Problem solving child behavior – Part 2
Week 11	Past, present and future
Week 12	Saying goodbye and celebration

Overall, the objectives for the mothers' group were to provide an opportunity to share their experiences and to gain an understanding of the impact that the violence has had for themselves as women and mothers, for their children, and also on their parent-child relationship.

The general layout of each mothers' group session was:

1. Check in
2. Housekeeping issues
3. Introduction of theme – mothers' and children's groups
4. Warm up game
5. Discussion
6. Check out and nurture

Following is a summary of weekly themes for the parent-child multi-family group:

Weeks 1 - 4	Acknowledging the violence in our families and establishing permission to talk about the violence, and Facilitating play between mothers and children that focused upon activities of nurturance, engagement, structure, and challenge
Weeks 5 - 11	Addressing issues related to family violence, including feelings of confusion, breaking the secret, stopping the violence, feeling afraid, feeling angry, healthy coping strategies, and living without violence, and Facilitating play between mothers and children that focused upon activities of nurturance, engagement, structure, and challenge
Week 12	Saying goodbye and celebration

The general layout for each parent-child multi-family session was:

1. Check in and sharing between groups
2. Puppet Play (weeks 5 - 11)
3. Theraplay activities
4. Closing song

(For further descriptions of the sessions see Appendix A).

Overall, the objectives for the parent-child multi-family group were to provide the mothers and their children with an atmosphere where they could discuss and problem solve the impact of family violence on their relationship. The introduction of the puppet play was designed to integrate the children's group content with the multi-family group experience. The weekly topic for the puppet play deliberately incorporated traditional family violence themes that the families likely experienced. As mentioned above some of the topics included, children's feelings of confusion, fear and anger, breaking the secret, stopping the violence, healthy coping strategies, and living without violence. The Theraplay activities that were incorporated throughout the parent-child multi family group were used as a means to facilitate positive parent-child interaction between the mothers and their children. Furthermore, the Theraplay activities were also designed to link the educational content discussed in the mothers' group with experiential activity in the parent-child multi-family group. The core relational elements of nurturance, engagement, structure, and challenge were specifically incorporated into all activities. Through the Theraplay activities, mothers received demonstration and practical application of various Theraplay theory. Both the viewing of and participation in Theraplay activities educated the mothers to the importance and powerful influence of play in strengthening their parent-child relationships.

Evaluation Plan

The essence of successful practice is the ability to demonstrate that our intervention has been effective. Evaluation therefore must be considered an essential part of social work practice. Probably the most productive way of assessing the efficacy of the intervention is through the use of systemized, objective methods of research (Bloom & Fisher, 1982).

For the purposes of this practicum, the Child Behavior Checklist (Achenbach, 1991) and the Parenting Stress Index (Abidin, 1983) were used to assess pre- and post-intervention functioning. These measures were selected based upon their ability to measure the constructs of maternal parenting stress and child behavior problems, two variables that have been demonstrated to be central within families affected by domestic violence. The empirical and clinical literature suggests that women who have been battered may experience elevated parenting stress, that their children may experience increased internalizing and externalizing behavioral problems, and that interventions that target the parent-child relationship are believed to decrease the parenting stress and child behavior problems they experience (Holden & Ritchie, 1991; Holden et al., 1998; Jouriles et al., 1989; Levendosky, 2000a Levendosky & Graham-Bermann, 1998). The hypothesis for the practicum was that mothers and children who had been impacted by domestic violence would display elevated levels of parenting stress and child behavior problems. Following the completion of the group, it was hypothesized that the intervention would positively impact these variables, decreasing both parenting stress and child behavior problems. The CBCL and the PSI were also chosen, because they are measures that are widely used in other studies of parenting

and domestic violence; therefore for comparison purposes use of consistent measures is advantageous. These measures were administered to mothers at the intake interview and within four weeks of the final group session. In addition to these standardized measures a qualitative feedback questionnaire and post-group interview were administered at the completion of the group program (see Appendix B).

Child Behavior Checklist (CBCL) (Achenbach, 1991)

The CBCL is a standardized measure that was designed to be filled out by parents to obtain a picture of their child's behavior as they see it (Achenbach, 1991). The CBCL determines the types of behavioral difficulty children are experiencing on two broadband scales, including Internalizing Behaviors and Externalizing Behaviors. Within these two broadband scales, further syndrome scales are designated. The syndrome scales designated as Withdrawn, Somatic Complaints, and Anxious/Depressed are grouped under the heading of Internalizing Behaviors. The syndrome scales designated as Delinquent Behavior and Aggressive Behavior are grouped under the heading Externalizing Behaviors (Achenbach, 1991). The CBCL measure can be used document behavioral changes that may occur after an intervention. The CBCL has been used in a number of studies regarding children who witness parental violence (e.g., Graham-Bermann, 1996; Holden, 1998; Holden & Ritchie, 1991; Levendosky, 2000). Furthermore, it has been found to be a good general measure of externalizing, internalizing, and social development problems (Kashani & Allan, 1998).

The CBCL consists of 113 items using a three-point scale including "not true", "very true" and "often true", which the parent completes. This measure is supposed to

take 20 minutes to complete and requires a grade 5 reading level. It is good for small sample research as client data can be compared with the well-established norms by gender and age. The CBCL has been used throughout the world and has shown to have high inter-interviewer reliability and test-retest reliabilities (Achenbach, 1991). Reliability of these scales is high, ranging from .81 to .87. The CBCL Manual also reports on the content, construct, and criterion related validity of the CBCL scores. The empirical strengths of this measure are impressive (Achenbach, 1991).

The evaluation of the CBCL relies upon T scores for Internalizing, Externalizing, and Total Problem scales. T scores above 64, which are greater than the 98th percentile, are considered to be clinically significant. T scores between 60 and 63, which are between the 95th and 98th percentile, are considered to be borderline clinically significant.

Parenting Stress Index (PSI) (Abidin, 1983)

The PSI is a standardized measure that assesses parenting stress. The PSI was designed to be filled out by parents to identify parent-child systems that were under stress for the development of dysfunctional parenting behaviors or behavior problems in the child involved (Abidin, 1991). The measure covers various aspects of parenting stress, including child and parent characteristics. There are four broadband scales, including Child Domain Stress, Parent Domain Stress, Total Stress, and Life Stress. The Child Domain Stress scale includes the characteristics of the child seen as stressors in parenting, including the temperament of the child, the degree to which the child fulfills parental expectations, and the degree to which the child rewards the parent. The Parent Domain Stress scale includes the characteristics of the parent and the parent's

environment that are seen as stressors. The Total Stress scale is the combined Child Domain and Parent Domain score, and is useful in useful in guiding professional judgements as to whether professional interventions might be necessary or appropriate for a given parent-child system. The Life Stress scale provides some index of the amount of stress outside the parent-child relationship that the parent is currently experiencing (Abidin, 1983). The PSI is a 120 item questionnaire where each item is rated on a scale of 1 (strongly agree) to 5 (strongly disagree). This measure has been widely used in studies of parenting children at risk (Holden & Ritchie, 1991; Webster-Stratton & Hammond, 1988). The instrument yields a global stress score and has been normed on clinical and non-clinical samples of parents. The reliability of these scales are .90 and .93 (Abidin, 1983). The PSI Manual also reports on the construct and predictive validity of the measure in relation to other studies that correlate the PSI with other measures and special populations (Abidin, 1983).

The evaluation of the PSI relies upon scores generated for the areas of Child Domain, Parent Domain, Total Stress, and Life Stress. Total Stress scores that are at or above 260, which are above the 85th percentile, are considered high and should be offered referral for professional intervention. The normative range for scores is within the 15th to 80th percentile.

Client Satisfaction Questionnaire and Post-Group Interview

The final methods used to evaluate the intervention were qualitative client satisfaction questionnaires and a post-group interview. Mothers were asked to complete the questionnaires following the completion of group and particpate in a post-

group interview. Mothers were also met with individually to provide feedback regarding their group experience.

Limitations of the Measures and Research Design

Both the CBCL and the PSI measures, which rely upon maternal reports and maternal self-reports, are limiting. The CBCL, which relies upon maternal report, has some limitations as it may be difficult for some parents to accurately estimate their child's behavior based upon a three-point scale. Also parents' reports may not be an accurate reflection of their child's behavior and could be skewed by any number of reasons, including their own attitudes and beliefs towards their children. The PSI which relies upon maternal self-report is also weakened by bias and social desirability.

With respect to the research design, there are some limitations that exist with the A-B design. Since measures are only obtained at pre-test and post-test the design can not provide clear information about whether or not the intervention caused the observed changes, as it does not control for other causal factors. In this practicum the intervention was comprised of a three-part program, the childrens' group, the mothers' group and the parent-child multi-family group. Due to the program containing several elements, it is hard to determine which one or combination of the groups were most influential (Bloom & Fisher, 1982).

CHAPTER IV - THE GROUP EXPERIENCE AND ANALYSIS

The Group

The group ran for twelve sessions from mid September to mid December 2001. The group initially began with six mothers and their children. By the third group session, three mothers remained. The attendance of these three mothers and their children was excellent, with no absences.

Group Member Profiles

Barb

"Barb" is thirty years old and Aboriginal. Barb had two previous common-law relationships and is the single parent to six children. Barb was self-referred to the group. Barb was interested in the group due to her eight year old daughter's (Betty) exposure to parental violence, with the last incident having occurred approximately one and a half years ago. Barb did not identify any specific emotional or behavioral concerns regarding Betty, however she felt that the group would be a good experience for her and her daughter.

Barb described a history of domestic violence between herself and her two significant male partners. Barb described that Betty overheard yelling, witnessed excessive drinking, observed mutual physical abuse between adults, and saw police attending to the home and removing her male partners. On at least one occasion, where Barb feared for her safety, Betty had been sent to call the police. There was at least one incident where Betty received a physical injury from her father. Barb indicated that her abusive relationships jeopardized her ability to care for the children and that Child and Family Services briefly apprehended her children following one violent incident. Prior

to coming to the group, Barb and Betty received some counseling through a women's shelter. Barb presented as very motivated to attend group. She and her daughter participated in all twelve sessions.

Cindy

"Cindy" is forty years old and Caucasian. Cindy had been separated from her husband for two years. Cindy is a single parent to two children. Cindy was self-referred to the group and had learned of the group through another counseling centre where her daughter had received prior therapy. Cindy identified both herself and her children, particularly her daughter, as being affected by family violence. Cindy expressed concern regarding her eight year old daughter's (Carrie's) current behavior. Cindy's primary concerns revolved around Carrie's aggression and defiance within the home. Cindy indicated a desire to attend the parent child group as a means to help her and her daughter resolve their abuse experiences.

Cindy described a history of violence perpetrated by her husband towards her and the children, particularly Carrie. Over the course of the marriage, the violence included episodes of yelling, physical fighting, restraining, and direct threats of physical harm, much of which Carrie witnessed or overheard. With respect to Carrie, Cindy indicated that her husband had hit, slapped, yelled and pulled her hair. Cindy described her husband as a harsh parent who frequently undermined her parenting strategies, judgements, and authority with the children. The couple's separation was prompted by Carrie's disclosure of physical abuse. Prior to coming to the group, both Cindy and Carrie had received individual counseling.

Cindy was very motivated to attend the group and she and her daughter attended all twelve sessions. As the group progressed, several events occurred in Cindy's personal circumstances that contributed to Cindy feeling overwhelmed. Cindy was offered individual sessions which she readily accepted. In addition to the group, Cindy participated in five additional therapy sessions, one of which included Carrie.

