"FAMILY THERAPY" WITHOUT THE FAMILY:

A PSYCHOEDUCATIONAL SUPPORT GROUP

FOR THE ADULT CHILD

BY

SUZANNE LEIGH RUTLEDGE

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
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FACULTY OF GRADUATE STUDIES

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ABSTRACT

The overall purpose of this practicum was to develop, implement, and evaluate an intervention which would assist the "Adult child" to improve her ability to cope with an aging parent whom she perceived as having a "difficult personality". An intergenerational and feminist groupwork intervention strategy was utilized in this project to provide support and improve the Adult child's coping skills. In particular, the aim of the intervention was to facilitate improved ways of coping through the reduction of feelings of burden, and/or the improvement of social support, and/or the improvement of attitude toward the parent, and/or the improvement of self-esteem.

The group, conducted for eleven weeks in Winnipeg, Manitoba, consisted of eight women who perceived a parent as having a "difficult personality" and who were drawn to the group by their desire to change their relationship with that parent.

The practicum findings indicated that the group was helpful to all group members. It was particularly helpful in improving members' perception of the quality of social support available to them, and in creating positive changes in members' attitudes toward their parents, as they engaged in resolving issues from the past. This form of group intervention was found to be an effective modality for helping the Adult child. Implications for the practice of social work with the Adult child whose parent has a "difficult personality" are outlined, and suggestions for future study are offered.

ACKNOWLEDGEMENTS

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DEDICATION

I am eternally grateful to my very special parents Kristin and Ken whose unwavering support, help and love made this pursuit possible.

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CHAPTER 1 - INTRODUCTION

In order to complete the requirements for my Master of Social Work Degree I chose to implement a practicum. This report encompasses the rationale for the practicum and provides as well, a summary of results. It is organized as follows: Introduction; Literature Review; Intervention; Observations; Evaluation; Discussion; and Conclusion.

The intervention chosen for this practicum involved a psychoeducational support group comprised of 11 sessions for the Adult child. Intergenerational and feminist theory guided me in my intervention. Members were recruited based on their interest in changing their relationship with their parent. Intervention focused upon the needs and challenges of the daughter rather than the mother and included mutual support, self-awareness, problem-solving, and skills development. This focus was chosen to help Adult children cope more effectively in interactions with their parent and to make positive changes in their attitudes and behaviour.

Within the scope of this practicum, examination focused on the experience of the Adult child who had an aging parent she perceived as having a "difficult personality". The term "difficult personality" was not intended to be used as a label, but rather was used in this intervention as a way of introducing and validating the difficulty the Adult child was having with a parent and engaging the Adult child in discussion about the dynamics of the relationship with her parent.

Throughout this report, the group member will be referred to as the "Adult child". The Adult child referred to in this practicum report is an individual who has experienced a parent's projection of emotionally abusive coping strategies on to the Adult child. I

am not using this term as a label but rather for the purposes of clarification. Throughout the intervention the focus was on the experience of the Adult child in her relationship with her parent. The "A" in adult is capitalized to signify the individuation and empowered status of the individual and emphasize that the individual is no longer a powerless child but rather a self-possessed adult.

The group member referred to as the Adult child will also be identified using female pronouns. I chose to use only female pronouns to improve the readability of the text. I also chose to use female pronouns because, although males were not screened out for this intervention, all members of this particular group were female.

The aim of my intervention was to facilitate the discovery of, and learning about, improved ways of coping for members. Examples of ways in which group members might be anticipated to experience improved ways of coping included the development of social support networks, and/or the reduction of feelings of burden, and/or improvement of one's attitudes toward the parent, and/or improvement of self-esteem.

This chapter of the practicum report provides a brief description of "the problem" and provides a survey of available resources on child/parent relationships. It also introduces the theoretical frameworks, practicum objectives, and plan for evaluation of this intervention.

1.0 THE PROBLEM

People with "difficult personalities" are often perceived as "manipulative, unmotivated, malingerers, psychopaths, and prone to acting out behaviours" (Straker,

1982, p. 124). Formal caregivers often find these people difficult because of non-compliance with, and misuse of, the health care system and resources.

I am a member of the Psychogeriatric Outreach Team at Deer Lodge Centre. This is a service which provides consultation, education, support and treatment to elderly clients and their caregivers. A number of referrals have been received by our team from formal caregivers requesting an assessment of individuals with "difficult personalities". The reason for referral is usually for an assessment of cognitive functioning because of the individual's difficult, demanding, and/or extremely passive behaviour. The team's assessment, in some cases, is that these individuals are not suffering from dementia and are cognitively well. The team sometimes also learns, after speaking with family members, that what may be perceived by the formal caregiving system as "difficult" behaviours have in fact been life-long patterns with these individuals. In general terms, many of these Adult children describe their parents as people who lack insight, blame other people for their problems, and refuse to take responsibility for themselves.

An Adult child with an aging parent who has a "difficult personality" often suffers from the consequences of what Susan Forward (1989, p. 6) labels as a "toxic parental" relationship. Forward uses the word "toxic" to describe a parent who inflicts ongoing trauma, abuse, and denigration onto his/her children, and continues to do so when his/her children are adults. The emotional damage inflicted by a parent can spread throughout a child's being, and as the child grows, so does the pain.

Many Adult children feel helpless and demeaned by their parent, others feel that nothing they do is ever "good enough". One Adult child I worked with stated that

according to her mother "I never measured up. I was always under my potential. I always underfunctioned".

It is extremely frustrating and at times disheartening for Adult children to see their parent behaving as chameleons, where their faces and behaviours change as they interact with different people. The Adult child may feel confused and may often doubt the validity of her perceptions of her parent and consequently her perception of life in general. Another Adult child I knew professionally said "I never felt like I had a mother. I wasn't mothered or nurtured, and I didn't know about checking out reality".

When, as a child, an individual is beaten, neglected, sexually abused, treated like a fool, overprotected, or overburdened by guilt, the individual may suffer from damaged self-esteem which may lead to self-destructive behaviour (Forward, 1989). Forward proposes that an Adult child, many times, may also feel worthless, unlovable, and inadequate in one way or another and, as a result, suffer socially, psychologically, emotionally, and physically.

1.1 A SURVEY OF AVAILABLE RESOURCES ON CHILD/PARENT RELATIONSHIPS

Very little work has been done in the area of working with Adult children whose parent has a "difficult personality". Few articles focus on the reactions, tasks, and coping mechanisms of an Adult child who cares for an elderly parent with a "difficult personality". As well, the nature of the relationship between the caregiver and the care receiver is seldom identified in the literature. Little if any content acknowledges the dynamics and impacts of the relationship between parent and Adult child or addresses

the general health and well-being of the Adult child. Similarly, the literature on the subject of groups for Adult-child caregivers of the elderly parent who has a "difficult personality" is non-existent. There are also no articles on groups, specifically designed for these caregivers. Most literature in the field focuses on groups for caregivers caring for an elderly person who is physically frail and/or suffering from Alzheimer Disease. Most groups for caregivers are also primarily informational and educational, and/or interactively supportive in nature.

More attention has been given in the literature to the indicators of relationship quality between the Adult child and her parent. However, attention has focused primarily on the amount of contact and types of assistance (Lang & Brody, 1983) which occur between the caregiver and care receiver. The literature addressing the psychological impact of role conflict between parent and Adult child is very limited. A computer search over ten years produced only two major studies exploring this area. Scharlach (1987) devised a study wherein his findings suggested the need for increased empirical attention to qualitative and quantitative aspects of filial relationships and the factors that affect relationship quality. This will be discussed in more detail in the literature review section of the practicum report.

Goldstein (1990) as well as other researchers (Hepburn and Waswa, 1986) have acknowledged further issues which groups for caregivers usually do not address. These include intergenerational conflict, family of origin issues, the caregiver's life after the aging person has died, and the need to stop caregiving before exhaustion occurs.

In facilitating a group with the intention of providing an opportunity for Adult children to address unresolved parental relational issues, and to integrate them into their present lives, I have taken into account several of the needs which Goldstein identifies as lacking in many caregiver groups.

1.2 THEORETICAL FRAMEWORKS

For the development and expansion of the theoretical framework, the literature review will address the areas identified below.

FURTHER EXPLORATION OF THE PROBLEM

1. A Profile of the Aging Parent with a "difficult personality"
2. Coping Strategies of the Aging Parent
3. A Profile of the Adult child
4. Coping Strategies of the Adult child
5. Feelings of the Adult child
6. Interpersonal Dynamics Between the Parent and Adult child

KEY ISSUES FOR THE ADULT CHILD

1. Emotional Abuse
2. Caregiving

THEORIES UTILIZED FOR THE INTERVENTION

3. Intergenerational Theory
4. Feminist Theory
6. Small Group Theory

The needs of many Adult children whose parent is perceived as having a "difficult personality" cannot be met through traditional support groups. Smith, Smith, and Toseland (1991) make reference to findings that caregivers themselves are likely to attribute their poor relationship with their parent to historical causes other than caregiving. Smith et al. believe that this may prevent them from perceiving professional

interventions labeled as opportunities for caregiver support (such as groups) as an appropriate setting in which to resolve long-standing parent-child conflicts (Brody, 1985: Tobin, 1987). This perception is accurate, as research indicates (Goldstein, 1990) that most caregiver support groups do not address or attempt to resolve long-standing parent-child conflicts. As well, it has been my experience that many Adult children do not readily seek help because they blame themselves for feelings such as anger, resentment, and inadequacy that were likely reinforced in early childhood. Besides, they may think, "why should I need help? It must be me, my parent does not have Alzheimer Disease, he/she is not physically frail without available help, nor does my parent have a drinking problem". The Adult child often cannot identify the source of her difficulties because there is no tangible "illness" to base it on. The Adult child often does not discuss these issues with others, and instead feels undeserving of support and understanding. She may also feel guilty if she does talk about it, thinking that she is "complaining" about her parent. One woman had difficulty talking to me about her mother because she somehow felt that her mother would find out and she would then "pay for it" later. Such thoughts and words reflect the ideas of Adult children who have grown up with a parent who has a "difficult personality", and demonstrate the children's low levels of self-esteem and feelings of inadequacy. These Adult children are products of families where at least one parent did not teach or model healthy ways of coping. It was hoped that the group could counteract some of the effect of the negative messages about themselves which they had been receiving from their parent.

Hargrave and Anderson (1992) suggest that patterns of dysfunctional behaviours/relationships in families of origin, may continue into succeeding generations if they are not resolved with other family members. While the authors identify parents who are very self-centered (which may indicate a "difficult personality"), they do not acknowledge this as an issue for the Adult child whose parent does not comprehend that they have any issues to resolve. Therefore, the authors do not identify whether the interventions they are suggesting can be helpful to the Adult child whose parent is not prepared to be involved in discussion or therapy.

It is my opinion that Adult children who are motivated to work on intergenerational conflicts can resolve past issues, and may begin to resolve issues with their own children, and with other interpersonal relationships, without the involvement of their parent. My intention in utilizing a group format was to provide an opportunity for Adult children to discover and/or create healthier coping strategies and become less emotionally affected by their parent. Through the group process, I provided an opportunity for members to establish and improve other relationships in their lives.