Sheri

"Sheri" is thirty six years old and Caucasian. Sheri had been separated from her husband for four years and is the single parent to four children. Sheri was self-referred to the group, although had been encouraged to participate by her Child and Family Services Worker. Sheri identified both herself and her children, particularly her ten year old son (Mark) as being affected by family violence. Sheri expressed concern regarding Mark's current behavior, particularly aggression and a fixation with violence. Sheri indicated a desire to attend the parent-child group as a means to help her son.

Over the course of the marriage, Sheri described episodes of violence perpetrated by her husband towards her which primarily included yelling, throwing items, and threats of physical harm. Sheri indicated that her husband was also extremely abusive in his interactions with the children, particularly Mark. Child abuse included excessive and rigid discipline and on several occasions corporal punishment. Since the separation, the father had continued to have sporadic contact with Sheri and the children. There continued to be episodes of harassment and stalking from her husband and while the abuse towards the children ceased, the children remained very fearful of their father. While participating in group, Sheri and her son continued to

receive a variety of support services from various other agencies. Sheri was very motivated to attend group and she and her son attended all twelve sessions.

Cathy

"Cathy" is thirty years old and Aboriginal. Cathy is a single parent to her five children. Cathy had previously participated in a parent-child group with her ten year old son. Cathy indicated a desire to repeat the group with her nine year old son. Following the initial screening and assessment interview, Cathy and her son did not attend group. It should be noted that Cathy 's attendance in the past group was very poor. Compounding Cathy's ability to attend was the birth of a new child.

Lisa

"Lisa" is thirty two years old and Caucasian. Lisa is a single parent of two children. Lisa was self-referred and had been encouraged to attend the group by her Child and Family Services Social Worker. She indicated that her nine year old son (David) was a very angry child who was very confused about his father's role in his life.

Lisa described a violent relationship with David's father. Lisa remained with her partner for one year following David's birth and indicated that the abuse continued to occur. Lisa indicated that David's father was inconsistent with visitation and on one occasion he assaulted David prompting Child and Family Services' involvement. David has had no contact with his father for nearly three years, but remains angry about his father's inconsistent role in his life and at times blames Lisa for these circumstances. In addition to the family violence, Lisa identified numerous difficulties for herself including substance abuse, health problems, and difficulty parenting. Lisa

had difficulty attending the initial screening assessment interviews and several appointments were required to accomplish this. Lisa did not attend the first group session and did not respond to contact initiated to review her attendance. Lisa attended the second group session but behaved in a hostile manner. I attempted to discuss the group's appropriateness for her and her son, as well as her desire to participate. Lisa presented as dissatisfied with the inquiries and withdrew from the group.

Gina

"Gina" is thirty six years old and Aboriginal. Gina is a single parent and is currently parenting two of her four children. Gina self-referred to the group and initially wanted to participate with both of her sons, ages ten and nine years. In discussion with Gina, it was decided that she and her ten year old son (Brad) would attend the program. Gina indicated that she and her son had been impacted by family violence and she had expressed concern regarding her son's behavior and emotional functioning.

Gina described a five-year marriage with her last partner. Gina indicated that Brad's biological father is deceased, and that Brad identifies her former husband to be his father. Gina indicated that there has been no visitation between Brad and his father since the separation. Initially, Gina minimized the violence directed at her by her husband. Eventually Gina described abuse that included punching and threatening behavior which Brad would have overheard and observed. Gina indicated that she voluntarily sought assistance from Child and Family Services within the last year to assist her with caring for Brad as she was feeling overwhelmed in caring for her son. Gina described herself to be very proactive in accessing help though various

organizations for past issues of abuse and family breakdown. Gina and her son attend the first group session, however did not return. Gina indicated that she was experiencing some health problems that were interfering with her ability to attend group.

Summary

In reviewing the client profiles a number of similarities became clear. The original six members of group all had involvement, past or present, with Child and Family Services. Two of the women had their children removed from their care due to the reported domestic violence within the home. Two of the women themselves had been in foster care as children. Two of the women identified histories of intergenerational alcohol abuse and had personal experience with dysfunctional coping strategies including substance and alcohol addiction.

All of the participants shared the belief that their children had been impacted by the family violence, to a greater extent than they reported it having impacted upon themselves as women, mothers, and on their parent-child relationship. None of the mothers indicated that they were receiving individual treatment in regards to their own experience of the violence. With the exception of one member, members did not present as being in immediate crisis, although all identified chronic stressors including criminal hearings, custody access disputes, and changes in employment. Safety planning for themselves and their children was also identified as a common concern.

Differences between the mothers included the degree of contact they and their children were having with their former partners. Variations also existed within cultural, ethnic and racial backgrounds, as well as employment status.

Group Analysis

The focus of this section is to provide an analysis of the group intervention. The five stage Relational Model of group development proposed by Shiller (1997) will be used as a framework for discussion. Themes of group development and group dynamics will be reviewed for each stage.

Stage One – Pre-Affiliation

Pre-affiliation, as the beginning stage of group development, can be characterized by members acquainting themselves with one another, the worker, the environment and the group expectations (Corey & Corey, 1997; Johnson & Johnson, 1997; Toseland & Rivas, 1995). The first three sessions of group revolved around these themes.

Within the first session the members were clearly in the pre-affiliation stage of group development as they demonstrated an interest in learning about each other, the facilitators, and how the group would meet their needs. Prior to the group commencing, all of the members had an opportunity to meet with Linda Perry and myself, as the primary facilitators and some had also met with the co-facilitators, Louise and Raul. The pre-group intake meetings likely contributed to creating some comfort for the first session as well as assisting members with understanding the overall goals, structure, process, and content of the group. The pre-group meetings also allowed the facilitators the opportunity to focus on each client's anxieties. Brown (1991) suggests that by discussing these uncertainties and eliciting personal expectations, one can relate how the member's personal goals can be met through the group.

Although members would have had an opportunity to meet with Linda, Raul, Louise, and myself to review the group process, members' anxiety is seen as a normal experience at the beginning of the group itself (Wickham, 1993). A worker needs to be appreciative of members' feelings and avoid situations that could possibly raise anxiety, such as premature confrontation or premature disclosure. The use of a structured, non-threatening question for check-in during these first few sessions was chosen to reduce anxiety and to build safety. Louise and I also participated in the check-in as a means to model the type and extent of self-disclosure that would be acceptable during this beginning phase of group. The use of the check-in did seem to reduce anxiety amongst the group members and facilitated the sharing of information.

In addition to anxiety, Toseland and Rivas (1995) describe an approach-avoidance conflict that emerges early in group whereby members approach each other in their desire to connect, but avoid getting too close because they fear the vulnerability that such intimacy implies. This struggle was evident when one mother indicated a desire to be at the group, but a fear that the group would make her feel more inadequate in her abilities to help her child. This was also evident when another mother expressed embarrassment about her child's behavior in the parent-child multi-family group component, and asked for tolerance from the other members.

To acquaint members to the group environment and expectations, several activities were used, including the reliance upon an agenda, the development of group guidelines, reviewing the group's purpose, and utilizing play activities as preparation for the parent-child multi-family component. Having Louise and I facilitate these activities in the pre-affiliation stage was helpful in setting the tone for the group and

establishing a safe and comfortable working environment for the treatment process. The use of the agenda, especially during the initial session, was important as it allowed the mothers to know in advance the session content for themselves and for their children. Group guidelines, which were principles of behaviors that would assist members feeling comfortable and secure, were established. The group guidelines reinforced a non-intimidating environment with importance placed upon confidentiality, a very crucial ingredient for building safety and trust. Louise and I also reviewed the group's purpose as it is believed to assist in actualizing the group's goals (Wickham, 1993). Since play was the central component of the parent-child multi-family group mothers were given an opportunity to play games, similar to those that would be played with their children. These preparatory play activities were important as a means to educate parents about Theraplay and to enable parents to become comfortable with play, touch, and nurturing. Initially parents may need guidance through their own play experiences so as to gain the emotional resources to promote their children's growth through play. Also, parents benefit from having some of their own needs met before being expected to be attentive and nurturing with their children (Jernberg & Booth, 1999; Rhodes & Zelman, 1986).

While in the pre-affiliation stage identifying common needs and interests of members is central (Glassman & Kates, 1990; Garland et al, 1972; Wickham, 1993). The weekly topics that were selected were chosen not only to provide educational information, but also to allow for an opportunity to discuss common themes that would promote dialogue between group members. Within the first few sessions commonalties were evident. Members openly confirmed with one another how the

family violence impacted upon themselves and on their children. Members also clearly identified a need to discuss their children's problems and requested assistance from the group on how to address them.

While in the first stage of group development there is a need for members to first establish non-intimate relationships, with more intimacy developing as the group progresses. The establishment of trust is a central component to this process (Toseland & Rivas, 1995). Trust gradually began to emerge as was evidenced by members increasingly sharing their personal stories. The issue of trust also emerged regarding group membership. By the third session the group membership had gone through some changes and had solidified with three members. Discussion occurred regarding the absence of certain group members. According to Toseland and Rivas (1995) it is important to discuss absences or withdrawals from the group in order for the remaining members to process the impact of these changes. In particular, one member expressed concern about the participation of another member from the week prior. The broaching of this subject appeared to provide permission for the remaining two members to share similar concerns. The tension regarding the issue was released by humor. The group demonstrated a collective relief when they understood the membership to be closed and it appeared that the group felt they could move on with their work.

With respect to group dynamics, communication and interactional patterns began to emerge as sessions continued. Initially communication was leader directed however the small size of the group provided increased opportunity for communication between all members. Group members were observed to positively reinforce each other's feelings and provide feedback regarding problem-solving strategies. Mutual

support was becoming very evident with members offering understanding and praise for each of the mother's own personal struggles.

The cohesion of the group was noticeable by week three. Members arrived early and frequently engaged in discussion outside of the formal group process. Similarly, members appeared to enjoy talking with one another at the break, and at times members needed to be reminded of joining the parent-child multi-family portion in a timely fashion. Once again the small group size and the finalizing of the group membership appeared to contribute to the development of a cohesive unit. Toseland and Rivas (1995) suggest that a decrease in group size can help the members to build cohesion because the potential for communication increases when less motivated members drop out. The increased personal sharing promoted an awareness of commonality to develop amongst members' experiences. In turn this commonality contributed to cohesion between members. The development of cohesion is necessary and important for the creation of safety and comfort necessary for members to risk later in the group process (Schiller, 1997).

The norms of the group also appeared to be well established by the third session. Punctuality, turn taking, and the use of respectful language became evident as important practices for the group. The development of the group guidelines in session one was instrumental in establishing these expectations of behavior. The power of these norms was evidenced by the late arrival of a new member, Lisa, in session two. This member had not been a part of the development or review of the group guidelines. Furthermore, this member's demeanor was significantly different from the other members, with some premature disclosure and strong expression of emotions. The

intensity of this member resulted in a high degree of discomfort for the members and to some extent Louise and I as the facilitators. In week three, when it had been determined that this member would not be continuing with group, there appeared to be mutual relief from the remaining group members. In hindsight, this new member's perceived differences could have been utilized to re-work the norms of the group that were still evolving. A possible change in the norms of the group might have included tolerance for expression of intense emotions, especially anger. As Toseland and Rivas (1995) caution, norms are very powerful and are not easily modified, however deviation from norms can be helpful in introducing new behaviors that can be beneficial to the group. If this member could have been successfully maintained within the group her contribution to the group may have been powerful.

In terms of roles that developed, within the first sessions Louise and I generally took the roles of "experts" to establish the group's structure and process. Although the group sessions had been previously outlined, I did identify at the onset of the group that content could be modified to meet the members' needs. With respect to the members, two notable roles evolved. Sheri emerged somewhat as internal leader for the group. By virtue of having four children, a professional career, and a pragmatic approach to her parenting style, Sheri was perceived by members to be quite competent. These perceptions elevated her status within the group. Lisa, the member who attended only session two, clearly occupied the role of deviant, as her behavior was extremely inappropriate during the mothers' group and the parent-child multi-family session. I believe my own discomfort with Lisa's hostile demeanor contributed to an ineffective intervention with this member. Perhaps this discomfort prompted me

to be more judgmental and less accommodating to her circumstances. The approach I chose to address the member's inappropriate behavior resulted in an early dismissal of her from group. Furthermore, I attributed her behavior to be related to her personal circumstances rather than the possibility that she was reflecting issues for the group as a whole. Shulman (1984) suggests several approaches to addressing the deviant including treating them as an ally or as a lever to promote group discussion. The fact that this deviant behavior emerged so early in the group complicated my ability to respond as I was invested in the success of the group and felt that the group could be derailed if the deviant behavior was not ceased. Perhaps, if I would have encouraged her to attend group her demeanor may have been different, and she may have possibly enriched the group experience for everyone, including myself.

Similar to the mothers' group, the parent-child multi-family group was also in a beginning/get-acquainted phase. The goals of the initial sessions were to establish a comfortable atmosphere to allow members to identify with the commonalties amongst their families (i.e., that they were all exposed to family violence), to establish permission to talk about these experiences, and to have an opportunity for the mothers and the children to enjoy themselves through play. Tasks included a reintroduction to rules and rituals. The ritual of sharing information between the children's group and mothers' group during the snack portion of the parent-child multi-family group was established early. Discussing what each group had done earlier in their separate groups dispelled secrecy and reinforced permission to talk about the violence. Talking in this way also demonstrated to the mothers and the children a way in which they could talk about issues when at home. The use of a consistent agenda also ensured that mothers

and children knew what to expect in each session. In order to reach the goals of this beginning phase of parent-child multi-family work, well structured, non-threatening activities that helped members get to know each other worked best (Cassano, 1989; Jernberg & Booth, 1999). Activities that were chosen were selected on their dyadic level of interaction, emphasizing contact between mother and child. The play that occurred between the mothers and their children appeared to be enjoyed by all, however there was a certain level of observed awkwardness for all mothers. This was understandable for the first few sessions since members were continuing to get to know one another while increasing their own comfort with touch and physical closeness implicit in Theraplay activities. Themes began to appear reflecting the cross-generational difficulties within each family. Most noticeable were the testing behaviors of the children with their mothers and the common inability of the mothers to exercise appropriate control of their children when they perceived them to be overly active or disobedient in group.

Stage Two – Establishing a Relational Base

Establishing a Relational Base, as the second stage of the Relational Model of group development, is characterized by building upon the commonalties initially identified in the pre-affiliation stage.

During this second phase the group continued to reach for similarity of circumstances. The structured content of the fourth and fifth sessions provided a continuation of linkages being made between the members of the group. Members frequently identified similar struggles with their children and with balancing their parental roles with outside obligations of family and work. Although check-in

questions continued to be structured and non-threatening, members began to increasingly disclose personal circumstances. For example, during session six, Cindy disclosed that she had been raised in foster care, which was information that had not previously been shared in pre-group or group sessions. The reactions she received were non-judgmental and supportive. Cindy's disclosure set the norm for group members to be more forthcoming in their disclosures and discussing the personal impact of their own experiences.

The emergence of a personal crisis for Cindy, which occurred by session six, prompted her to approach the group for assistance. Cindy detailed her personal dilemmas and requested guidance from the group on possible strategies to address the issue that involved a need to share pertinent information with her daughter. Barb, also the mother of daughters, indicated that although she could not identify with the particulars, "Could only imagine how difficult it would be", and offered several helpful problem solving suggestions that were based on her own experience with her girls. Similarly, Sheri, provided very concrete direction to Cindy, specifically indicating what information was necessary to share, when to share it, and what to say.

These detailed disclosures, on the part of Cindy, and the supportive response from Barb and Sheri, suggested the group had established itself to be a place of safety which is an important issue for women in groups (Schiller, 1997). Furthermore, the level of intimacy which developed, especially by session six, supports the Relational Model's view that intimacy emerges earlier in women's groups (Schiller, 1997). Overall, the increase in trust and disclosure resulted in the development of intimacy, which reinforced and strengthened the group's relational base.

Although the Relational Model suggests that conflicts typically occur later in women's groups, the potential eruption of conflict did occur in session four and session six. During session four, Cindy, while attempting to be empathic, made some judgmental statements to the other mothers regarding their children's attire and behavior. Although there was no noticeable reaction from the group members, the inappropriateness of these comments was not overlooked by the facilitators. During session six, although Sheri had presented as supportive to Cindy while in group, she approached Louise at break to share her concerns regarding Cindy's monopolization of session six. Sheri indicated that while she empathized with Cindy's predicament, "all of the members have issues and could benefit from a session to talk about them". While Sheri's concern was legitimate, as the entire session had been dedicated to assisting Cindy, it appeared that Sheri was uncomfortable with the attention that had been paid to Cindy.

The Relational Model suggests that if some type of conflict should arise at this stage of development it needs to be addressed, however encouraging engagement in conflict, disagreement or expression of anger is not supported. The model indicates that at this stage of group there is likely not enough safety and closeness to resolve these issues fully without losing the still fragile connective bonds (Schiller, 1997). As a means to address the issues of conflict without jeopardizing the affiliative process, Louise and I discussed the incident from a theme of commonality, rather than the specifics of each situation. With respect to Cindy's inappropriate comments in session four, I felt it was safe to use Cindy as an example, in terms of her frequent references of embarrassment by her child's behavior. Bringing forth the issue by way of the

theme "Children's Misbehavior" allowed further identification of commonalties to emerge, with the need for acceptance, tolerance and understanding from the group. In response to this discussion, Sheri was instrumental in stating "That is why we are all here!". Sheri's exclamation not only solidified, but also shifted, from implicit commonality to explicit commonality. With respect to Sheri's concerns regarding Cindy's monopolization of session six, it was decided that the check-in procedure would be modified for further sessions. Louise and I incorporated an unstructured opportunity for members to briefly talk about a personal issue if they chose. Once again, we used the issue of commonality to reflect that all group members might want some personal time and that this was acceptable and encouraged within the group.

The group dynamics continued to evolve within this second stage of group development. In terms of communication and interactional patterns, the members were observed to initiate communication with one another, introduce issues for group discussion, and provide positive feedback to each other, requiring less direction and guidance from the facilitators.

The cohesion in the group was very strong. Members appeared to look forward to coming to group. Attendance and punctuality were excellent, in spite of obstacles, such as childcare and work commitments, which could have interfered. The increased degree of risk taking and disclosures that were occurring, was evidence of the high level of cohesion within the group.

In terms of roles, Barb was noted to be quiet within group, often seeming more of an observer than participant. Sheri remained the internal leader of the group. Although Sheri acknowledged several pressing issues outside of group, she managed to portray

herself as in charge and in control. The members appeared to admire her for these abilities. Cindy, who similarly had many external stressors, increasingly presented herself as emotionally needy, which peaked by session six. Both Barb and Sheri had acted as caretakers for Cindy, as observed by the nurturing and support of her throughout the sessions.

This stage identified a number of issues and tasks for Louise and me. While the emphasis in this stage for the worker is empathizing with the need for connection, the resolving of potential conflict, while maintaining relationships, was necessary. The issues of balancing individual vs. group needs, as well as power and control also emerged. Although the group had given permission for Cindy to problem solve her personal struggles in session six, the quantity of time which was taken was inappropriate. Having this brought to my attention by a member was helpful in modifying the structure of the check-in process, as well as assessing Cindy's needs for support outside of group. As mentioned, following this session, the check-in became less structured, encouraging members to use the time for personal sharing if they chose. It was also at this point that Cindy was encouraged to engage in individual sessions with myself between group sessions to address her individual needs.

Fortunately, neither the potential for conflict in session four and session six derailed the group. Although the members had various differences, including their ethnic, cultural, and racial heritages, a noticeable group culture was emerging. The group culture that was emerging reflected the previous group discussions regarding similarities and tolerance for differences. The culture of the group appeared to include acceptance for openness, fairness, and diversity of opinion.

With respect to the parent-child multi-family group component, the members continued to become more familiar with the group rules and were increasingly more comfortable with each other. When this commonality emerges, Theraplay activities can be chosen that require more trust, self-control, and group cooperation (Jernberg & Booth, 1999). The Theraplay activities continued to include a high degree of dyadic play between mothers and children, but increasingly included more inter-family activities. There was more physical contact between all members of the group and there was observed to be more support, in terms of praise and encouragement, offered between families for their efforts during challenging activities. It appeared that the mothers were also observing each other's parenting styles and strategies. On more than one occasion, mothers were observed to replicate strategies they had observed from other mothers within the multi-family portion of group.

The issue of family violence began to be directly addressed in session five with the introduction of "Max", a weekly puppet show. An activity, such as Max, can be brought forward to address an issue that the group or an individual is dealing with. The puppet show was tailored to resemble some commonalties in all of the families' experiences with the first two sessions focusing upon a violent incident in Max's family and Max breaking the secret. The reaction to the puppet play was notably cautious. During the first two sessions of Max both the mothers and the children were very quiet, and anxiety appeared to be elevated. The children's anxiety was evident by their level of distraction and heightened physical activity. It was also interesting to note that the children appeared to blame Max for the violence in his family. The mothers' reactions to their children's responses appeared to reflect surprise that their

children would have these perceptions. The puppet play promoted dialogue between families that contributed to members hearing diverse approaches to problem solving Max's predicaments. Prior to the puppet show, the mothers only speculated about their children's perspectives on family violence. The puppet show provided an opportunity for mothers to observe and hear their children's reactions, thoughts, and feelings in a direct way.

Stage Three – Mutuality and Interpersonal Empathy

Mutuality and Interpersonal Empathy, as the third stage of the Relational Model of group development, is characterized by building upon the commonalties and intimacy established is stages one and two, while acknowledging differences (Shiller, 1997).

The commonality of the members' experiences had been well established during the first two stages. The structured content of sessions continued to provide opportunity for discussion, and although consensus existed regarding numerous issues, some noticeable differences emerged regarding parenting strategies and expectations. Barb frequently indicated that some common struggles which Sheri and Cindy presented were unfamiliar to her. In another particular situation, Cindy indicated that she heavily relied upon knowledge and strategies she gained from books to manage parent-child dilemmas. Contrary to Cindy's perception that these books were helpful, Sheri outwardly criticized such books, and indicated that in many instances they did not work with her children. This disagreement prompted the group to spend some time discussing differences in child temperament, parenting style, and the merits of certain parenting strategies over others. The level of intimacy achieved within the group permitted the discussion and acceptance of differences between members'

experiences and opinions. This acceptance of differences was also demonstrated in session seven when a homework task was assigned. Members were requested to generate topics of discussion for sessions nine and ten. Members produced varied responses, identifying the most salient issue that would meet their own needs. Barb wanted to discuss attention-seeking behavior. Cindy wanted to discuss managing her daughter's anger and Sheri wanted to discuss parenting strain and guilt. At this third stage of group development the ability to be candid regarding differences in needs was based upon the existence of trust and respect.