1.3 PRACTICUM OBJECTIVES

The broad learning objectives (including my professional development goals) I attempted to meet through the development and implementation of this practicum are listed below. These were

- to develop and implement a support group targeted towards the Adult child whose parent was perceived as having a "difficult personality";
- to improve my skills and techniques in short-term group facilitation;

- to further enhance my knowledge of the difficulties associated with provision of care to an elderly parent who is perceived as having a "difficult personality", and the effect it has on the Adult child; and

- to develop knowledge and skill in collecting and analyzing evaluative data.

My hope was to advance knowledge in the area of social work by

- identifying unique interpersonal issues pertaining to this particular population as displayed through coping mechanisms demonstrated by the Adult child;

- testing out a therapeutic intervention for the Adult child whose parent has a difficult personality, focusing specifically on the development of new coping mechanisms to deal with the triggers of the past;

- analyzing the benefits of utilizing a psychoeducational support group format with this population; and

- adding to the literature regarding how "social norms" impact on, and form expectations in, families intergenerationally.

1.4 INTERVENTION

The value of group interventions for members is identified positively throughout the literature. Given the reality that the parent with a "difficult personality" will likely refuse to engage in family therapy, the use of a group format for therapeutic purposes provides an alternative interactive environment for the Adult child. Positive support for group intervention is provided by researchers such a Toseland and Rossiter (1989), and Goodman (1991).

A closed, time-limited group was utilized for this group intervention. The group ran for eleven two-hour weekly sessions and was facilitated by myself. The content and provcess of particular group sessions varied depending upon the specific needs of those Adult children who were part of the group.

Sessions were audio-taped for supervisory purposes and data gathering. Information was also gathered from the Literature Review, and pre- and post-group interviews with the Adult children.

Group members had the opportunity to opt out at any time. Their identity was not disclosed in any material which resulted from these sessions/interviews. Records were kept in a locked file and were destroyed upon successful completion of the practicum.

Records were accessed only by members of my practicum committee who were as follows: **Shirley Grosser** who provided me with supervision, regarding formation and development and termination of the group, and feedback from taped group sessions; **Diane Hiebert-Murphy** who assisted in interpreting evaluative findings; **Geri McGrath** who was available on-site daily, has an extensive background in gerontology and assisted in editing my practicum report.

The effectiveness of the group was measured by evaluating members' improved ways of coping either through the reduction of feelings of burden, and/or the development of social support networks, and/or improvements in attitude toward the parent, and/or improvements in self-esteem. The evaluation was comprised of both quantitative and qualitative data which was collected through pre and post group interviews, monitoring of group interactions, and data obtained from self-anchored scales.

CHAPTER 2 - LITERATURE REVIEW

The purpose of this practicum was to develop, implement, and evaluate an intervention which would assist the Adult child to improve her ability to cope in her interactions with a parent whom she perceived as having a "difficult personality" . In particular, the aim of my intervention was to facilitate improved ways of coping for members through the development of social support networks, and/or the reduction of feelings of burden, and/or the improvement in attitude toward the parent, and/or the improvement of self-esteem.

I chose a short-term group facilitation intervention and incorporated intergenerational theory and feminist theory into the intervention. By utilizing these two theoretical perspectives, I attempted to develop an effective group intervention.

This chapter explores selected relevant literature that assisted me in exploring the issues facing Adult children, and in developing and implementing my intervention. The first part of the Literature Review includes further exploration of the problem. It provides a profile of the aging parent with a "difficult personality", the coping strategies of the aging parent, a profile of the Adult child, and coping strategies of the Adult child. Feelings of the Adult child as well as a description of interpersonal dynamics between the parent and Adult child are also discussed. The second part of the Literature Review focuses on two particular issues arising from the exploration of the problem relevant to the Adult child, i.e. emotional abuse and caregiver issues . The final section describes the theories utilized for the intervention.

A. FURTHER EXPLORATION OF THE PROBLEM

2.0 A PROFILE OF THE AGING PARENT WITH A "DIFFICULT PERSONALITY"

Rose, Soares, and Joseph (1993) propose that personality disorders are actually exacerbated by old age due to increased losses and deteriorating health. Older individuals with personality disorders often come to the attention of social workers (and I would add other health care workers) because of their lack of support systems. Increased dependency and deteriorating health that often come with aging make a social support system even more necessary for those individuals with personality disorders (Rose et al., 1993). I would also add that family members involved in this person's care may require as much, if not more, support than their parent. Rose et al. state that providing services to individuals experiencing personality disorders are actually impeded if recognition of these disorders are overlooked, because professionals either become overly/inappropriately involved, or terminate relationships with these individuals too early because of frustration and burnout. A diagnosis of "personality disorder" can help professionals to recognize the importance of setting limits and to clarify boundaries early on. A recognition of the disorder can also help the professional to depersonalize difficult and abusive behaviour (Rose et al., 1993). I would add that the recognition of a personality disorder may also provide the social worker with an idea of the possible issues faced by others who care for someone with this diagnosis, and encourage them to consider other possibilities for intervention.

The Diagnostic and Statistical Manual of Mental Disorders describes a personality disorder as:

> an enduring pattern of inner experience and behavior that deviates markedly from the expectations of the individual's culture, is pervasive and inflexible, has an onset in adolescence or early adulthood, is stable over time, and leads to distress or impairment (DSM-IV, 1994, p. 629).

For the purpose of this practicum report, I have chosen to use the term "difficult personality" and to avoid the psychiatric label of personality disorder. I am not completely comfortable with this term either, because labels have a tendency to blame, categorize and stigmatize. It was after much thought that I chose to use the term "difficult personality" . My experience in working with Adult children who have interactional struggles with their parents is that they often have a great tendency to blame themselves for the difficulties. It has also been my experience that friends, family and society in general have a tendency to blame and oppress the Adult child, sometimes feeling sorry for the parent. This reinforces feelings of guilt within the Adult child and, again, the Adult child tends to blame herself, often becoming resentful. I chose to use the term "difficult personality" as a way of acknowledging and validating the Adult child's experience. This acknowledgement and validation is in no way an attempt to absolve the Adult child of responsibility for her own behaviours. Rather, it is an attempt to help her understand which aspects of her parent's personality she has difficulty coping with and then help her modify her own behaviour to make it easier on herself. It is also a step toward helping her accept who her parent is and learning to accept who she is as well.

Another reason for avoiding the label of personality disorder is that it tends to be overused. When a person is labelled as having a personality disorder, one is less likely to ask "how?' The term "difficult personality" is one which hopefully is sufficiently open-ended that the professional will be confronted with the need to explore questions such as "In what way are they difficult", "How does this difficulty impact on the Adult child or the lives of other people in the environment of the aging person?", "What aspects of the Adult child's personality contribute to the interactional conflicts?", and "How have others coped with the parent's behaviours and has it been effective?" . In other words, in contrast to the term "personality disorder" the term "difficult personality" challenges the therapist to explore the impact of the parent's way of presenting self to the world with the Adult child. Further, it provides an incentive for the child to develop new interactional responses. It also can provide an opportunity for the therapist to help the Adult child put into context the reason her parent may behave as he/she does.

The intent of this practicum report is not to label the aging parent but rather to help the Adult child to understand and explore her view that one's parent may have had a life-long pattern of difficult behaviours which are deeply ingrained and very difficult to modify.

Research indicates that early childhood deprivation, abuse, and neglect contribute to the emergence of a "difficult personality". To develop a stable sense of oneself, a child needs to grow up in a reasonably predictable environment that provides some degree of consistency and is sensitive to a child's emotional needs. A person's sense of self, his/her capacity to trust others, to cope with conflicting emotions, and his/her ability

to see others as separate from him/herself, develops in infancy and early childhood (Robinson & Schogt, 1992). If a child's needs are responded to inappropriately, inconsistently, and/or unpredictably, the child's view of the world may be distorted. When external support is lacking, the child's emotional needs constantly overwhelm his/her capacity to deal with his/her self and with the environment. Unconscious coping strategies develop and maintain themselves into parenthood and constitute some of the symptoms of a "difficult personality".

Some coping strategies to which the aging parent with a "difficult personality" may resort include detachment, narcissism, passivity, and blaming. These ways of coping are attempts at meeting their own perceived needs, and these coping methods may be emotionally abusive to others. The parent may have his/her reasons for adopting these coping strategies. The intervention implemented in the practicum focused primarily on the outcome of the parent's projection of emotionally abusive coping strategies on to the Adult child and on improving the internal and external coping strategies of the Adult child.

Neugarten, Havighurst, and Tobin (1968) identify four major personality types which they view as crucial in determining a person's level of success in aging. The four are as follows: 1) **the integrated personality** 2) **the armor-defended personality** 3) **the passive dependent personality, and** 4) **the unintegrated personality**. The ideal state is the integrated personality. This describes the person who is able to accept his/her strengths and weaknesses. This type of personality maintains intimate relationships with family and others, and is able to adjust as he/she grows older. In contrast, the personality

type which best fits the majority of the parents I have described would fit into the third category; **the passive dependent personality**. This personality type has little interest in, or commitment to, taking care of themselves cognitively, emotionally, socially or physically. This individual is often highly dependent on family members and formal caregivers, expecting that others will care for him/her. Some of these individuals are generally dissatisfied with their lives and often believe that others, not themselves, have control over their own happiness.

Neugarten, Havighurst, and Tobin (1968) identify two subcategories to their category of the passive-dependent personality. The first is the succor-seeking type wherein the individual behaves or copes by maintaining a high level of activity as the person seeks to gain the attention of others. The other subcategory involves an individual who behaves apathetically. This type of personality may maintain low levels of activity and display little interest in life in general. While this apathetic behaviour could place less physical and emotional expectations on family members, the lack of physical and emotional care for oneself often requires that the Adult child be more involved in direct "hands on" physical and emotional caregiving.

Because of the inflexible and narrow ways in which a person with a "difficult personality" copes with living, including their lack of insight and incapacity to reflect, their vulnerability increases. This makes it more likely that such individuals will suffer stress and break down under unpredictable circumstances. The many losses, role changes, and dependency that come with aging are very difficult to adapt to (Robinson

& Schogt, 1992, p. 174). As indicated previously, these stresses are most likely to intensify and/or exacerbate difficult behaviours.

2.1 COPING STRATEGIES OF THE AGING PARENT

The behavioural manifestations, or coping strategies, of people with "difficult personalities" vary from individual to individual. The behaviours to be highlighted in this report are those which have impacted on the Adult child, as reported by the Adult child, making it difficult for them to cope in their relationship with their parent and/or with life in general.

Framo (1992) identifies the qualities of behaviours that these parents may exhibit. They may be rejecting, detached, unreachable, narcissistic, and self-centered to the point that the needs of the Adult child to have her own life, and to have time away from caregiving, are not considered by the parent. These parents may cope by attempting to provoke guilt, or to humiliate, exploit, deceive, and/or manipulate others. These ways of coping are attempts to absolve themselves of the responsibility of making life decisions for themselves. An Adult child once informed me that her mother would tell her "you're the only one who knows my needs" and upon hearing this she would feel guilty and, in her words, be "sucked in" to taking responsibility for decisions which were ultimately her mother's decisions. She remembers being asked at the age of fourteen, by her mother, if she should divorce her husband. She had replied that she did not want her parents to have a divorce, and subsequently was blamed by her mother for condemning her for the rest of her life to live with him. She also told me that she was accused many times of having almost killed her mother as a result of the birthing process.