A key component of the Relational Model's third stage of development is the recognition of mutuality in the therapeutic relationship between worker and members, as well as the mutual aid amongst members (Shiller, 1997). Mutuality in the therapeutic relationship between facilitators and members was built upon from the onset of group. Beginning with the first session, the facilitators participated in the weekly ritual of check-in. By sharing our own personal stories, frustrations, and vulnerabilities, the members began to identify with the facilitators as women and mothers, similar to themselves. Over the course of the group, members increasingly shared personal stories of struggle. While neither facilitator could understand fully the extent of some of these circumstances, empathy nonetheless existed and feedback that acknowledged members' abilities to share was given. Furthermore, the common thread of motherhood existed amongst members and facilitators. The members of the group all had more years of parenting experience than Louise and I combined. In this sense, the members were often the experts and this was outwardly acknowledged on several occasions. Shifting the view from facilitators as "experts" to that of "mothers

and/or women", contributed to reducing a perceived power imbalance between workers and group members.

Mutual aid had clearly evolved within the group, as was evidenced by the sharing of advice and support between members while in session. The facilitators became aware of mutual aid also having developed outside of the group when the mothers participated in children's clothing exchange following a group session.

Communication, in this third stage of group, continued to be open and interactive, directed more between members and less through facilitators. At the onset of the seventh session, both Barb and Sheri inquired from Cindy the outcome of the week's prior crisis. Cindy directly thanked the members for their support and assistance describing it as "invaluable". The cohesion and group identity remained strong making it possible for members to discuss similarities, voice differences, and gently challenge each other's opinions.

With respect to roles, Cindy appeared to appreciate that she had dominated the group in session six and she directly stated that she would be more aware of her use of group time in future sessions. Through Cindy's own recognition, and her involvement in individual sessions with me, her neediness significantly diminished. During this stage no obvious power struggles were noted.

In this third stage of group development, the workers' central tasks involve promoting mutuality and empathy. Having surpassed the half way mark, the workers' tasks also include focusing the group on work still to be accomplished prior to termination. Requesting the members to be actively involved in the planning of sessions nine and ten assisted members in identifying relevant topics that they still

wanted to discuss and goals that remained. Discussing the final sessions in advance also provided members and facilitators with the opportunity to recognize closure issues well in advance of the termination process. For Cindy, the prospect of termination was very concerning as she felt that she and her daughter had "only scratched the surface" and she worried that her family would be without supports for anticipated stressful events. Having members articulate their worries helped the facilitators assess the need for ongoing interventions.

With respect to the parent-child multi-family group component, the identification and ownership of the group had evolved. The children began to express preferences for certain activities, frequently requesting repetition of favorite games. On one occasion, the welcome song was not sung, and one child pointed this out to the group. The importance of this ritual was obviously not overlooked. Mothers gradually began to take on greater leadership roles in terms of leading games for the group and requiring less prompting in dyadic play with their child. The children frequently volunteered their families for activities. The level of intimacy between the children appeared to have evolved and this was carried over to the parent-child multi-family group. An example of this intimacy occurred during sharing time when one child, who was usually more reserved regarding personal disclosure, whispered in her mother's ear apparently asking permission to share some information with the group. The mother initially replied to her child that they would talk about it later at which point the child indicated that she had already discussed it with the group. Intra-family difficulties remained obvious for two families who continued to struggle with exercising authority over their children. One child continued to challenge and test limits with her mother

and the mother continued to have difficulty managing this behavior, whereas another mother struggled with her child's constant clinging behavior in the group. Although the mothers assumed the leadership role for some of the group Theraplay activities, I continued to assume the primary leader role while Linda, Raul, and Louise would assume intervening roles, with the goal of altering interaction within families.

Max continued to be a medium through which common themes of family violence were brought forward and discussed. Max became a powerful activity that encouraged the families, especially the children, to provide support, confrontation, and assistance with problem solving to Max, and indirectly to each other. Although anxiety appeared to resurface sporadically, the families appeared more comfortable with Max. As Max's story line progressed the children all became more vocal in direct dialogue with Max. The familiarity of Max's circumstances contributed to the mutuality and empathy of experiences within the parent-child multi-family group.

Stage Four- Challenge and Change

As mentioned in Chapter Two, the Relational Model of group development suggests that conflicts typically occur much later in women's groups. With this in mind, Challenge and Change, as the fourth stage of group development, is characterized by addressing issues of power, authority, and managing conflict (Shiller, 1997).

Contrary to the model suggesting that conflict would occur in this stage, no overt conflicts between group members appeared. As mentioned earlier the potential conflict that occurred took place in sessions four and six. In this regard, the group's development did not fit with the Relational Model that suggests conflict would emerge

later in the group.

A very significant content issue regarding conflict did arise for the group in this fourth stage of group development. What became evident was the difficulty that the members had with the concepts of power and authority and their ability to appropriately exercise them within their relationships with their children. For women this difficulty can be associated with their experience of being battered as well as the socialization process in general. The content of sessions seven and eight revolved around the themes of "Structure" and "Challenge" as necessary components within a healthy parent-child relationship. These sessions set the tone for sessions nine and ten, which revolved around themes of "Problem Solving Child Behavior". The importance of structure within the parent-child relationship became especially central to the group's discussions in sessions nine and ten. For the group members, the concept of structure was closely intertwined with their experience of family violence. Not surprisingly the group members tended to have negative associations with the concept of structure, generating words such as "mean", "rules", "limits". Only one word in the list "necessary" suggested that the associations were anything but negative. In general, Schiller (1997) describes that for women who have been socialized into being "nice", being "not nice" can feel like a threat to their ability to hold onto relationships, and in fact a threat to their self identity. For these members, the notion of exercising authority and power over their children was uncomfortable. Cindy openly acknowledged extreme efforts that she made to avoid conflict. Like Cindy, some mothers who have been battered may often feel that they need to compensate for prior harsh parental behavior therefore they avoid exercising parental authority (Levendosky,

2000). For Cindy, this avoidance often was counterproductive as it frequently resulted in heightened emotional angry outbursts from her daughter, which was a central concern for Cindy.

Stage four is thought to be the most growth producing stage of group development as it challenges women to negotiate conflict without sacrificing the bonds of empathy (Schiller, 1997). Although the group itself did not have to negotiate conflict in terms of a group process at this stage, the group did however address conflict in the content of the group. The discussions on exercising power and authority, in terms of providing structure, not only permitted, but also encouraged the group members to do things differently with their children. Exercising parental authority became recognized as an appropriate means for enhancing their relationship with their children. The members began to realize that "conflict" could exist in a parent-child relationship while still maintaining a connection with their children.

The role of the worker at this stage is to help women maintain their connection through the expression of the full range of emotions, including anger and conflict (Schiller, 1997). The members were encouraged by the facilitators to reframe "conflict" and "structure" to include the beneficial outcome of creating huge potentials for growth for them and their children. While the members were completing this final working stage of group, the facilitators were also preparing the group for termination. This preparation involved discussing the content of the remaining session and planning for the farewell party.

Communication, in this fourth stage of group, continued to be open and group directed. The problem solving format of sessions nine and ten provided increased

dialogue, sharing of information, and reinforcement of knowledge and skills acquired. The cohesion in the group remained strong. Members discussed the importance of the group experience for themselves, placing emphasis upon the sadness their children were expressing at the thought of group ending.

The parent-child multi-family group component continued to provide meaningful opportunities for the mothers and children to interact in playful ways. By now, the Theraplay activities appeared to be creating some changes within each parent-child relationship. For Barb and her daughter, the need for separation and differentiation had begun to occur. For Sheri and her son, balance of nurture with structure appeared to be more evident. For Cindy and her daughter, the lack of structure remained evident. On one occasion, a child was upset with me because I was not prepared to play a game that she had requested. In response to my limit setting the child stated "You're mean!", to which I replied "No, I am structured". The child's mother appeared to appreciate the use of humor to diffuse the situation, and she received a simple demonstration of exercising authority. When issues pertaining to an individual family arose, spontaneous interventions that involved other families occurred. This was observed by the families sharing personal examples and utilizing humor to diffuse potential conflict between mothers and children.

With respect to the issues of family violence, Max continued to be a central medium to promote discussion regarding common issues that families encounter when violence has occurred in their families. Themes for Max included feeling afraid and angry, using healthy coping strategies, and living without violence. The children were able to empathize with Max's situation and Max's mother's reasoning when Max was

unable to visit with his father on a special occasion. In the following session, the children actively partook in the play, where each of them provided a positive coping strategy to prevent a violent incident from escalating between Max and a peer. For the mothers, observing their children's abilities to understand and then articulate feelings about these circumstances was helpful. The mothers were encouraged to learn that their children possessed the "knowledge" about their circumstances, and therefore had the potential to apply this knowledge to their own circumstances.

Stage Five- Termination

Termination, as the final stage of the group's development, can be characterized by the shifting of focus from the group to that of the individual. The content of session eleven provided the members the opportunity to summarize and evaluate the gains that they had made.

A final exercise conducted with the members in session twelve supported the variety of patterns of behavior that can occur at termination. Members described reactions of despair, relief, and recapitulation. This array of feelings was recognized and normalized for the group.

At this stage, the primary efforts of the facilitators were directed towards identifying and reinforcing the gains that members had made and providing reassurance that achievements would not be lost. As the group member involvement decreased, the facilitators' interaction with individual group members increased. This occurred in terms of scheduling individual feedback sessions with each member.

With the ending of the group, cohesion was no longer the emphasis, however it remained high even at the final session. This was observed when Barb prioritized

attending the final group session over attending an important school function with her daughter.

The final two sessions of the parent-child multi-family group were geared towards helping members prepare for and commemorate the ending of the group. During session eleven favorite games were repeated as a way of saying goodbye. Mothers and the children continued to express sadness about the group coming to an end. The children exchanged school pictures, cards, and telephone numbers, and they discussed keeping in contact with one another. In spite of the sadness regarding the group's ending the members appeared proud of their accomplishments and the progress they had made in group. Max made a final appearance and he and the group members revisited the past and looked ahead to the future. Similar to the children in group, Max's future did not include his father as part of the family. The children supported Max with words of encouragement and reminders that living without violence would be better. All the children gave Max a farewell hug and wished him well.

The final group session was the farewell party. All the members appeared prepared to celebrate, and there were no obvious signs of regression amongst the group members. The party was marked with special activities including the creation of group t-shirts, group photographs, certificates of group completion, and the sharing of a celebration cake. The singing of the closing song marked the completion of the group.

Summary

The Relational Model of group development suggests that womens' groups move through a sequence of stages, which emphasizes different themes for each. The group appeared to progress through these stages, with some alterations of themes noted

along the way. Contrary to the model's suggestion that conflict typically happens much later in women's groups, the potential for conflict did arise earlier in the group's development. The model suggests that extreme conflict at an early stage of development can pose the potential to destroy the group since relational bonds between members have just begun to be established. The potential conflict, although not directly acknowledged, was addressed through the theme of commonality. It appeared that this strategy was helpful in dissipating the conflict, thereby enabling the group to continue with its work. The second alteration to the sequential group process was related to the lack of overt conflict within the group, which the model proposed would occur in a later stage of group development. This lack of conflict within group was replaced by discussion of conflict within relationships. This discussion enabled the group to review the fear and negative associations women tend to have regarding conflict.

The group displayed a high level of intimacy and cohesion throughout. Mutual support and empathy appeared to be achieved. The establishment of group norms and the display of various roles and behaviors appeared more related to personalities rather than a reflection of control and power. Overall, the mothers' group provided an environment for the members to share their experiences and feelings with other women in similar circumstances.

Similar to the mothers' group, the parent-child multi-family group also appeared to move through a sequential development process. Initially interaction within the group appeared to mainly be intra-family between mothers and their children. As the group progressed, more inter-family interaction occurred between the

families and also across the generations. This was observed when the children asked mothers questions and when the mothers provided praise and reinforcement to the children. This development reflected the intimacy and cohesion that was also developing in the parent-child multi-family group component. The parent-child multi-family group environment reinforced the commonality of parenting experiences for the mothers and for their children who had been exposed to violence. The format provided a fun atmosphere where the mothers could learn from one another and interact with their children in meaningful ways.

Evaluation

This section will present and analyze by family the information obtained from the pre- and post-test measurements including the Child Behavior Checklist (CBCL) and Parenting Stress Index (PSI). In addition to these standardized measures, the general findings of the Consumer Satisfaction Questionnaires and post-group interviews will be discussed.

Betty and Barb

On the CBCL Betty's T scores pre- and post-test for Internalizing Problems dropped from 58 to 52, Externalizing Problems increased from 57 to 60, and Total Problem remained constant at 51, as reported on Table 1. Both pre- and post–test scores remained in the normal range for Total Problems. These T scores seem to suggest that Betty did not present with clinically significant emotional or behavioral problems at the onset of group, and that the group intervention produced little change in these areas.

Table 1

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

Group Member		Internalizing	Externalizing	Total Problem
Betty	Pre-Test	58	57	51
	Post-Test	52	60	51
Carrie	Pre-Test	72	77	67**
	Post-Test	73	74	67**
Mark	Pre-Test	80	76	71**
	Post-Test	71	70	63*

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).**

The CBCL pre- and post-test findings did fit with my clinical observations of Betty. Betty did not present as an overly challenging child throughout the group. Betty appeared to be compliant to her mother's direction and did not demonstrate significant externalizing behavioral problems in the parent-child multi-family portion of group.

On the PSI Barb's scores pre- and post-test on the Child Domain dropped from 138 to 130, on the Parent Domain dropped from 153 to 127, and on Total Stress dropped from 291 to 257, as reported on Table 2. Similarly Life Stress dropped from 39 to 27. Although these scores remained in the high, clinically significant range, the scores seem to suggest that the group intervention produced positive changes within the Child Domain, Parent Domain, and Total Stress Domain.

My clinical observations of Barb only partially fit with the PSI pre- and post-test findings. I found that Barb's pre- and post-test results were surprising. Based on clinical observations, I would not have thought that Barb would be within the high range in all three domains. Overall, Barb's presentation at intake and throughout the group was that of a non-distressed parent. It appears I misinterpreted her demeanor to suggest that she was not experiencing parenting stress. Furthermore, the vocal nature of the other two mothers, who frequently described their stress, likely contributed to my own minimization or distortion of Barb's circumstances.

Barb completed a post-group written client satisfaction questionnaire and a post-group interview as a final component of evaluation. With respect to the mothers' group component, Barb responded positively on the written questionnaire indicating that she had liked the group a lot. Barb particularly liked the small group membership and felt

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
BARB	Pre-Test	138	153	291	39
		99%	99%	99%	99%
	Post Test	130	127	257	27
		95%	75%	85%	99%
CINDY	Pre-Test	154	133	287	32
		99%	75%	99%	99%
	Post-Test	159	149	308	24
		99%	90%	99%	95%
SHERI	Pre-Test	171	156	327	17
		99%	95%	99%	90%
	Post-Test	177	187	364	10
		99%	99%	99%	70%

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

that it provided more time to talk and discuss issues within the group. Regarding responses about what she would have changed, Barb indicated that the location was not a convenient distance from her home. In the post-group interview Barb described the group to have been enjoyable and helpful to her and her daughter. Barb indicated that her daughter had benefited from the children's group that ran simultaneously with the mothers' group. Barb also felt that her daughter had benefited from the parent-child multi-family group. Barb indicated that her daughter had made friendships within the group and this created a positive social experience. Barb also felt her daughter had developed the ability to speak for herself, a skill that she had previously been lacking.

Carrie and Cindy

On the CBCL Carrie's T scores pre-and post-test for Internalizing Problems increased from 72 to 73, Externalizing Problems decreased from 77 to 74, and Total Problem scale remained constant at 67. Both pre- and post-test scores remained in the clinically significant range. These T scores suggest that Carrie did present with clinically significant emotional and behavioral problems at the onset of group and that the group intervention did not have much of an effect in changing Internalizing and Externalizing Problems. For Carrie, this lack of positive changes reported at post-test could be a reflection of Carrie's mother's perceptions that old problematic behaviors were being replaced by new problematic behaviors, or the possibility that Carrie's behavioral problems reflected the stress which her mother chronically experienced throughout the group. For example, towards the later part of group Carrie was reported to have increasing problems with peers at school and on more than one occasion this involved physical altercations.

The CBCL pre- and post-test findings did fit with my clinical observations of Carrie. Carrie did present as a more challenging child throughout the group process, perhaps even more so as the group evolved and her initial desire to please wore off and her shyness waned. Also, it was my clinical impression that Carrie appeared more settled when her mother presented as managing better. Conversely, Carrie appeared agitated when her mother was in a similar state.

On the PSI Cindy's scores pre- and post-test on the Child Domain increased from 154 to 159, on the Parent Domain increased from 133 to 149, and on Total Stress increased from 287 to 308. Surprisingly, Life Stress dropped from 32 to 24. These scores all remained in the high range, above the 85th percentile, and they suggest that the group intervention produced no positive effect on the Child Domain, Parent Domain and Total Stress Domain.

With respect to Cindy my clinical impressions fit with the results of the measure. At intake Cindy presented with significant parenting issues that would account for her high score on the pre-test measure. Cindy's post-test measures reflected a negative result with increased scores across the Child and Parent Domains for each. I was not surprised by this negative change since she had growing concerns about her child's behaviors and she continued to doubt her effectiveness as a parent. In reviewing these findings, it is important to consider the domain that the stress appears to be emanating from. In Cindy's case, between pre- and post-test the stress appears to be slightly more within the Child Domain. These results suggest that, for Cindy, her child's characteristics are the major factors contributing to the overall stress in the parent-child system. This is not surprising considering that, at intake, Cindy identified her primary

concern to be her daughter's behavior. This concern remained consistent throughout group, and actually escalated in later sessions. Specifically, Cindy described increased episodes of aggression from Carrie to have occurred at school. Previously, the aggression had been primarily within the home; therefore Cindy was quite disturbed with the occurrence of these incidents. It is interesting to note that the significant decrease in Life Stress reported at post-test coincides with the resolution of a court case in which Cindy was involved. The elevated Child Domain score suggests that further intervention may need to focus on the behaviors of the child versus other domains of the parent-child system.

Cindy completed a post-group written client satisfaction questionnaire and a post-group interview as a final component of evaluation. With respect to the mothers' group component, Cindy also responded positively on the written questionnaire indicating that she had liked the group a lot. Cindy described a feeling of safety where she could share her thoughts and feelings in the group. Regarding responses about what she would have changed, Cindy felt the group could have been longer. In the post-group interview Cindy described the group to have been enjoyable and helpful to her and her daughter. Cindy specifically appreciated the emotional and verbal support given by the facilitators and the other mothers. Cindy also liked learning more about play and its usefulness in building healthier parent-child relationships. Cindy indicated that her daughter had benefited from the children's group that ran simultaneously with the mothers' group. Cindy also felt that her daughter had benefited from the parent-child multi-family group. Cindy indicated that her daughter had developed a better understanding of her own and other's feelings.

Mark and Sheri

On the CBCL Mark's pre-and post- test scores for Internalizing Problems decreased from 80 to 71, Externalizing Problems decreased from 76 to 70, and Total Problem scale decreased from 71 to 63. At pre-test Mark's scores were within the clinically significant range, whereas post-test they were in the borderline clinically significant range. For Mark, the findings suggest that the group intervention had a significant positive effect in decreasing Internalizing and Externalizing Problems. Aside from the group another factor that could have contributed to the positive post-test results could have been the termination of visitation with his father. Mid-way through the group Mark's mother decided that the father's visitation with the children, as it existed, was more harmful than beneficial. Although Sheri initially feared a negative reaction from Mark, this did not occur, and in fact she described him as more settled and relieved.

The CBCL pre- and post-test findings did fit with my clinical observations of Mark. At the onset of group Mark was probably the most noticeable in terms of externalizing behavioral problems. Mark chronically sought the attention of the group and did so in disruptive ways. Mark's activity level also appeared to be very high and he was difficult to settle and focus at times. As the group progressed, all of these issues appeared to diminish. Mark particularly appeared to increase his compliance to his mother's requests and he remained more on task with the group activities.

On the PSI Sheri's scores pre- and post-test on the Child Domain increased from 171 to 177, on the Parent Domain increased from 156 to 187, and on Total Stress increased from 327 to 364. These scores all remained in the high range, above the 85th

percentile, and they suggest that the group intervention produced no positive effect on the Child Domain, Parent Domain, and Total Stress Domain. Life stress dropped from 17 to 10.

With respect to Sheri my clinical impressions partially fit with the results of the measure. Sheri presented at intake with significant parenting issues that would account for her score on the pre-test measure. For Sheri, between pre-and post-test, the Child Domain remains fairly constant, however, the Parent Domain reflects a significant increase. For Sheri, I was somewhat surprised by the lack of positive change on the Child Domain in light of the significant positive changes reported on the CBCL for Mark. The higher scores in the Parent Domain suggest that the source of the stress is more related to dimensions of her parental functioning. Once again this is not surprising given Sheri's presentation at the initial group session where she identified her fear that the group would make her feel more inadequate in her abilities as a parent. Although the group did not intentionally contribute to increasing Sheri's feelings of inadequacy as she feared it might, the group was the first therapy that she had ever engaged in, which could have related in an increase in awareness of her difficulties within the parent-child relationship. It is also important to note that the higher score in the Parental Domain at post-test were in the subscales of health and spouse. These higher scores coincide with Sheri requesting a stress leave from her employer, as well as increased stress between her and the children's father regarding custody and access. It is interesting to note that the significant decrease in Life Stress reported at post-test coincides with the employment leave commencing. Sheri anticipated that while on leave she would be less reliant on external supports to provide child care and have

more time to respond to her children's needs for attention. The implication of the elevated Parent Domain score suggests that further interventions may need to focus more on the dimensions of the parent's functioning.

Sheri completed a post-group written client satisfaction questionnaire and a post-group interview as a final component of evaluation. With respect to the mothers' group component, Sheri also responded positively on the written questionnaire indicating that she had liked the group a lot. Sheri enjoyed the small group membership and indicated she had liked being with other women who had experiences similar to her own. Sheri also specifically appreciated hearing positive feedback about her son. Sheri did not share any response regarding what she would have changed about the group. In the post-group interview Sheri described the group to have been enjoyable and helpful to her and her son. Sheri indicated that her son had benefited from the children's group that ran simultaneously with the mothers' group. Sheri also felt that her son had benefited from the parent-child multi-family group. Sheri indicated that through the group her son reduced his feelings of isolation by meeting other children who had similar circumstances.