2.2 A PROFILE OF THE ADULT CHILD

Like their parents, some Adult children have grown up in an unpredictable environment. Like their parents, their sense of self, their capacity to trust others, to develop intimate relationships, to cope with conflicting emotions, and their ability to see others as separate from themselves are issues which may have been the result of childhood deprivation, abuse, and neglect. Robert Subby (1990) identifies that people who grow up in these situations will suffer from a proactive "dis-ease of the spirit". He describes that they will have:

> A delayed identity development syndrome characterized by a psychological, emotional and behavioral pattern of coping that develops as a result of one's prolonged exposure to and practice of a set of dysfunctional family or social rules .....This dis-ease is all about the unfinished business of the past getting in the way of what is going on in the present. An adult child/co-dependent always gets yesterday mixed up with today, so that whenever something happens in the here and now, it triggers off some unresolved feelings from the past. The adult child/co-dependent retreats into whatever form of behavior he or she used in the past to get through (Subby, 1990, p. 26).

If the message is interpreted by children that they are responsible for their parents' abandonment, neglect or abuse of them, then they might learn to see themselves as people who do not deserve to be cared for. "As adults they are drawn toward people, places, and things that reinforce this script" (Subby, 1990, p. 86). As a result, Adult children's attempts at healthy and mutual connections are often met with pain, rejection, and alienation. In their desire to maintain relationships, they also sacrifice their own needs and wants (Malloy & Berkery, 1993).

Subby (1990) points out that many family systems theorists such as Bowen, Haley and Satir have suggested that "dependency problems in childhood and later in adulthood are the direct result of dysfunctional parenting patterns that call upon children to act as either partner or parent to an adult caregiver who is acting like a child" (Subby, 1990, p. 68). Therefore, I would suggest that some children have learned to survive in their family by acting in a parenting role, although as mere children they were unequipped for the job. Somehow the child may have felt expected to be the "family hero" (Wegscheider-Cruse, 1990) or to be a "Super-responsible child" (Black, 1981). It could also be said that as an adult, this individual may continue to be a caregiver to her parent, and may respond to the social expectation that she must give care when her parent requires even more attention. I think it would be very difficult for an Adult child to be expected by society to revert back to previous survival tactics of being the "family hero" or the "Super-responsible child". This would undoubtedly lead to a resurfacing of unresolved feelings from the past in the Adult child. It would be as if having finally escaped the parent's requirement that the child be caregiver, (with the attendant coping strategies that the child was capable of developing) the social milieu now demands that previous and child-like patterns of coping be re-instituted as the Adult child takes on the role of caregiver once again.

In addition, social role expectations of women precipitate a situation where most caregivers are female and most often daughters. As a result it is women who appear to be the more vulnerable gender to suffer from the burden of caregiving (Brody, 1985).

Subby (1990) also points out that "instead of developing a clear identity, the individual under the influence of these rules develops a chameleon-like identity". Adult children have learned to conform to outside pressures in order to blend in, and disguise their true self. These children learned to avoid the truth by becoming overly involved with, and manipulative of, outside activities. An Adult child reported that she "put my feelings on hold or out on a limb so I wouldn't hurt her". Another Adult child stated, "I didn't realize what feelings were". When practiced in early life, these patterns of coping may have represented a creative effort to avoid punishment and pain. Eventually this style of coping leads to an unconscious emotional and psychological split within the self and further isolation from the self and others.

The Adult child's self-protective identity is what has allowed survival, as the fact of living with a parent expressing a "difficult personality" often forces one to develop a strong, creative, and persevering spirit. This self-protective identity, while denying the Adult child's emotional and physical needs, was the foundation which helped them to survive (Subby, 1990). These survival skills, however, are often applied when there is no real threat to one's life, and as a result, the skills are no longer an asset and sometimes become a liability. When they persist the Adult child will continue to feel like a victim with no choice. To continue to hold this belief is to misperceive and/or deny their adult reality. The surrender of personal responsibility for one's own life, can result in emotional abuse to oneself or others. Hence, the cycle continues as the Adult child becomes a parent to a child, relying on unhealthy coping strategies learned in the past.

2.3 COPING STRATEGIES OF THE ADULT CHILD

An Adult child who has grown up with a parent who has a "difficult personality" often behaves or copes by mirroring her parent. If her parent was rejecting, detached, unreachable, narcissistic, and/or self-centered she may cope by rejecting herself, and detaching from her own physical, emotional, psychological and social needs (Framo, 1992). Like her parent, she does not take responsibility for herself. However, unlike her parent, she may have grown up expecting to meet one or more of her parent's physical, emotional, psychological and/or social needs to the detriment of herself.

Demaris (1991) writes that families are drawn together again physically and emotionally with the signs of their parents' mortality and the beginning of the later life phase. Emotional intensity increases as unresolved emotional issues from the past emerge. Family members also work closely around practical considerations of decision-making and changes in caregiving patterns between the generations which can also increase the emotional intensity. Some Adult children may find themselves attempting to cope with unresolved issues of abuse while caring for the parent who had been (and may still be) abusive towards them.

It is interesting to me that Finkelhor (1984), who writes about the signs of childhood abuse, identifies many of the same signs that Toseland and Rossiter (1989) identify as symptoms which many caregivers experience. These symptoms include depression, anxiety, guilt, self-blame, psychosomatic disorders, exacerbation of long-standing interpersonal problems, sleep loss, and isolation. Finkelhor identifies additional

symptoms including entrapment, self-contempt, and an inability to trust and develop intimate relationships.

2.4 FEELINGS OF THE ADULT CHILD

A child who grows up in a family where the needs of the parent have consistently taken precedence over the needs of the child, even into adulthood, often feels "defective", "wrong", and "to blame" (Donaldson-Pressman & Pressman, 1994, p. 8).

Although an Adult child may predictably fall into an unhealthy caregiving role with his or her parent, this is not done without an emotional impact. Many children feel a significant loss of control when they are around their parent and do not understand why this feeling occurs. This loss of control also produces fear, frustration, anger, resentment, guilt and anxiety as they react to unsatisfactory interactions with their parent. In order to heal, these Adult children must come face to face with their fears of losing control, getting hurt, being rejected or abandoned. The lack of basic trust is a core issue in these Adult children's lives and their fear of change is due to a lack of trust in themselves (Subby, 1990).

2.5 INTERPERSONAL DYNAMICS BETWEEN THE PARENT AND ADULT CHILD

Adult children may want to resolve issues from the past, but may be unable to do so with their parent because the parent is unwilling or unable to understand, reconcile or accommodate this desire. This circumstance can add further frustration, anger, fear, anxiety, guilt, and resentment to the Adult child's already existing emotions.

Framo (1992) found that most of his clients had a great need for their parents to validate their childhood memories, perceptions, and feelings about their past. Erik Erickson (1986) also has identified that validating their own children's experiences is a developmental task for the elderly, when they are in the final stage of life contributing to integrity or despair. Hargrave and Anderson (1992) also note that it is necessary for parents to do this for their children in order for the family to resolve unfinished business. When this validation occurs the Adult child may feel a great relief and even an increase in self-worth; she may not feel so "crazy" anymore. Hargrave and Anderson believe that if an Adult child does not receive this confirmation about what occurred, she may have difficulty trusting her own memories, thoughts, and perceptions.

Adult children who cannot resolve issues (both past and present) with their parent feel stuck as they attempt to function or "over-function" in an unhealthy, dysfunctional relationship. Roberto (1992) summarizes Boszormenyi-Nagy and Ulrich's findings (1981) and identifies three major obstacles to functional relationships. They are

- discrepancies between one's own internal expectations and the external relational realities, which create projective identification, displacement, narcissism, and an inability to adapt to loss;
- rigid repetitive patterns of relating with one another, which obstruct negotiation on the transactional level; and
- punitive or vengeful behaviours by a person who feels entitled and has no remorse for her behaviour, and therefore is clearly rejecting interpersonal growth (Roberto, 1992, p. 51).

An inability to exercise healthy moral and emotional boundaries is usually a characteristic of the Adult child and/or the parent (Subby, 1990). In the case of the

parent, the absence of healthy moral and emotional boundaries creates a lack of compunction about continually asking for help or presenting as pathetically inadequate around her own self-care. Subby refers to this as a lack of conscience and, I would add, this may also be the parent's only way of understanding how to cope with the situation. Subby goes on to indicate that usually the Adult child has a conscience and experiences "guilt and remorse" when compromising "someone else's moral or emotional boundaries" (Subby, 1990, p. 138). Unfortunately, the Adult child often does not feel guilt and remorse when her own moral or emotional boundaries are compromised. This leads to further denial and neglect of the self.

B. ISSUES

2.6 CHILDHOOD ABUSE ISSUES

Further exploration of the problem indicates to me that issues of emotional abuse are very relevant to the Adult child who has a parent who she perceives as having a "difficult personality". Steven Farmer (1989) proposes that until recent decades, the philosophy of raising a child had been that a child needed to be trained early on in life to be passive and obedient, and whatever a parent had to do to control and limit the normal outbursts of a child's emotions was permitted.

Finkelhor (1983) suggests that each type of family abuse (i.e., physical, emotional, psychological, etc.) has gone through a similar evolution as a social problem. Historically, all forms of childhood abuse have been minimized by families and by society as a whole, as it was believed they did not occur frequently.

The purpose of this section of the literature review is to give an overview of the impact of childhood abuse, symptoms, goals for change, and interventions. Particular attention is given to issues involving emotional abuse.

2.6.0 Definitions of Emotional Abuse

Finkelhor (1983) suggests that abuse is a situation in which a more powerful person takes advantage of a less powerful one. He states that all family abuse seems to occur in the context of psychological abuse and exploitation. Farmer (1989) writes that emotional abuse and psychological neglect or "starvation" are of equal, if not greater, importance than physical assault.

Emotional abuse as described by Eliana Gil (1988), refers to verbal assault or a lack of verbal or physical affection. It also refers to a general lack of positive attention, which may include such things as lack of eye contact or lack of positive feedback.

Farmer (1989) expands on the issue of emotional abuse, describing it as including "unreasonable demands put on a child that are beyond her capabilities and may include persistent teasing, belittling, or verbal attacks" (p. 11). It also "includes failure to provide the emotional and psychological nurturing necessary for a child's emotional and psychological growth and development" (1989, p. 11).

Authors Patricia Love and Jo Robinson (1990) discuss "the emotional incest syndrome", a style of parenting which involves the parent turning to his/her child rather than his/her partner for emotional support. The parent's love is not a nurturing or giving love but one which is an unconscious ploy to satisfy his/her own unmet needs. As a result of this role reversal a child is rarely given adequate protection, guidance, or

discipline, and is often exposed to experiences which are well beyond her age. The authors continue by stating that an Adult child victim of "emotional incest" often cannot pinpoint what was wrong with her family. As a result she has limited insight into the underlying cause of her problems. In reading this book I found the term "emotional incest" synonymous with emotional abuse.