Summary Analysis

In general, the results of the CBCL at pre-test reflected a range in scores for the children. This range is not surprising considering the variability in children's functioning that can exist among children exposed to domestic violence. Elevated scores do support the various studies that report domestic violence to harm children in emotional and behavioral areas of functioning (Carlson, 1990; Davies, 1991; Davis & Carlson, 1987; Graham-Bermann, 1996; Graham Bermann, 1996c; Graham-Bermann

& Levendosky, 1998; Hughes, 1988; Hughes & Barad, 1983; Jaffe et al., 1986; Jouriles, Murphy, & O'Leary, 1989; Sate & Heilby, 1992; Saunders, 1994). Furthermore, it should be noted that in addition to the exposure to the domestic violence, the children with elevated scores were reported as directly abused to a greater extent by their fathers. This child abuse could also account for the elevated clinical ranges.

The comparison of the pre- and post-test scores provides an assessment of the group's effect on the children's behavioral and emotional functioning. Both positive changes and a lack of changes were observed. As described earlier, these positive changes and the lack of changes need to be interpreted with caution as other influences, aside from the group, could account for these results.

In general the results if the PSI were mixed. Pre- test scores suggested that all the mothers were in the high range at the onset of the group and for two mothers the domain scores increased at post-test. These high PSI scores are not surprising considering that various studies report domestic violence elevates women's parenting stress (Holden & Ritchie, 1991; Holden et al., 1998; Levendosky & Graham-Bermann, 1998) and that maternal stress combined with child behavior problems place the mother-child relationship under strain (Erel & Burman, 1995; Wolfe et al., 1986).

The comparison of pre- and post-test scores provides assessment of the group's effectiveness in reducing the stress within the parent-child system. All of the members who participated in this practicum remained in the high range, with scores above the 85^{th} percentile, at pre-and post-test. This would suggest that the members did have significant problems with their parent-child relationship prior to and following group

intervention. Two of the mothers appeared to remain under significant stress for the development of dysfunctional parenting behaviors or behavior problems in the child involved.

The feedback that was received from the group members, both in the written client satisfaction questionnaires and again verbally in the post-group interviews gave important data for evaluating the intervention. This was information received directly from the members about how they perceived the group to have benefited themselves and their children. Overall, the members reported positive outcomes resulting from the intervention and satisfaction with their experience. This satisfaction of the members seemed to be demonstrated by their perfect attendance.

Conclusion

The purpose of this practicum was to develop, implement, and evaluate a mothers' group and parent-child multi-family group intervention for mothers and their children who had been impacted by family violence. The results of the CBCL and PSI suggest that the groups provided a marginally beneficial intervention for the mothers and their children. Although the standardized measures reflect the positive changes to have been limited, the Client Satisfaction Questionnaires and post-group interview feedback received suggest that that group was a positive experience for the mothers and their children with beneficial outcomes being described.

It is also useful to consider the implications of this evaluation within the context of these families' ongoing therapeutic needs. The members, Cindy and Sheri, who continued to present with parent-child relational problems post-group, had committed to accessing ongoing therapeutic involvement. Both had committed to attending

individual counseling. Sheri had also enrolled herself and another son for the next parent-child group. In this regard, this intervention could be considered a beginning process for these families in addressing the mothers' individual and parent-child needs.

CHAPTER V – PRACTICE AND LEARNING THEMES

Several themes that had originally been identified in the literature review regarding the intervention method and the population emerged through the implementation of the practicum. This chapter will focus upon these themes.

Intervention

Benefits of Group Format

The results of the evaluation of the practicum, especially the qualitative measures that were based upon the personal experiences and comments of the group members, suggest the group format was valuable to the members. These findings support the literature which suggests that when working with women who have been battered a group format is preferred, not only to address their need for emotional support as women, but also their need for parent education as mothers (Boyd, 1985; Breton & Nosko, 1997; Hughes, 1992; Lecklinter, et al., 1999; Levendosky, 2000; Levendosky & Graham-Bermann, 2000; Saunders, 1993).

Developing the group required the consideration of many factors including homogeneous and heterogeneous member selection, group size, open and closed membership, and time limits.

The mothers' group had both homogeneous and heterogeneous member characteristics that I believe contributed to its successful outcome. The group membership was homogeneous in that all of the members were single parent mothers and they and their children had been exposed to family violence. These criteria served as the primary factors that determined eligibility for the group, but they also provided the initial commonality of experience that promoted identification amongst group

members. As the group evolved members learned of other similarities of circumstance such as the chronic life stressors they were encountering which included socio-economic difficulties, changes in employment, custody and access issues, and emotional challenges from their own family experiences.

The heterogeneous aspects of the group members were numerous, including variations within cultural, ethnic, and racial backgrounds, employment status, and the degree of contact mothers and their children were having with their former partners/fathers. There did not appear to be any associated discomfort generated by these differences. Rather, Toseland and Rivas (1995) suggest these variations amongst the membership provided an opportunity to appreciate the diversity in life experiences and problem solving skills, as well as providing multiple opportunities for support, validation, and mutual aid. An example of the heterogeneity I noticed within the group was the various parenting strategies the mothers' employed to solve similar child behavioral problems. These variations within parenting approaches demonstrated the mothers' diversity and also provided numerous alternative strategies that each mother could draw upon in the future.

The literature on group work suggests an optimal number for a treatment group should be about six to eight persons (Wickham, 1993). In keeping with this suggestion the initial size of the group included six mothers and their children. By the third session the group had been closed and was established with three mothers and their children. Although unplanned, I believe the small group size had a positive impact for the mothers' group and the parent-child multi-family group. With respect to the mothers' group, the small size appeared to contribute to the level of intimacy and

cohesion that emerged. Furthermore, the small group size permitted ample opportunity for members to address individual issues within the group setting. I believe this opportunity contributed to the mothers feeling satisfied with their group experience. The smaller size of the group was also advantageous to the parent-child multi-family component. For the members the small size provided an atmosphere conducive to increased sharing amongst families that permitted intimacy and cohesion to develop within the larger group. For myself as the facilitator the smaller group size was more manageable for planning activities and it also allowed for more interactions with each mother-child dyad, which I believe met the families' needs better.

The group began in mid September and finished in mid December. The intervention involved eleven formal sessions and one informal session for celebration and termination. I believe the time-limited structure was helpful in planning sessions and promoting goal-oriented work for the mothers and children. At the end of the group the members varied in their readiness for termination. Members' reactions included elements of sadness and relief. These variations in response fit with those commonly identified in the literature (e.g., Garland et al., 1973). Two members identified a need to continue in therapy and this was supported by my assessment of their functioning, rather than a reaction to termination. Both of these members were able to be transitioned from the group to individual therapy at EHCC. This transition eased what likely could have been a more difficult ending. The ending of the group coincided with the arrival of the holiday season. It appeared appropriate for the group to finish at this time to avoid a disruption in the momentum of the group that might have arisen due to external commitments. For example, for one family, the last session

of group coincided with a school concert. The family did choose to come to group, but if the group continued, there would have likely been more incidents such as this one that could have potentially impacted attendance.

Models of Group Intervention

The models used for this group intervention consisted of a mothers' support group and a parent-child multi-family group that primarily utilized Theraplay activities. I believe that each group component and the Theraplay activities had certain merits and limitations.

With respect to the mothers' group the support group format was utilized to address the mothers' own need for support as well as their need for parent education. The literature suggests that support groups for women who have been battered commonly work towards the achievement of increased self-esteem, locus of control, and social support, and decreased stress levels and levels of family violence (Tutty et al., 1996). The literature also suggests that support groups that specifically focus upon parenting education needs of women who have been battered are valuable as they are tailored to meet the population's unique parenting issues (Levendosky, 2000). I believe the mothers' group addressed both needs, however my impression was that the parent education needs were met to a greater extent than the women's own needs for support. Throughout the group the mothers continued to identify many issues, aside from parenting struggles with which they required assistance. Often these issues were intertwined with their children, however certain matters were distinct and separate. For all of these mothers the group was the only venue where they could talk about these issues and it was evident that they appreciated an opportunity to do so. The nature of

the group's purpose, which predominantly focused upon parent education, at times contributed to limited time being available to address the women's personal needs in as detailed a manner as the mothers may have required. In spite of this limitation, the support group format established a safe place where the women could share their experiences, and this seemed to be the most significant component of the intervention in relation to meeting their own needs for support.

As mentioned, a substantial portion of the mothers' group was dedicated to addressing issues specifically related to parenting and the mother-child relationship. The support group was an ideal format to address these issues. Not only was the group able to discuss common parenting dilemmas, but it was also able to explore these issues specifically in the context of family violence. As the literature suggests, a specific parenting issue for the mothers is their need to develop appropriate parental authority and control over their children (Levendosky 2000; Levendosky & Graham-Bermann, 2000). These mothers could have participated in an array of parenting courses but none would have likely addressed their specific concerns and issues. It is my belief that incorporating discussion regarding the effects of family violence on women, children, and mother-child relationships, was important in providing a context within which their parenting issues occurred.

In my opinion the parent-child multi-family group component was a positive extension of the mothers' group in terms of providing support and parent education. Participation in the parent-child multi-family component provided a natural reinforcement of similarities in parenting experiences for these mothers. The mothers saw for themselves and appreciated the struggles other families encounter. Mothers

were then able to provide peer support and encouragement to one another in subsequent mothers' sessions and parent-child multi-family sessions. Furthermore, mothers learned by observing each other and then integrating alternative strategies they observed in group. Finally, bringing the mothers and children together supported the therapeutic nature of the mother-child relationship.

Utilizing Theraplay, both within the mothers' group and the parent-child multi-family group, had merits. Within the mothers' group, the four components of Theraplay (nurture, engagement, structure, and challenge) provided a helpful framework to discuss dynamics of the parent-child relationship likely impacted by family violence. Within the parent-child multi-family component the Theraplay activities appeared to create meaningful exchanges between the mothers and the children. Although there was some initial discomfort for the mothers with the centrality of play, which is inherent in this approach, I believe the mothers progressively became more comfortable. I believe that the mothers developed an appreciation for the power of play as a helpful intervention for themselves with their children. Incorporating Theraplay within the parent-child multi-family group was helpful to provide hands on, fun activities that parents can use with their children to address dynamics identified as concerning.

Population

Lasting Effects of Violence

The literature suggests that lasting effects of violence may carry over to the parent-child relationship even after women and children are no longer in their abusive environments (Holden et al., 1998). The three families that completed the group varied

in the length of time since their last exposure to the violence, ranging from ten months to four years. Despite these differences, each family presented with parent-child issues they identified as emanating from the family violence. For some families, they reported their situations to have continually deteriorated in spite of the increasing time lapse since the exposure to the violence. These lasting effects, as well as the perceived deterioration, are useful in understanding the need for interventions to occur at various stages of families' recovery. Both Barb's and Cindy's families had received some counseling immediately following the violence stopping. While immediate services are essential to assist families through the initial crisis that can occur following a disclosure of family violence, professionals who work with this population need to appreciate the powerful carry-over effect of the violence and continue to offer services to prevent further harm to the parent-child relationship.

Environmental Stressors

It became apparent from working with these families that many of these mothers and their children were experiencing significant stress in their day to day lives. Jaffe et al. (1990) discuss how partner violence is often to be accompanied by additional burdens including stresses from divorce, money problems, unemployment, or homelessness. All of the families that participated in the group were experiencing one, usually more, of these stresses simultaneously. Within the context of the group, members frequently needed time to discuss and problem solve issues related to these external stressors. In addition to support from the group process, members frequently needed assistance from the practitioners to advocate on their behalf with external systems. An example of this was when one of the mothers was seeking an Order of

Prevention and Linda Perry accompanied the mother to the law courts to complete an application. While the identified purpose of the group was to address the parent-child issues that had arisen from the family violence, practitioners need to be mindful of these associated environmental stressors and to anticipate additional service needs of group members which they can be called upon to assist with.

Systemic Perspective

When working with families who have been affected by parental violence it is important to view the family as a system unto itself and within its larger environment. Treating the mothers and children separately in concurrent groups, and then simultaneously in the parent-child multi-family group, was essential to recognizing the interrelated and reciprocal nature of their parent-child issues. Furthermore, the parent-child multi-family group acknowledges the importance of including mothers in the process of changing the relationship between themselves and their children. This appears to be consistent with the literature on this population that recommends the most effective interventions to include both the mother and child in terms of improving children's behavior and improving mothers'parenting capacity (Holden et al., 1998; McKay et al, 1995).

The use of a systemic perspective was also helpful in reviewing the involvement of other agencies with the families. Not only was this perspective important to ensure that existing services supported the families in accessing the group and were complementary in working towards similar goals, but it was also important in identifying potential needs that were not being addressed. For one family in particular, there were extensive services being provided through Child and Family Services and

the school system. As the family progressed through group, further needs emerged that the group could not address. The sharing of information between organizations was helpful to coordinate post-group services within the community to ensure that gains made in group would be supported beyond the group's completion.

Maternal Parenting Style and Practice

All three mothers who completed the group acknowledged that the domestic violence impacted upon their parenting style and practices. Similar to Levondosky's (2000a) study these mothers reported both positive and negative effects of the violence on their parenting. Positively the mothers perceived themselves to have developed an increased appreciation and sensitivity to their children's needs, specifically in terms of providing a home environment free from violence. Adversely, the desire to compensate for the prior violence often resulted in the undesired effect of increased aggression being displayed by their children. As was the experience of these mothers, the literature suggests that mothers may fail to teach their children to control aggression and may even unwittingly reinforce aggressive tendencies by ignoring them or backing down from confrontations over violent acts (Wolak & Finkelhor, 2000). The centrality of this issue, fear of confrontation with their children, reinforces the need to incorporate ample discussion of this issue into group work practice with women and children impacted by family violence.

Resiliency of Mothers

The mothers who participated in this group are testimony to the resiliency of mothers who have been impacted by domestic violence. All three mothers mobilized their personal resources to stop the violence that they were experiencing in their family.

In itself, this act requires extensive personal strength. Despite several obstacles to coming to group, including the burdens of environmental stressors and the personal energy required to participate, these women attended and completed group. The participation and completion of the group signifies a huge accomplishment and demonstrates a commitment to creating a better environment for themselves and their children.

CHAPTER VI – CONCLUSION

I believe that through the implementation of this group work approach, with women and children impacted by domestic violence, I was able to achieve the personal learning objectives that I had established at the onset of the practicum process. In reflecting upon the practicum I was also able to identify several recommendations for future interventions with this population.

Personal Learning Objectives

Three educational objectives were initially identified that I had hoped to achieve by the completion of this practicum. The first objective was to increase my knowledge and understanding of the issues facing women and their children who have been impacted by domestic violence. The clinical and empirical literature that I reviewed was very informative in providing a basis for understanding the circumstances of women and children exposed to domestic violence. The clinical supervision that I received from Dr. Diane Hiebert-Murphy and Ms. Linda Perry provided further insight towards understanding the issues that face this population. Perhaps the most meaningful learning occurred through the implementation of the group itself. Working directly with the women and children blended the theory that I had read about, with the real life experiences of families impacted by domestic violence. Through the members' willingness to share, I learned about the challenges that face women who have been battered and the difficulties they encounter in their capacity as mothers.

The second learning objective was to implement and evaluate a group intervention for women and their children who have been impacted by domestic

violence. This was accomplished from August 2001 to January 2002 and involved the pre-group activities, group facilitation, and post-group activities. Throughout this process I developed an appreciation for the amount of work involved in all stages of group work. The pre-group activities that involved advertising for the group, screening of potential members and planning for the group sessions were labor intensive, and at times frustrating. Recruiting members for the group required extensive effort in soliciting referrals and following up with those received. Many times, it seemed that the group membership was coming together, however as quickly as this evolved, it also unraveled. The screening of potential members required a high degree of availability and flexibility to accommodate appointments for potential members' schedules. Finally, the preparation of group sessions was a continual process. Although the content of sessions had been planned somewhat in advance, the desire to tailor the group to the members' needs resulted in frequent changes being implemented. Observations regarding the discussions and activities that appeared to work well were also incorporated into future sessions. While it is necessary to have a framework for the group prior to the onset of sessions, it proved more helpful to modify the agenda in order to meet the group's needs.

The evaluation of the group process, which included standardized measures, post-group interviews, and qualitative client satisfaction questionnaires, was educational for me. I learned when and how to implement standardized measures and to interpret the results. The post-group interviews and the qualitative questionnaires were beneficial to me in terms of enhancing my understanding of standardized measures and their limitations. I learned the importance of implementing post-group

measures in a timely fashion, not only to capture members' perspectives immediately following the group, but also in terms of having members complete measures which they might otherwise lose interest in. In hindsight, I would have liked to modify the existing qualitative consumer satisfaction questionnaire to specifically ask more detailed questions regarding the change mothers perceived to have occurred within their parent-child relationship. I believe that more direct questioning regarding this relational issue would have provided richer responses from the members and possibly have been more useful for the purposes of this practicum.

The third and final learning objective was to develop practice skills in short term group counseling and become more familiar with the application of multi-family group work and Theraplay in small group work practice. I found the facilitation of the group to provide additional learning about the worker's various roles, leadership style, and tasks necessary in group work. The facilitation experience also reinforced prior skills that I acquired in group facilitation, but also provided new opportunities for me to practice skills in leadership, advocacy, and conflict resolution. I also learned the difficulty inherent in group work, that of balancing the needs of individual members with that of the group itself. With respect to multi-family group work, I developed an appreciation for the various ways that this approach can facilitate learning for group members. The ability for mothers and children to interact together and with other families who have common issues proved useful in accomplishing the objectives of the group. The parent-child multi-family component also provided a context for me to practice assessment of intergenerational dynamics through direct observation. Incorporating Theraplay activities within the parent-child multi-family group required

me to develop a comprehensive understanding of the core elements of nurture, engagement, structure and challenge within healthy parent-child relationships. Understanding these elements contributed to my ability to assess family dynamics and plan practical interventions to address identified issues.

Overall, this practicum experience provided me with a challenging experience that contributed immensely to my professional and personal learning. As a social work practitioner, I believe that the experience has enhanced my skills in areas of family assessment and intervention planning. While the presenting issue for these families was exposure to family violence, I believe that the skills I developed can be easily transferred to other parent-child populations. In this regard, I believe that my professional work will benefit from the practicum experience by continual application of the knowledge I gained to my ongoing work with families. Personally, having practiced as a social worker in the field of child welfare for nearly ten years, it was refreshing to learn new information regarding a specific population group and intervention strategy. I feel great satisfaction in having undertaken and completed the challenge of this practicum.

Recommendations

Based upon the experience of implementing a support group for women and a parent-child multi-family group for the women and their children, several recommendations are suggested for future work with this population.

1. Continue to use this model for future groups with women and children impacted by domestic violence. The combined approach of concurrent mothers' and children's groups with a parent-child multi-family group appears

to work well. The treatment of families in a systemic manner reinforces the importance of the interrelatedness of the issues for the women and children. Furthermore, by providing therapy in this manner, it reinforces the impact of domestic violence upon the family system, rather than tendencies to individualize the problems and pathologize the women and children.

2. Ideally, group size should remain small. Although having only three members could have been detrimental to the survival of the group, the small size of the group appeared to work well for these women and their children. The small group size within the mother's group appeared to contribute to strong cohesion, which ultimately led to the group's success. For the facilitators, the small membership enhanced the ability to provide members with individual attention within a group format. The small group size also permitted the facilitators to understand each family unit on a more meaningful basis. For the multi-family group, the small group size contributed to the Theraplay activities being more manageable and also provided increased opportunity for facilitators to provide assistance and direction to parents through partnering of one facilitator per family.

3. Integrate Theraplay assessment and intervention to a greater extent. Within this group experience it appeared that more work could have been done with the mothers and their children to allow for greater integration of Theraplay material. Extending the group by a few more sessions could possibly have accomplished this, thereby creating more opportunity for practice within sessions. Another strategy might have been to provide feedback to the

mothers earlier in the group process. If initial formulations are evident regarding parent-child dynamics, it might be helpful to provide feedback earlier in the process so that the families can incorporate this information and attempt to directly act upon it in remaining sessions.

4. Obviously, when implementing a group approach such as this practicum intervention, ample support and assistance are necessary to achieve a successful outcome. Pre-planing is of utmost importance. For example, for these families, the availability of on-site child care was critical. Without such a service, many of the families would not have been able to attend. In circumstances where additional resources are required, it is helpful to coordinate with referring agencies to gain their support and assistance in actualizing their client's completion of the group.

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APPENDIX A

Outline of Group Sessions

Week One

Goal: To orient the members to the group, its purpose, the members and the facilitators.

Mothers' Group

1. Check-in and introductions
- Welcome and introductions of members and facilitators
- Have mothers share the names and ages of their children and one thing that they do for fun with their children

2. Housekeeping issues

- The group will be twelve weeks in duration beginning tonight, September 27th, and finishing on December 13th, 2001.
- Structure of session- each group session is approximately 2 hours long. Each session will have a portion of the group, which is mothers only and children only. Each session will also include a portion of time for mothers with children. Gradually the portion of multi-family time will increase as the group progresses.
- For the next few weeks the mothers' group portion will be approximately one hour in length followed by a ten-minute break allowing for members to use the washrooms or to step outside for a few minutes.
- Snack will be with the children and it is important that all mothers participate in snack time. The sharing of food with our children is an important nurturing aspect of the parent-child relationship.
- It is important for everyone to attend sessions and to be punctual. If you are unable to attend or anticipate being late we would appreciate hearing from you prior to group.

3. Group guidelines

- Brainstorm what women need to feel safe in the group i.e., respect, confidentiality, openness, tolerance etc.

4. Warm up game
- Name game
- Cotton ball throw

5. Themes of the week

A) Why are we here?

Mothers and children will be discussing this theme. Facilitators review the purpose for providing the group.

- Mothers – share experiences and gain an understanding of the impact of family violence has had on the parent child relationship. Develop an understanding of the importance of play in strengthening the parent-child relationship.

- Children – will be helped to develop social skills and express feelings in socially appropriate ways. The group will provide children with a positive experience that will increase their self-esteem and have an opportunity to experience positive peer relationships.

- Mothers and children – will learn to have fun together using play and activities to strengthen the parent-child relationship.