2.6.1 Symptoms of Emotional Abuse

Eliana Gil (1988) and Finkelhor (1984) identify many symptoms of childhood abuse which they attribute specifically to "emotional incest". The symptoms are listed below:

- Depression
- Anxiety
- Guilt
- Self-blame
- Psychosomatic disorders
- Exacerbation of long-standing interpersonal problems
- Sleep loss
- Isolation
- Entrapment
- Self-contempt
- Inability to trust and develop intimate relationships

It is interesting to note that the first nine symptoms identified are the same symptoms which are identified with a person who experiences caregiver stress as discussed by Brody (1985), Garcia and Kosberg (1992), Hargrave and Anderson (1992), and Toseland and Rossiter (1989, 1991).

Patricia Love and Jo Robinson (1990) identify symptoms of emotional incest and are included in the list below:

- Depression
- Anxiety
- Problems with self-esteem and love relationships
- Overly loose or rigid personal boundaries
- Forms of sexual dysfunction
- Eating disorders
- Substance abuse

All of these symptoms, as well, may exist with the Adult child who has been physically, sexually and emotionally abused (Farmer, 1989; Finkelhor, 1984; Gil, 1988).

The symptoms which have been identified above are also identified in the Adult children of alcoholic/dysfunctional family literature. Mellody, Miller, and Miller (1989) identify the "five core symptoms of codependence". These are:

- difficulty experiencing appropriate levels of self-esteem;
- difficulty setting functional boundaries;
- difficulty owning our own reality;
- difficulty acknowledging and meeting our own needs and wants; and
- difficulty experiencing and expressing our reality moderately.

These symptoms complement the findings of the literature which focuses on the effects of childhood abuse and therefore indicate to me that one or more forms of childhood abuse occur in an alcoholic/dysfunctional family.

2.6.2 Psychological Impact of Emotional Abuse

Finkelhor (1984) states that the distortion of reality and self-image is generally one of the most devastating effects of family abuse. The psychological manipulation common among all types of family abuse is the tendency for the Adult child to blame

herself. The individual often sees herself as having provoked the abuse or having deserved it, no matter how severe or arbitrary the abuse may have been. Both Finkelhor (1984) and Gil (1988) believe that another result of abuse is the tendency for the Adult child to be exceptionally loyal to the person who has abused her despite the damage that has been done.

A pattern common to a person who has been abused, according to Finkelhor (1984) and Gil (1988), also includes an extreme sense of shame and humiliation and the belief that another person could not possibly understand or identify with her feelings and experiences. The Adult child who has grown up in an abusive environment often thinks that she is the only one who has undergone this kind of experience. This individual will often go to great lengths to keep secrets and then suffer from the feelings of stigma and isolation.

A significant final effect of abuse, as reported in the literature, is a feeling of entrapment (Finkelhor, 1984; Gil, 1988). The Adult child has difficulty either stopping the abuse, avoiding it or leaving the situation entirely. She may want to go back to the abuser and may often go to great lengths to prevent interventions from occurring outside of the relationship (Gelles, 1976). Entrapment is connected to an imbalance of power present in most abusive situations, to the lack of social supports that are available to the Adult child, and also to the potent ideology of family dependency. This makes it difficult for the Adult child to even think about surviving outside of their family, no matter how abusive it was (Finkelhor, 1983).

Although a person who has been emotionally abused has cause to be angry, she may feel uncomfortable with anger. Many Adult daughters feel they have no right to express their anger. This emotion becomes repressed and stockpiled, and expressed in disguised forms such as passive-aggressive behaviour, depression, manipulative behaviour, anxiety, and somatic complaints. The Adult female, in particular, often suppresses her anger, expressing it through "self-blame, self-contempt, self-defeating and self-abusive behaviours" (Courtois, 1988, p. 209). The emotion of anger will be discussed in further detail in the section of the literature review entitled Caregiver Stress.

2.6.3 Definition of Codependence

Robert Subby (1990) defines codependency as a:

> delayed identity development syndrome characterized by a psychological, emotional and behavioural pattern of coping that develops as a result of one's prolonged exposure to and practice of a set of dysfunctional family or social rules (Subby, 1990, p. 26).

It is not uncommon in the experience of the Adult child that the "unfinished business" of the past gets in the way of current life tasks and activities. For the Adult child/co-dependent, whatever may happen in the here-and-now, may trigger some unresolved feelings from the past. The Adult child/co-dependent may retreat into whatever form of behaviour she used in the past to cope. Instead of learning to face the conflicts of life, the child learned that the truth was to be avoided. As a result the individual becomes overly involved with, and manipulative of, outside activities. A person may learn to conform to outside pressure in order to blend in, and the true self may be disguised. "Instead of developing a clear identity, the individual living under the influence of these

dysfunctional rules develops a chameleon-like identity" (Subby, 1990, p.42). The dysfunctional rules of a codependent system give rise to a self-protective identity that changes on the outside but remains the same within.

2.6.4 Goals for Change

Several authors have suggested sets of goals to keep in mind when working with survivors of abuse. Gil (1988) identifies a number of goals that victims of emotional abuse may work on during treatment. These include: repairing the client's self-image; combating the client's sense of entrapment, despair, helplessness, isolation, and self-blame; and increasing support in the client's life.

Courtois (1988) believes that in order to heal from the effects of any type of childhood abuse the Adult child must accept her losses, stop trying to heal her family and stop the self-sacrifice entailed in the effort. Framo (1981) also identifies the importance of working on accepting the loss of the parent one wished for but never had. Farmer (1989) adds that it is very important for the Adult child to recover what she has lost, which is her real self buried behind psychological barriers which were constructed to help her cope with abuse. The strategies used in childhood have turned into roles, have limited growth potential, and have contributed to the individual's rigid emotional and spiritual isolation.

Courtois (1988) identifies that the goals for change for someone who has been abused include:

1. acknowledgement and acceptance of abuse;
2. recounting the abuse;
3. breakdown of feelings of isolation and stigma;
4. recognition, labeling, and expression of feelings;

5. resolution of responsibility and survival issues;
6. grieving;
7. self-determination and behavioural change; and
8. education and skill building.

In addition to the goals identified by Courtois, Farmer (1989) also emphasizes the importance of helping the Adult child to learn to play again and the importance of learning to set physical and psychological boundaries with people in her life.

Finkelhor (1983) states that family abuse is any abuse of power and is one which is a response to a perceived power deficit. His perspective recognizes that individual perceptions of life, whether they are based in reality or not, can be powerful influences in one's life.

Donaldson-Pressman and Pressman (1994) write from the perspective of children of dysfunctional families. They identify the need for individuals to revisit the past, mourn the loss of the fantasy of the ideal parent, recognize reality, evaluate one's present situation, and take responsibility for change. Many of these needs are identified in the child abuse literature as well.

2.6.5 Interventions

The clearest set of interventions for therapists working with individuals who have experienced childhood abuse, are explicated by Courtois (1988). She suggests that a child who has experienced incest or has come from other types of dysfunctional family systems grows up with misinformation or a lack of information in various life tasks and skills. A child may have missed the normal learning experiences of a healthy family life.

> The therapist may need to function as both parent surrogate and educator in teaching such basic life skills and information around communication, decision-making, conflict resolution, friendships, intimacy, sexuality, parenting, and boundary setting (Courtois, 1988, p. 182).

Courtois (1988) identifies four categorical interventions when working with an Adult child who has experienced abuse. These are:

- stress/coping techniques;
- experiential/expressive-cathartic techniques;
- exploratory/psychodynamic techniques; and
- cognitive/behavioural techniques.

2.6.6 Summary

This section of the literature review has identified the effects of emotional abuse, goals for change and interventions. As will be seen in the following section, symptoms of childhood abuse have their parallels in symptoms of caregiver stress.

2.7 CAREGIVER ISSUES

Bowen (1978) defines differentiation as emotional maturity where an individual has a well defined basic "sense of self". He believes that while people at all levels of differentiation experience stress, those at higher levels are less vulnerable to the negative impacts of stress than those at lower levels of differentiation. Based on this theory, it is my opinion that caregiver stress is greater for an Adult child if she has lower levels of differentiation with the parent she is caring for. Hargrave and Anderson (1992) also cite Williamson who sees successful differentiation and adjustment as dependent upon an individual's ability to take an adult position with her parent.

The pervasive myth which continues to exist in our society is that the Adult child does not care for her parent as she did "in the good old days" (Brody, 1985). Bengston

and Treas (1980), and Hareven (1982) report that the Adult child provides more care and more difficult care to her parents over a much longer period of time (as people are living longer than they have in the past) than the Adult child of previous generations. There is also evidence that the Adult child provides even more emotional support to her parent than was done in past generations.

Brody (1985) believes that parent care is not a simple "Stage" that fits neatly into the developmental stages of an individual over the life span. Caring for a young child involves working toward a gradual decrease of dependencies on the parent/caregiver. In contrast, caring for an elderly parent involves an increase in dependencies with great variability and irregularity over a much broader time period. As well, the patterns and sequence of events are not uniform.

Toseland, Toseland, and Smith (1991) report that a number of authors including Johnson and Catalano (1983), Noelker and Poulshock (1982), and Scharlach (1987) believe that poor caregiver-care receiver relationships are highly associated with caregiver distress. Brody also adds that the demands of parent care often do not match the Adult child's psychological, emotional, and physiological capacities or well-being (Brody, 1985).

Lewis and Meridith (1988) studied caregiving daughters and elderly mothers and discovered that difficulties within the intergenerational relationship usually arose out of an imbalance of power, wherein one person was overdependent, dominant or manipulative. Relationships were mutually supportive if both daughter and mother gained from the relationship and valued the contributions and competencies of the other.

2.7.0 Who are the caregivers?

Anna Scheyett (1990) notes that although caring is extremely important in our society, it is largely women who are expected to be caregivers regardless of their living situations. They often bear the burden of caring, which then results in their oppression. Tronto (1989) believes that caring may also be a reflection of a survival mechanism for women or others who deal with oppressive conditions, rather than a quality of intrinsic value on its own. Just as women and others who are not holding the majority of the power in society adopt a variety of deferential mannerisms, so too it may have served their purposes of survival to have adopted an attitude that might otherwise be understood as the necessity to anticipate the wishes of an older person.

The literature identifies that, generally, adult daughters or daughters-in-law are the principal caregivers to the elderly parent (Brody, 1985, Cantor, 1983). Most of these women fall between the ages of forty and sixty years. Just as the majority of caregivers are women, the majority of care recipients are also women (Aronson, 1986).

Brody (1985) emphasizes, however, that sons also sustain "bonds of affection", and act as primary caregivers, when they have no sisters or there are no sisters close by. It has been my experience that, although daughters are often the primary caregivers to their parents, the situations in which men play this role are not as limited as Brody suggests. I have known sons who have been the primary caregiver for their parent even when sisters in the family existed and lived close by.