B) The importance of play

- Brainstorm with the mothers the definition and the importance of play.
- Share psychoeducational material regarding the four functions of play, including: biological, intrapersonal, interpersonal and social-cultural.
- Discussion
- Why is play important in families where there has been violence?
- How comfortable are adults with playing?

6. Nurturing and check-out

- Request a volunteer to summarize our activities and share this information with the children in multi-family group
- Pass the lotion – have each mother massage her own hands with lotion
- Have each woman check-out with a brief comment about what she will be taking from group tonight

<u>Multi-Family Group</u>

1. Check-in, sharing, snack and welcome song

2. Theraplay activities

- Hello song
- Cotton ball throw
- Balloon toss
- Pass the lotion

3. Closing song

Week Two

Goal: To provide education and facilitate discussion regarding the impact of family violence on women.

Mothers' Group

1. Check-in and re-introductions
- How did the children respond to last week's group? Any feedback? Any observations?

2. Housekeeping issues

- The group will be closed to new members after tonight
- Request volunteer spokesperson to share with the children
- Sessions will be equally divided; it appears mothers need the full hour
- Children's theme – Becoming a group

3. Warm up game
- Name affirmation

4. Theme of the week - Effects of family violence on women and parenting

Present educational material on the topics:

- Effects on women
- Effects on parenting
- Influences on parenting (depression, stress, inconsistency, discipline)

5. Discussion

6. Nurturing and check-out

- Pass the lotion – have each mother massage her own hands with lotion
- Have each woman check-out with a brief comment about what she will be taking from group tonight

Multi-Family Group

1. Check-in, sharing, snack and welcome song

2. Theraplay activities
- Hello train

- Balloon walk
- M& M hunt

3. Closing song

Week Three

Goal: To provide education and facilitate discussion regarding the impact of family violence on children.

Mothers' Group

1. Check-in
- Welcome
- "Name a feeling that you had today"

2. Housekeeping issues

- The group is closed
- Request volunteer spokesperson to share with the children
- Children's theme – Feelings

3. Warm up game – Sit in your spot like…

4. Theme of the week - Effects of family violence on children
- Informational handouts
- Read "Mommy and daddy are fighting"

5. Discussion

6. Nurturing and check-out
- Pass the lotion – have each mother massage her own hands with lotion
- Have each woman check-out with a brief comment about what she will be taking from group tonight

Multi-Family Group

1. Check-in, sharing, snack and welcome song

2. Theraplay activities
- Slippery, slippery slip
- Donut on a finger
- Lotioning of hurts

3. Closing song

Week Four

Goal: To introduce the four Theraplay dynamics and to establish the element of nurturance as important within healthy parent-child interaction

Mothers' Group

1. Check-in
- Welcome
- "Name one thing you lie to do to nurture yourself?"

2. Housekeeping issues

- How do moms want the group to assist when they feel their children are acting up?
- Request volunteer spokesperson to share with the children
- Children's theme – Different kinds of hurt

3. Warm up game
- Cotton ball touch

4. Theme of the week - Nurture
- Brainstorm ways in which we nurture
- Read nurture excerpt from Theraplay

5. Discussion
- How easy is it for us to nurture?
- How easily do our children let us nurture them?
- Whose needs are we meeting through nurturance?

6. Nurturing and check-out
- Pass the lotion – have each mother massage her own hands with lotion
- Have each woman check-out with a brief comment about what she will be taking from group tonight

Multi-Family Group

1. Check-in, sharing, snack and welcome song

2. Theraplay activities
- Check up/measure
- Tangle
- Row, row, row the boat

3. Closing song

Week Five

Goal: To establish the element of engagement as important within healthy parent-child interaction.

Mothers' Group

1. Check-in
- Welcome
- "Who is someone who really enjoys your company?"

2. Housekeeping issues

- What is it like to hear other members talk about your children? Emphasize the commonality of experience
- Request volunteer spokesperson to share with the children
- Children's theme – Fighting in families

3. Warm up game
- Mirroring

4. Theme of the week - Engagement
- Brainstorm ways in which we engage
- Read engagement excerpt from Theraplay

5. Discussion

6. Nurturing and check-out
- Pass the lotion – have each mother massage her own hands with lotion
- Have each woman check-out with a brief comment about what she will be taking from group tonight

Multi-Family Group

1. Check-in, sharing, snack and welcome song

2. Max – "Mixed up feelings"

3. Theraplay activities
- Move your body
- Progressive pass around
- Mirroring

4. Closing song

Week Six

Goal: To establish the element of structure as important within healthy parent-child interaction.

Mothers' Group

1. Check-in
- Welcome
- "Where was a place you felt safe as a child?"

2. Housekeeping issues
- Request volunteer spokesperson to share with the children
- Children's theme – Fighting in families should never be a secret

3. Warm up game
- Pop the bubble

4. Theme of the week - Structure
- Postponed to address a member in crisis

5. Discussion

6. Nurturing and Check-out
- Pass the lotion – have each mother massage her own hands with lotion
- Have each woman check-out with a brief comment about what she will be taking from group tonight

Multi-Family Group

1. Check-in, sharing, snack and welcome song

2. Max – "Breaking the secret"

3. Theraplay activities
- Pop the bubble
- Sticky nose
- Red light, green light

4. Closing song

Week Seven

Goal: To establish the element of structure as important within healthy parent-child interaction.

Mothers' Group

1. Check-in
- Welcome
- Personal time for check in

2. Housekeeping issues
- What type of check in would members prefer – structured vs. non-structured?
- Homework – brainstorm scenarios of problematic child behavior for future topic discussion
- Request volunteer spokesperson to share with the children
- Children's theme – Mixed up feelings

3. Warm up game
- Mother may I?

4. Theme of the week - Structure
- Brainstorm ways in which we provide structure
- Read excerpt from Theraplay

5. Discussion
- Why is providing structure so difficult?
- How do we perceive structure?

6. Nurturing and Check-out
- Pass the lotion – have each mother massage her own hands with lotion
- Have each woman check-out with a brief comment about what she will be taking from group tonight

Multi-Family Group

1. Check-in, sharing, snack and welcome Song

2. Max – "Stopping the violence"

3. Theraplay activities
- Mother may I?
- Lotion or powder prints
- Measuring with fruit tape

4. Closing song

Week Eight

Goal: To establish the element of challenge as important within healthy parent-child interaction.

Mothers' Group

1. Check-in
- Welcome
- "Who was the one person who believed in as you wee growing up?"

2. Housekeeping issues
- Request volunteer spokesperson to share with the children
- Children's theme – Coping with feeling afraid

3. Warm up game
- Paper punch

4. Theme of the week - Challenge
- Brainstorm ways in which we provide challenge
- Read excerpt from Theraplay

5. Discussion

6. Nurturing and check-out
- Pass the lotion – have each mother massage her own hands with lotion
- Have each woman check-out with a brief comment about what she will be taking from group tonight

Multi-Family Group

1. Check-in, sharing, snack and welcome song

2. Max – "Feeling afraid"

3. Theraplay activities
- Balance on pillows
- Paper punch
- Paper toss
- Musical pillows

4. Closing song

Week Nine

Goal: To assist members with identifying positive problem solving/behavioral management strategies to assist their children.

Mothers' Group

1. Check-in
- Welcome
- "Describe one incident where you felt that you handled your child's problematic behavior well"

2. Housekeeping issues
- Request volunteer spokesperson to share with the children
- Children's theme – Anger- what is it?

3. Warm up game
- Balance on pillows

4. Theme of the week – Problem solving your child's behavior
- Handling "Mother guilt"

5. Discussion

6. Nurturing and check-out
- Pass the lotion – have each mother massage her own hands with lotion
- Have each woman check-out with a brief comment about what she will be taking from group tonight

Multi-Family Group

1. Check-in, sharing, snack and welcome song

2. Max – "Max gets angry"

3. Theraplay activities
- Balance on pillows

4. Closing song

Week Ten

Goal: To assist members with identifying positive problem solving/behavioral management strategies to assist their children.

Mothers' Group

1. Check-in
- Welcome
- "Describe one incident where you set a limit with your child. Why did you set the limit?"

2. Housekeeping issues
- Request volunteer spokesperson to share with the children
- Children's theme – Dealing with "bad" feelings

3. Warm up game
- Streamer bust out

4. Theme of the week – Problem solving your child's behavior – part 2
- Aggression
- Aggression between siblings

5. Discussion

6. Nurturing and check-out
- Pass the lotion – have each mother massage her own hands with lotion
- Have each woman check-out with a brief comment about what she will be taking from group tonight

Multi-Family Group

1. Check-in, sharing, snack and welcome song

2. Max – "Max apologizes"

3. Theraplay activities
- Pretzel challenge
- Shoe race
- Streamer bust out

4. Closing song

Week Eleven

Goal: To assist members with reviewing their accomplishments and planning for the future.

Mothers' Group

1. Check-in
- Welcome
- "On a scale of one-ten, with ten being wonderful, where are you at with your relationship with your child?"

2. Housekeeping issues
- Request volunteer spokesperson to share with the children
- Children's theme – Getting along with others

3. Warm up game
- Rock-a-bye-baby

4. Theme of the week – Past, present and future
- What progress do you feel you and your child have made?
- What issues remain for you, your child, and your family?
- How will you address these?

5. Discussion

6. Nurturing and check-out
- Pass the lotion – have each mother massage her own hands with lotion
- Have each woman check-out with a brief comment about what she will be taking from group tonight

Multi-Family Group

1. Check-in, sharing, snack and welcome song

2. Max – "Max in the future"

3. Theraplay activities
- Squeeze is going around
- Licorice eating
- Rock-a-bye-baby

4. Closing song

Week Twelve

Goal: To celebrate the completion of group

Mothers' Group

1. Check-in
- Welcome

2. Housekeeping issues
- Schedule follow up interviews

3. Theme of the week - Termination
- Farewell exercise

4. Discussion

5. Nurturing and check-out
- Pass the lotion – have each mother massage her own hands with lotion
- Have each woman check-out with a brief comment about what she will be taking from group tonight

Multi-Family Group

1. Welcome song

2. Farewell activities
- T-shirts
- Pictures

3. Celebration cake

4. Closing song

APPENDIX B

Qualitative Measures

Mother's Evaluation

1. How much did you like the group? A lot 5 4 A little 3 2 Not at all 1

2. What did you like about the group?

_____
_____
_____

3. What did you dislike about the group?

_____
_____
_____

4. How much do you think the group helped your child? A lot 5 4 A little 3 2 Not at all 1

5. Have you noticed any change in your child as a result of participation in the group?
Yes No

If you answered yes, what changes did you notice?

_____
_____

6. How much did you learn in the group? A lot 5 4 A little 3 2 Nothing at all 1

7. What would you suggest that should be done differently in future groups?

_____
_____
_____

8. Would you tell a friend who has problems in her family to come to this kind of group?

Yes No

Mother's Caretaker Evaluation

1. What did you like about your child's participation in the group?

_____

_____

_____

2. How much do you think the group helped your child? A lot A little Not at all
   5 4 3 2 1

3. Have you noticed any change in your child as a result of participation in the group?
   Yes No

   If you answered yes, what changes did you notice?

   _____

   _____

4. How much information did you receive about what your child was learning and doing in the group? A lot A little Not at all
   5 4 3 2 1

5. What would you suggest that should be done differently in future groups?

_____

_____

_____