Selig, Tomlinson and Lickey (1991) explain that the Adult child takes on the caregiving role often at the cost of her own well-being because of the Adult child's feelings of filial obligation. The strength of these feelings impacts on the Adult child's perceived level of stress, burden and role conflict. The authors highlight three views about the basis for filial obligation. First, an Adult child may follow the "Honour Thy Father and Thy Mother" commandment based in Christian history. Second, an Adult child may feel indebted to her parents for raising her as a child. Finally, an Adult child may simply feel obligated to her parents out of love and friendship.

Goldner (1985) writes that as family life remains in the woman's sphere, it is the woman, in her role as wife, mother, and I would add Adult child, who typically brings her family members in for professional help. A woman, as well, is more likely to seek help for herself than is a man. Societal norms also operate from the premise that the woman is to blame for problems in the family and is responsible for problem resolution (Imber-Black, 1988). If a woman feels responsible for her family she will also experience guilt and inadequacy when the family system is not operating optimally.

Alice Miller (1983b) writes of the pressures on some young children to deny their true selves and assume false selves to please their parents. She believes that these children are faced with the choice of being authentic and honest or being loved. If they chose wholeness, they were abandoned by their parent. If they chose love, they abandoned their true selves. Pipher (1995) suggests that adolescent girls experience a similar pressure to split from their true selves. This pressure comes from the culture rather than from parents. It is my opinion then, that if a female is caused to assume a

false self as a child, in adolescence North American culture only serves to reinforce this. Simone de Beauvoir (1952) believes that adolescence is when girls realize men have the power and that their only power comes from consenting to become submissive adored objects. Pipher writes "that girls stop thinking, 'Who am I? What do I want?' and start thinking, 'What must I do to please others'" (1995, p. 22). Many Adult children who have a parent with a "difficult personality" have often not asked themselves these questions of who they were and what they wanted. Pipher writes that caring for others is another way of being submissive and to win approval and acceptance from others. The unwritten social rules of having to be attractive, lady-like, unselfish, of service, to make relationships work and to be competent without complaint, may result in depression, eating disorders, self-criticism, deferentiality, anxiety, somatic complaints, and addictions (Pipher, 1995).

2.7.1 Symptoms of Caregiver Stress

Although there are positive effects of caregiving, such as providing meaningful roles and an important purpose, this role can be extremely demanding and stressful (Toseland & Rossiter, 1991). Even the integrated individual with a well-functioning family can be disrupted when confronted with the many demands of caring for her parent (Brody, 1985). Brody (1985) notes that many studies have identified that the most pervasive and most severe consequences of caregiving occur in the area of emotional strain. Bowers (1987) has referred to two aspects of the caring role, with one being the task dimension and the other being the emotional dimension. He suggests that it is the expressive aspects of the caregiving role which have been considered by the caregiver to

be the most difficult to handle. Interestingly, Brody also reports that many studies identify emotional support (socialization, concern, affection, and a sense of someone to rely on) as that which most individuals want in their old age. Further, Smith, Smith and Toseland (1991) report that in their research, emotional support, rather than physical or financial support, is the most common and important type of assistance provided by a caregiver.

Various symptoms of caregiver stress have been identified in the literature. These include depression, self-blame, anxiety, frustration, anger, premature aging, helplessness, sleeplessness, lowered morale, lowered levels of life satisfaction, and exacerbation of long-standing interpersonal problems. Restrictions on time and freedom create isolation, conflict from competing demands of various responsibilities, difficulties in setting priorities and interference with life-style and social and recreational activities (Brody, 1985; Garcia & Kosberg, 1992; Hargrave & Anderson, 1992; Toseland & Rossiter, 1989, 1991). Braithwaite (1990) has identified five crises which are commonly experienced by the caregiver of a dependent elder. He proposes that these crises have direct bearing on the ability of the caregiver to provide emotional and psychosocial aspects of care as well as instrumental care. These crises are: awareness of the elder's degeneration; unpredictability of the elder; the nature of the relationship to the elder; restriction of choices; and time constraints.

Garcia and Kosberg (1992) write that many of the feelings outlined above, as well as the increasing dependency of an elderly relative, may result in not only anger but also the propensity for abusive behaviour, as long-term anger leads to chronic hostility. This

anger can result in physical problems, such as high blood pressure, cardiovascular problems, and skin rashes. Other factors which relate to unresolved anger and abuse include a hypercritical nature, economic dependency, lack of sympathy, stress, economic problems, alcohol consumption, and emotional and/or mental immaturity (Garcia & Kosberg, 1992). Fuel is added to the fire of anger when the elderly parent holds unrealistic expectations of the quality of care given to them by their family members (Garcia & Kosberg, 1992).

According to Brody (1985), further exacerbations of anger and resentment occur when the Adult child provides care due to indebtedness and feelings of guilt. The Adult child feels that she must care for her parent as many of her peers do and defend against the guilt by denying her own negative and "unacceptable emotions" (Brody, 1985, p. 26). It has been my experience that giving the Adult child permission to express these "negative feelings" is very therapeutic. It is also very therapeutic for individuals to hear from others that their feelings are not altogether unique.

As if the usual stresses of caregiving were not enough, further strain is created as unresolved issues "rear their ugly heads". Demaris (1991) indicates that emotional intensity heightens with the emergence of unresolved emotional issues from the past, as family members work around decision-making and changes in caregiving patterns between the generations. The Adult child may want to resolve issues from the past but may be unable to do so with her parent because the parent is unwilling or unable to understand, reconcile, or accommodate this desire. This circumstance may result in an exacerbation of stress-related symptoms and/or behaviour in the Adult child. Demaris

notes that the caregiver may experience even more feelings of frustration, anger, resentment, and guilt.

Often the Adult child feels compelled by internal and/or external pressure to act in a quasi-parental capacity in her parent's old age. Brody (1985) indicates that if this expectation is held by both the parent and the Adult child it will further intensify the strain that each may experience. In a later article Brody (1990) suggests that "people cannot become children to their children, and children cannot become parents to their parents. Love for a parent is different from the love one experiences for one's child" (1990, p. 17). Hargrave and Anderson (1992) believe that when older people are treated like children it deprives them, as well as other members in the family, of "finishing life well". If the elderly are absolved of the responsibility of working through unresolved issues they, as well as future generations, may suffer.

Brody (1985) and Tobin (1987) believe that dysfunctional caregiver-care receiver relationships are often indicative of long-standing interpersonal conflicts, pathological co-dependence, or psychopathology. As noted in the Introduction, caregivers may attribute their poor relationship with the care receiver to historical causes other than caregiving, and this may prevent them from perceiving interventions labeled as caregiver support as an appropriate setting to resolve long-standing parent-child conflicts. This belief is reinforced potentially, since most professionally initiated caregiver groups do not focus on long-standing parent-child conflicts. The presence of services which allow for the examination of parent-child conflict would allow the Adult child an important opportunity.

Anger and burden are increased further by current societal values and social policy. Pressure on the Adult child to provide services and supports that are urgently needed add further strain and guilt whether or not the caregiver is able or willing to meet these needs. Further stress can occur when the parent is unwilling to accept help from resources outside of the family or the help is unavailable.

2.7.2 Needs of Caregivers

Smith, Smith and Toseland (1991) studied the problems identified in counselling by caregiving daughters. Rather than view these issues as problems I prefer to refer to these as caregiver needs. The authors found that some of the needs identified by caregivers included that their parent be evaluated by a professional and that they be provided with information about their parent's problems. Other needs included learning how to manage problems and better understand and respond to the care receiver's psychosocial needs, family issues, support, obtaining respite services, finding a cure, and help with feelings of guilt and anger. Toseland and Rossiter (1989) add that other needs of caregivers include preventing psychological problems, increasing caregiver support systems, and improving caregivers' ability to care for themselves.

Tronto (1989) believes that there is no simple way that one can generalize from one's own experience to determine what another person needs. She states that there is some relationship between what the care receiver states she wants and needs and what the care receiver's actual interests and needs are. Genuine attentiveness would presumably allow the Adult child to see through these pseudo-needs and learn to appreciate what are the actual needs. Alice Miller (1981), in discussing the parenting

needs of children, suggests that many parents act not so much to meet the needs of their children as to work out their own unmet needs, which they continue to carry from when they were children (Boszormenyi-Nagy agrees with this view). If an Adult child is not aware of her own needs, this will cloud her ability to see what another's needs truly are. Baines, Evans and Neysmith believe that:

> Caring must be viewed as a source of both women's oppression and women's strengths. Although feminists recognize how women have been vulnerable to exploitation, social work practitioners must also pay attention to the ways in which women clients have learned to be flexible and creative in dealing with life's contingencies. A feminist perspective in social work practice reframes many of the deficits attributed to women clients as strengths (1992, p. 34).

2.7.3 Interventions

According to Smith, Smith and Toseland (1991), areas which should be addressed in psychoeducational programs include improving coping skills, involving other family members in counselling, helping caregivers to better understand and respond to the care receiver's psychosocial needs, encouraging caregivers to use formal and informal resources, encouraging caregivers to ventilate distressful feelings, counselling caregivers regarding possible residential placement, and attempting to improve the quality of the caregiver-care receiver relationship.

Selig, Tomlinson and Hickey (1991) propose that caregivers often need to be permitted to expect less of themselves. Women, in particular, need this permission due to strong socialization norms which direct them into caregiving roles.

Scharlach (1987) devised a study with Adult daughters and their mothers looking specifically at the quality of the relationship between mother and daughter. He found

that when a daughter is assisted in reducing her own feelings of discomfort, rather than when she is encouraged to do more for her mother, the effects are beneficial. A cognitive behavioural intervention was compared with a supportive intervention. The cognitive behavioural intervention involved assisting the daughter to modify unrealistic expectations of her responsibilities for her elderly mother and encouraging the daughter to interact with her mother in a manner that promoted the mother's self-reliance and provided the daughter with emotional gratification. Utilizing this intervention, the daughter was advised of the benefits of an older person having the opportunity to maintain as much choice and control over her life as possible, and the harmfulness of well-meaning assistance that fosters unnecessary physical and psychological dependency. The daughters in the study were encouraged to recognize their own limitations in terms of meeting their mother's needs and to reassess unrealistic expectations which could promote dissatisfaction and increased dependency. Specific techniques used were value clarification, priority setting, challenging self-defeating automatic thoughts, and role playing. Additionally,

> the normal developmental tasks of mid-life were discussed, and it was suggested that participants attempt to interact with their mothers in such a way that the independence and emotional needs of both would be met to the maximum degree possible (Scharlach, 1987, p. 10).

Participants were also reminded of the importance of being realistic about their ability to help their mothers: "When you try to do more for your mother than is reasonable, it can end up making both of you unhappy" (Scharlach, 1987, p. 11).

In contrast to the cognitive-behavioural intervention the supportive intervention developed by Scharlach (1987) involved educating the daughter about the difficulties experienced by the elderly and encouraging the daughter to interact with her mother in a manner that best met her mother's needs. From this description I would think that this intervention would only increase guilt, resentment, frustration, and invalidate any of the daughter's feelings, needs, or wants.

Scharlach (1987) found that the cognitive behavioural approach was more effective than the supportive intervention because it focused on the needs and limitations of the daughter, rather than those of the mother. He speculates that this approach aimed:

- to help the daughter modify unrealistic attitudes about filial responsibility and may have reduced the pressure felt as a result of competing role demands;
- to emphasize the importance of the mother's self-reliance which may have inhibited unnecessary dependency, which is frustrating for a daughter and destructive for the psychological well-being of an elderly mother; and
- to explain that feelings of burden can be deleterious for both a daughter and a mother which may have given the daughter tacit permission to alter her filial attitudes and behaviour to decrease her own feelings of discomfort (Scharlach, 1987, p. 12).

Garcia and Kosberg (1992) identify a number of techniques for helping caregivers to manage their anger. I think these techniques can also be utilized for many other emotions that a caregiver experiences. The following techniques are suggested.

- Teaching cognitive behavioural techniques to help the caregiver gain more personal power over her behaviour and her life (Garcia & Kosberg, 1992; Smith, Smith, & Toseland, 1991).

- Asking the caregiver to keep a diary and document when she experiences the emotion, what and who made her feel the emotion and what was the result of the emotion. This not only helps an individual identify the person who stimulates the emotion, but also identifies the different behaviours used when experiencing the emotion.

- Sharing information with the caregiver. "The awareness and identification of their own anger and self-interventions leading to the reduction in anger can only be a beneficial step to the prevention of elder abuse and maltreatment" (Garcia & Kosberg, 1992, p. 97). I would add that the caregiver must also be made aware of the adverse physical, psychological, and emotional consequences of unexpressed emotions to oneself and other people in their lives.

Smith, Smith, and Toseland (1991) also identify behavioural techniques and training in communication skills as useful interventions with the caregiver. Interestingly, the authors noted that one of the most difficult tasks in counselling was to convince the caregiver to give up some control over caring for her parent.

Brody (1985, p. 24) notes that successful resolution of unresolved issues involves the caregiver accepting what she cannot do as well as accepting what she can "and should" do. I am uncomfortable with Brody's reference to what the caregiver "should" do and prefer to help the Adult child to explore and accept those aspects of care that she is psychologically and physically prepared to do.

2.7.5 Summary

The impact of caregiver stress on the Adult child can have major psychological, emotional, and physical consequences. As unresolved emotional issues resurface, or become exacerbated, they increase the intensity of the stressors. The caregiver may experience "double jeopardy" as both the pressures of caregiving and the unresolved issues of the past come to the forefront. Providing the Adult child with the opportunity to

address emotional issues and integrate them into her present life may prevent or minimize the impact of this experience. The recommended goals for change are similar for both emotional abuse issues and caregiver stress issues. Therefore, recommended interventions from both of these fields of practice may be integrated and utilized as appropriate in a group setting.

C. THEORIES UTILIZED FOR INTERVENTION

2.8 INTERGENERATIONAL FAMILY THEORY

This section of the literature review focuses on several authors who have selected and discussed Ivan Boszormenyi-Nagy's (1973; 1981; 1986) contextual family therapy model in some detail and who have reviewed other relevant intergenerational family perspectives. Two references are of particular relevance to this project; the work of Laura Giat Roberto in Transgenerational Family Therapies (1992) and the work of Terry D. Hargrave and William T. Anderson in Finishing Well (1992).

As signs of mortality and the stage of later life approach, emotional intensity is rechanneled back towards the family of origin (Demaris, 1991). Parents and children generally have had to move apart enough emotionally to allow for committed outside-the-family attachments and living arrangements. It is my opinion that this is a critical time for intervention to occur with those family members who are willing to participate.

Subsequent writers, including Hargrave and Anderson (1992), express a view similar to that of Demaris and write that unresolved issues of the past and emotionally charged relationships once again resurface as the family is forced to deal with issues of aging. Harold Bloomfield (1983) notes that conflicting and unresolved feelings about

one's parent can affect a person's "moment-to-moment health and well-being" (p. 12), career satisfaction, work and leisure time and her most significant emotional relationships. Hargrave and Anderson (1992) believe it is necessary for family therapy to occur in those families where long-standing rigid relationship imbalances exist. If therapy does not occur, members will likely be unable to achieve successful resolution of issues from the past on their own. Many Adult children whom I have seen in my work have a parent who refuses to resolve issues from the past and often does not identify that there are any issues to resolve. As a result family therapy is not possible with all members present.

Murray Bowen (1978) believes that as individuals resolve undifferentiated relationships with their family of origin, they become less anxious, more differentiated, flexible, able to cope with stress, and have fewer personal and marital problems. In Bowen's Natural Systems Model, which will be discussed in greater detail, resolving past emotional issues influences both the nuclear and intergenerational families.

2.8.0 The Contribution of Ivan Boszormenyi-Nagy's Contextual Family Therapy Model

Piercy (1986) summarizes the contextual family therapy model as one which examines the idea that multigenerational obligations and pressures play a direct role in the formation of emotional symptoms. This model's central method uses an exploration of "familial legacies", "invisible loyalties", and "ledger balances". The therapist guides the family toward tasks that increase mutuality, strengthen and identify resources for trustworthiness, and encourage exoneration of previous generations, so that they are seen

in a less blaming way. When possible, the therapist seeks to sort out the personal needs, motives and capacities behind power alignments. The goal is to achieve a responsible orientation to issues of fairness and trust between family members on the part of the individual and the therapist (Roberto, 1992).

Boszormenyi-Nagy's (1986) contextual model is based on the idea that there are four "relational realities," or templates for understanding and constructing the interpersonal world and through it, "the self". The theories of healthy functioning and dysfunction, the process of change, and clinical intervention as well are based on four dimensions. These dimensions are listed below.

1. Objectifiable Facts
2. Individual Psychology
3. Systems of Transactional Patterns
4. Relational Ethics: The Balance of Fairness (Boszormenyi-Nagy, Grunebaum, Ulrich, 1991)

1. Objectifiable Facts

Objectifiable Facts refer to existing environmental, relational, and individual factors that are objectifiable. They include genetic predisposition, physical health, basic historical facts, and events in a person's life cycle (Hargrave & Anderson, 1992).

2. Individual Psychology

Individual psychology represents "subjective internal psychological integration of experiences and motivations of individuals in the family" (Hargrave & Anderson, 1992, p. 48). This dimension specifically focuses on a person's own perceptions. An

individual's feelings of pride, shame, guilt, jealousy, and resentment can often have a powerful influence on the structure and development of other relationships. Additional important components of the individual's psychology include hope, loss, trust, needs, stress, identity and defenses.

I believe that Bowen's Natural Systems model supports Boszormenyi-Nagy's dimension of Individual Psychology. Bowen's model particularly emphasizes one's identity and sense of self. Bowen (1978) highlights the term "differentiation of self". Differentiation of self is seen on a continuum that ranges from "undifferentiation" or ego fusion, to a "perfect" self which can never be achieved (Bowen, 1978, p. 200). Differentiation is theorized by Bowen to represent emotional maturity, and the less differentiated one is, the more vulnerable one is to stress. As a result, one recovers more slowly from stress-related symptoms, if at all. The greater the undifferentiation, the greater the tendency to react emotionally to others.

Roberto (1992) summarizes Bowen's concept of low differentiation as having the following characteristics: "emotionality, dependency, lack of capacity for autonomy, rigidity, externalization, and psychosomatic or psychotic-level symptoms under stress" (p. 12). The individual has less ability to problem-solve, and avoids conflict. The person's life is "totally relationship-oriented" (Roberto, 1992, p. 12). She expends her energy seeking approval, security, and/or love or attacks another for not providing it (Bowen, 1978, p. 201).

High differentiation is experienced by an individual when she has clear goals and values. The person can state beliefs calmly, without attacking the beliefs of others and

without having to be defensive about attacks from another (Bowen, 1978). She can demonstrate "flexibility, security, autonomy, conflict tolerance, and neurotic-level symptoms under stress" (Roberto, 1992, p. 12). The individual has a basic sense of self, less fusion in close relationships, less energy invested in maintaining a sense of self with others, and more energy and satisfaction in goal-directed activities. She reacts less to either praise or criticism, "is more realistic in self-evaluation, and can lose himself/herself in intimacy when he/she wishes to without anxiety"(Roberto, 1992, p.12).

Goldenberg and Goldenberg refer to Bowen's concept of "undifferentiated family ego mass". This conveys the idea of a family emotionally "stuck together", where "a conglomerate emotional oneness...exists in all levels of intensity" (1991, p. 149). An example of this is cited as the symbiotic relationship of interdependency between mother and child which may represent the most intense version of this concept; a father's detachment may be the least intense. This suggests to me that the Adult child is at greater risk of being undifferentiated from the mother in contrast to the father. Therefore, she may be more vulnerable to stress if there are more unresolved issues with the mother as compared to the father.

3. Systems of Transactional Patterns

The dimension of Systems of Transactional Patterns deals with the communication or interaction patterns in relationships. These transactions produce organization or laws that define power alignment and/or coalitions, structure, and belief systems (Boszormenyi-Nagy & Krasner, 1986).

Karpel and Straus (1983) discuss Boszormenyi-Nagy's third dimension as addressing the question of how the motivating and determining forces as well as order, pattern and predictability of the larger social systems affect the individual. Areas of exploration include subsystems, boundaries, communication, common patterns, roles, acknowledgement and claim (Karpel & Straus, 1983). These areas provide various ways of describing current observable aspects of interactions and how these interactions influence or prevent change, stability, and/or adaptation from occurring (Boszormenyi-Nagy et al., 1991). Boszormenyi-Nagy et al. continue by stating that lack of adequate "self-delineation" or differentiation of self leads to an unhealthy imbalance of reciprocity, whereby a person protects another person in the relationship from having to define boundaries, make choices, and function as a separate and autonomous individual.

Framo (1992) expands on the area of common patterns and roles in families where parents make it virtually impossible for communication to improve. He focuses on the development of intrapsychic conflicts in individuals which stem from their families of origin and are later played or acted out in other relationships. He acknowledges the occasions when the attitudes or behaviours of family members are such that they are not presently open to reconciliation or accommodation. He describes parents who will use guilt provocations, exploitation, tantalizing and never delivering, parentification, humiliation, teasing accusations of treason, deceit, dishonesty, double-binding, twisting their children's decent or autonomous motives into something evil or unhealthy, and expressing fixed distorted views of their children. He suggests that most clients get relief from parents validating their memories, perceptions, and feelings about

the past. There is an increase in self-worth in many individuals when this validation occurs. When they do not receive this confirmation they vaguely distrust their own memory and senses (Framo, 1992).

Framo (1992) explains that it is not easy, and even seems to be a travesty, for some individuals to get past their anger and forgive. He cautions the therapist about asking clients to forgive their parents too soon. Bloomfield (1983) also cautions about this. Alice Miller (1990) stresses that the love a child has for his or her parents ensures that the parent's conscious or unconscious acts of mental cruelty will go undetected. This, as well as the child's dependence on his or her parents' love, can make it impossible as an adult to recognize these early traumatizations, which often remain hidden behind the early idealization of the parents for the rest of the person's life. The conviction that the parent is always right and that every act of cruelty, whether conscious or unconscious, is an expression of love, is ingrained in a person because it is based on the process of internalization that occurs during the beginning months of life, and during the time which precedes separation from the primary caregiver.

4. Relational Ethics: The Balance of Fairness

The dimension of Relational Ethics is seen as the cornerstone of the contextual family therapy model and it focuses on specific relational processes. These processes include the following:

- consequences of past decisions and actions for current relationships;
- impact of these consequences on all members of a family;
- development of relational resources with emphasis on the most vulnerable members; and

- prevention of further injury or damage in the present and future generations (Boszormenyi-Nagy & Krasner, 1986).

This dimension deals with the subjective balance of trustworthiness, justice, loyalty, merit, and entitlement between members in the family. In order to develop a sufficient basis on which to experience emotions and thoughts, individuals are dependent on the experience of relating, giving, and receiving from another person. Relational Ethics is based on an innate sense that demands balance between what an individual is entitled to take and what she is obligated to give to relationships (Hargrave & Anderson, 1992). When an individual responsibly fulfills her obligations, she basically empowers the next generation to do the same; "this enhances family existence and mutual caring" (Hargrave & Anderson, 1992, p. 56).

People who do not receive care, nurturing, and love from a relationship often will seek a replacement for these emotions, probably in a destructive manner. They move to get what they "deserve" for themselves, using threats, manipulation, or even more dysfunctional behaviour. Destructive entitlement can manifest itself in such ways as "paranoid attitudes, hostility, emotional cut-offs, and destructive behaviour" (Hargrave & Anderson, 1992, p. 58).

Roberto (1992) discusses seven unique concepts identified by Boszormenyi-Nagy, within the dimension of Relational Ethics which describe relevant emotional processes. They are listed below.

1. Legacy - a transgenerational mandate which links the inherited characteristics of a current generation to its obligation to the next generation.

2. Trustworthiness - the perception of a partner or parent as trustworthy is an outcome of "a) being given credit for one's own contributions to the family; b) being responded to in a responsible manner when in need; c) observing that the partner or parent shows concern for fair distribution of familial burdens and benefits" (Roberto. 1992, p. 46).

3. Merit - identifying the contributions of another to her quality of life. "It is a way of acknowledging the efforts of other family members openly" (Roberto, 1992, p. 46).

4. Earned Entitlement - the opposite of dominance or control. It is "a stance in which a family member receives caring or giving in the context of having earned or merited trust" (Roberto, 1992, p. 46).

5. Autonomy - personal growth or goal-directed behaviour which exists along with trustworthiness. Consistent and caring connectedness over long periods of time is universally essential for healthy functioning.

6. Revolving Slate - displacement of feelings towards another or projection on to an innocent third party.

7. The Ledger - the balance of fairness in a relationship. In an adult child relationship the parent is entitled to provide love, care, protection, security, nurturing and discipline. The child's only obligation is to grow (Boszormenyi & Spark, 1973). In healthy adult relationships individuals are both entitled and obligated to trust, respect, and establish intimacy.

Roberto (1992, p. 48) indicates that in Boszormenyi-Nagy's model, "healthy functioning is rarely defined interactionally, but instead ethically (between individuals), societally (within social systems), and contextually (within larger systems)". Characteristics of desirable behaviours between family members are not specified. Instead, it is the various aspects of a relationship which define whether a healthy relational context exists between family members. In Leupnitz's (1988) summary of Bowen's theory she notes that interaction and communication between family members during therapy are less likely to occur and more conversation is directed through the

therapist. In my opinion, this is similar to Boszormenyi-Nagy's model in that interaction is less of a focus. As indicated previously, Bowen believes that as a person becomes more differentiated from their family of origin, she will be able to more fully engage in current relationships and as a result communicate more effectively. I think that these intrapsychic views of healthy functioning may encourage individuals to understand and question their own value systems more objectively, and to take responsibility for making decisions as to whether these values are positively affecting their ways of coping within their own social context. Boszormenyi-Nagy and Spark (1973) write that the needs of another person are not to be aligned with one's own "objective" characteristics , but that the person learns to discriminate the other's needs as valid and distinct from one's own needs.

Roberto (1992, p. 51) highlights Boszormenyi-Nagy's theory that there are three major obstacles to functional relationships. These are:

> 1. collision between internal expectations and external relational realities, creating projective identification, displacement, narcissism, and inability to adapt to loss;
>
> 2. rigid, repetitive feedback cycles, which become barriers to negotiation on the transactional level; and
>
> 3. punitive or vindictive behaviour by a person who feels entitled and has no remorse for this behaviour--in other words clearly is unprepared to grow interpersonally.

2.8.1 Goals for Change

Roberto (1992) summarizes that transgenerational therapists understand the intention of intervention for change as expanding the abilities of family members to

achieve greater relational competence, enhance self-confidence and self-esteem, complete important tasks in the individual and family life cycles, and care for and provide (parental) guidance to children and young adults (Roberto, 1992, p. 93).

Contextual family therapy seeks to deal directly with invisible loyalties which influence family members' availability to one another. Its central assumption is that "fair consideration of ...relational obligations can result in personal freedom to participate in life's activities, satisfactions, and enjoyments" (Boszormenyi-Nagy, 1986, p. 414).

Roberto (1992) indicates that the chief methodology in the contextual model is "multidirectional partiality", which requires an individual to examine her experience of intimate relationships. One's ability to make change is related to the extent to which one is open to examining the quality of one's family relationships, especially in asymmetrical bonds with vulnerable members such as children or elderly parents. Thus, Roberto (1992) would identify Boszormenyi-Nagy's goals for change as:

- to allow each family member to rely on self-validation, or validation built on fair consideration of others;
- to work towards a "balance of fairness", which is never fully attainable. This requires exploration of the trustworthiness or fairness of family relationships; and
- "to mobilize positive relational resources, rather than focusing on removing symptoms or presenting problems" (Roberto, 1992, p. 54).

In addition to these goals for change Roberto (1992) discusses Bowen's Natural Systems Model as having two different goals for change. The first goal is " to help individual members increase their basic differentiation of self" (Roberto, 1992, p.19). The second goal is to "detriangle pre-established three-person systems in steps, by

helping the client in therapy to remain emotionally separated while original two-party tensions are addressed and resolved" (Roberto, 1992, p.19). Both Boszormenyi-Nagy's and Bowen's goals for change, as specified by Roberto, have been incorporated into my intervention.

2.8.2 Interventions

Seven specific interventions are identified by Roberto (1992) using the Contextual Family Therapy Model and used in this group intervention. They are eliciting, moratorium, rejunction, therapeutic crediting, siding, loyalty framing, and exoneration. A brief description of each follows.

Eliciting - encourages members to spontaneously address their own concerns constructively. Their "beliefs and behaviours are considered within the framework of balancing obligations and entitlements" (Roberto, 1992, p. 56) between individuals. Support is given to any member who takes the steps to improve this balance.

Moratorium - guides members to consider the benefits of making relational change, without insisting that the change must be made. The therapist provides active therapeutic input about options while respecting the person's individual timing. This presents to the Adult child the message that she is accountable for making changes but also has the freedom to decide when she is prepared to make the changes.

Rejunction - involves reconnecting after a long period when dialogue has been severed or restricted. According to Roberto (1992) this is equal to what Bowen identifies as "detriangling". It requires taking risks in acknowledging responsibility for past problems and re-working them in a therapeutic setting.

Therapeutic Crediting - involves crediting one member after another, in order to create a basis for trust from outside the family. It focuses on any initiatives taken, to build hope and create prospects of more reciprocity in the future. "Pathological symptoms are often related to unutilized or underutilized resources of support. The therapist can mobilize unutilized resources by focusing on latent sources of support and caregiving, in order to emphasize them" (Roberto, 1992, p. 57).

Siding - involves earning trust by spontaneously relating to each member at different times. Siding with one member is balanced by the expectation for accountability from the same person. This begins with requiring the person to define his/her point of view. There is an expectation, as well, to listen to and consider the interests of other members. An inability to offer consideration indicates that deeper siding is necessary. Siding softens periodic confrontation, and may be used to offer the benefits of making seemingly difficult or painful changes in one's life.

Loyalty framing - therapy is framed to respect existing loyalties, and examine disloyalties. "It is based on the idea that leaving family members in unresolved antagonism is damaging, and has multigenerational implications" (Roberto, 1992).

Exoneration - "is the process of exploring parents' and grandparents' choices and behaviours in a more human(e), less judgmental context" (Roberto, 1992, p. 57). The therapist raises these topics for discussion, as a way of partly dispelling the "effects of shame, blame, and implicit negative connotation that are attached to those relationships" (Roberto, 1992, p. 57). The goal is not insight, but rather a re-exploration and a commitment to understanding the parent's situation, his/her choices, efforts and limitations. "If there is intense ambivalence, rage, guilt, or grief, this procedure takes a long time and requires repeated use of multidirectional partiality" (Roberto, 1992, p. 57).

It is my opinion that each member should be encouraged to explore her feelings and should be encouraged not to rush into letting her "parent off the hook" so to speak. This has been mentioned previously when I cited Framo (1981) who cautions the therapist from asking clients to forgive their parents too soon. Donaldson-Pressman and Pressman (1994) also highlight that self-imposed (and I would add, other-imposed) pressure to forgive often gets in the way of genuine recovery, as it can shut off the necessary expression of anger and self-validation.

A working premise operationalized throughout my intervention involves Alice Miller's (1986) approach which she utilizes in therapy. She approaches an individual by consciously identifying with the child within that person. She believes that asking an

individual questions about early childhood experiences will draw a person out much more effectively than if the approach is one in which the therapist has an unconscious identification with the parent and the parent's methods of raising a child.

Framo (1981) believes that it is necessary for the Adult child to reconcile the wish with the reality; that her parent is the way she is and that the Adult child will have to "cut their losses" and give up the dream. He says it is important to stress that just because their parents could not love, for reasons not understood, it does not mean that they are unlovable. I think this is an important area to address in a group setting. Letting go of the dream of the parent one wished for can serve to free up an individual and may even help an individual to receive more from their parent. At the very least, it can help a person to recognize that her own needs will have to be met elsewhere. "Elsewhere", I believe, sometimes includes meeting one's own needs independently of others.

Framo (1981) also suggests that an Adult child should not cut off from her parents and give them up. He believes that an Adult child needs coaching to become more of a differentiated self when she is with her parents. To be a differentiated self, I believe, means being empowered to decide for oneself how involved one wants to be with one's parent. As adults it is up to each child to decide what is best for them. If an Adult child cannot interact with her parent without continued antagonism, why should she continue to do so? Alice Miller (1986) warns that some therapists' efforts are often directed toward reconciling clients with their parents because they themselves have been taught and are also convinced on a conscious level that only forgiveness and understanding bring inner peace. I have found that Bloomfield (1983) agrees that an

Adult child needs to release resentments, ventilate anger, and defuse guilt, before she moves into understanding and forgiving her parent. It is my opinion as well that an Adult child's quick forgiveness of her parent may be her way of avoiding her own feelings and thus being absolved of responsibility over her own life.

Bowen's theory, as mentioned previously, focuses on the differentiation of self, another area which I have chosen to explore with group members. Bowen (1978) contends that the basic self can change only from within the individual, and must be based on new knowledge and experience. It is not influenced by interpersonal patterns of behaviour, in that it is not changed by coercion, pressure, approval, or power. He explains that the "pseudoself" is a more fluid shifting of self, where beliefs and values are acquired within a relational system. These beliefs are learned in order to gain rewards from a relationship. They are negotiable and are usually influenced by positions taken by others. Pseudoself is the part of self that fuses in intense emotional interactions. Roberto (1992) adds that, in all families, if parents are highly undifferentiated they will project this onto one or more of their children.

According to Bowen's theory (1978), techniques involve role modeling and coaching by the therapist who often will elect the most motivated member to induct change in the wider family system. Another technique used in this model, as summarized by Roberto (1992), includes individual psychotherapy involving a "seeding" technique in which one member is coached to alter behaviour in family conflicts or relationships in general, in order to force other members to alter their behaviour as well. In the group I facilitated, I acted as one of the coaches to alter individuals' behaviour. Other group

members also acted as coaches. It was not my goal to alter these individuals' behaviours or to force others to change. Rather, the technique was used to help them learn alternative ways of caring for themselves, decreasing their stress and improving their ways of coping. The option of continuing to cope in their usual ways was always available to group members.

2.8.3 Summary

This section of the literature review highlights the attitude and philosophy which has guided me in my intervention. More specifically, the section on intergenerational theory provides guidelines which were implemented during group sessions utilizing psychoeducational techniques. This section also highlights several therapeutic techniques which were utilized in the group context.

2.9 FEMINIST THEORY

The intention of this intervention required an understanding of selected feminist approaches as well as intergenerational theory. The two perspectives are not always compatible in philosophy, emphasis, or methods. This section of the literature review discusses intergenerational family therapy from a feminist perspective. In order for my intervention to be guided by both feminist and intergenerational theory it was necessary to seek those aspects of each which supported the intervention..

Feminist theory in general "...recognizes what is involved in caring for others and underlines the importance of increasing the autonomy and choices of caregivers and those who they care for" (Baines, Evans, & Neysmith, 1992, p. 24). Many of the ideas from feminist practice literature have been discussed in relation to caregiver issues.

General guidelines from feminist therapy which were taken into account in working with this group are also included in this section of the Literature Review.

Walters, Carter, Papp, and Silverstein (1988) believe that unless the underlying patriarchal values about the family are addressed openly and/or taken into account in family therapy formulations and interventions, they will be understood by clients to be implicitly accepted. Formulations based in "gender-free" or "neutral" interventions are in fact sexist. This is because they reproduce the social pretense that there is equality between men and women.

2.9.0 Feminist Theory and Boszormenyi-Nagy's Contextual Family Therapy Model

Deborah Anna Luepnitz (1989) has reviewed Boszormenyi-Nagy's contextual family therapy model and contrasted it to feminist theory. She notes that there is great potential for the integration of contextual family therapy and feminism. She supports that Boszormenyi-Nagy's emphasis on sensitivity, courage, and integrity and the importance of remembering the past as opposed to ignoring it. She identifies the overlap of these qualities with the values of a number of feminist therapists (such as Jean Baker Miller and Susie Orbach). Like feminist theory, the contextual family model explores loyalty and power issues which place responsibility on the parent when the child is young. Gelinas (1983, p. 320), too, notes that Boszormenyi-Nagy's concepts of loyalty, fairness and the "revolving slate" are very constructive in doing responsible therapy with for example, families in which incest has occurred. She identifies that the incest victim usually feels loyalty to the abusing parent, and that this loyalty must be taken into account if one is to make a therapeutic alliance with the client. She goes on to write that

a child will 'allow' herself to be parentified in large part because of her loyalty toward her family, particularly her parents. Because of this loyalty, a child's attempt to assist, reassure, and protect her parent, at a very young age, and under significant parentification may result in complete role reversal, with the child caring for the parent. In time the parentified child begins to meet the needs of other family members and sacrifices her own needs. As a result, many daughters and some sons will grow up being attracted to partners who are looking for a caretaker, and who are often immature, narcissistic, and sometimes psychopathic.

According to Luepnitz (1989), Boszormenyi-Nagy does not mention feminism or raise the issue of gender. However, he does mention that young women can be exploited by involuntary sexual assault through rape or seduction, and that the physiological processes of menstruation, pregnancy, childbirth, lactation, etc. all tend to make women unilaterally vulnerable. He states that "they are entitled to receive compensatory measures from society so that reciprocal fairness can prevail. Otherwise, the mothering capacity of many women will be undermined by their feeling of unilateral, sex-limited exploitation" (Boszormenyi-Nagy & Spark, 1973, p. 385). He does not take into account the social history of women's mistreatment and unmet needs over the centuries. He does however, support "assertiveness' and societal "protection" of women against harm and violation. Luepnitz believes that Boszormenyi-Nagy's model could be characterized by "subtle blaming" or "overimplicating mothers". She does say however that his style is "gentle and respectful".

2.9.1 Feminist Theory and Bowen

Feminist therapist Harriet Goldhor Lerner (1985) speaks very highly of Bowen's theory and believes that it fits very well with her feminist values and beliefs. Luepnitz (1989) has also reviewed Bowen's theory in relation to feminist theory. She writes that like feminist therapy, the goal of Bowen's therapy is broader than symptom remission. It emphasizes the importance of family members gaining information about their family of origin and insight into its significance in their daily lives. Harriet Goldhor Lerner indicates that:

> through both Bowen's work and feminism, a woman's sense of isolation about her so-called pathology is replaced by an empathic understanding of the continuity of women's struggles through the generations and the ways in which she is both similar to and different from those who came before her (1985, p. 37).

Bowen also believes that if any kind of therapy is finished and a person cannot hold a conversation with her parents or be in the same room with her mother "something is very wrong". Betty Carter, a feminist theorist, also believes that "cutoffs" from one's parents, grandparents, and siblings are to be avoided wherever possible (Luepnitz, 1989, p. 37). As discussed previously, other authors such as Bloomfield (1983), Framo (1981), and Miller (1983b) do not totally support this last point.

"A consistent theme in Bowen's work is that mothers "overinvest" in their children because of their inability to separate from their own mothers, who in turn could not separate from their mothers" (Luepnitz, 1989, p. 39). Theorists Dinnerstein (1976) and Rich (1976) identify the difficulty of establishing adequate boundaries between mother and child. These theorists place this relationship in a social and historical

context, whereas Bowen does not. As a result maternal "overinvestment" retains the connotations of a character problem which can be translated into mother-blaming, and the father's role is minimized. He writes that "the father plays a passive role in the mother-child relationship, adding his approval to her actions" (Bowen, 1978, p. 435).

According to Luepnitz (1989) Bowen has consistently repeated that a truly differentiated person is not synonymous with the "rugged individual" or the "lone wolf". He reports that he does not equate differentiation with separation or isolation from others, rather he believes that only differentiated people can have mature, loving relationships. According to Luepnitz, even though Bowen insists that differentiation does not mean unconnectedness, he describes a highly differentiated person as "autonomous, goal directed, intellectual and being-for-self". Luepnitz writes that one would expect the high point of his differentiation scale to be more characterized by phrases such as "the ability to integrate thoughts and feelings," " the ability to tolerate conflict and avoid cutoffs," and "the capacity both to compete and to collaborate" (1989, p. 42). Bowen instead seems to separate the rational and emotional systems within human beings. Leupnitz notes that it is noticeable that "what is valued in Bowen's system are the qualities for which men are socialized and what is devalued are those for which women are socialized" (1989, p. 42). Luepnitz continues by saying that it may be said that society socializes females to be undifferentiated by teaching them to always put others' needs first and by denying them the same degree of discretion as men with regard to their economic and physical fates.

Bowen, unlike many family therapists, has attempted to apply his ideas about therapy to society at large (Leupnitz, 1989). However, his view is that society has regressed. Leupnitz questions whether this implies that Bowen does not support women's advancement in the last half century and the improvements made in the rights of cultural minorities.

Harriet Goldhor Lerner (1985) believes that Bowen and his followers view "feminism as an emotionally reactive position that can lead clients down the non-productive path of linear thinking (i.e., blaming men) or the relinquishing of self-responsibility" (p. 39). Lerner's view, in contrast is "that a feminist perspective is crucial to gaining a clearer, more objective view of the self and the factors shaping dysfunctional family patterns" (1985, p. 39).

2.9.2 Codependency Re-defined

Malloy and Berkery (1993) write that the problem with the label "codependency" is that it ignores the social, political, and economic factors that contribute to a women's highly developed skills in working/caring for people. The authors continue by saying that a "Growth in Connection" (Malloy and Berkery) occurs if there is sufficient mutual empathy and energy invested in the mother-child relationship. An expansive growth process can occur for both under these circumstances. It is the lack of shared and flexible understanding which feeds worth, power, and energy, that is believed to be the source of shame and guilt. I have some difficulty with this concept, in that it gives me the impression that the child can give reciprocally to the parent. I agree with Boszormenyi-Nagy's (1991) belief that as a child grows it is up to the parent to provide

such things as caring, loving, security, and it is the child's only obligation to grow. Walters, Carter, Papp and Silverstein (1988) also emphasize that a child is not responsible for abuse, does not have equal power or responsibility, or equal options , or equal ability to change the cycle in families.

Malloy and Berkery (1993) also note that a woman (and, I believe, a man to a lesser extent, as well) who experiences shame and guilt will go to great lengths to maintain relationships because relationships are the source of self, her ability to feel emotionally real, vital, and autonomous. From the "Growth in Connection" perspective, a woman (man) who grows up in a particularly fragile family can be said to suffer from a lack of mutually empowering relationships and to feel disconnected and isolated.

Many girls who grow up in these kinds of families have learned early in their lives to assume the parenting role, to become the "family hero" (Wegscheider-Cruse, 1990) or to be a "super-responsible child" (Black, 1981). The woman desires connection, yet her experience of nonmutuality leads her to believe that relationships are not gratifying and/or are burdensome.

From the "Growth in Connection" perspective (Malloy & Berkery, 1993) everyone is codependent to some degree. Dysfunctional codependence occurs when a person's attempts at healthy and mutual connections are met with pain, rejection, and alienation and when she, in an effort to maintain the relationship, loses sight of her own needs and wants. If others respond in a disconfirming way, dysfunctional patterns repeat themselves, which then creates shame, uncertainty, disempowerment, worthlessness, and self-blame.

2.9.3 Guidelines toward Feminist Therapy

Walters, Carter, Papp, and Silverstein (1988, p. 26-29) identify guidelines for incorporating feminist therapy into practice. They include:

- identification of the gender message and social constructs that condition behavior and sex roles;
- recognition of the real limitations of female access to social and economic resources;
- an awareness of sexist thinking that constricts the options of women to direct their own lives;
- acknowledgment that women have been socialized to assume primary responsibility for family relationships;
- recognition of the dilemmas and conflicts of childbearing and child rearing in society;
- an awareness of patterns that split the women in families as they seek to acquire power through relationships with men;
- affirmation of values and behaviours characteristic of women such as connectedness, nurturing, and emotionality;
- recognition and support for possibilities for women outside of marriage and the family; and
- recognition of the basic principle that no intervention is gender-free and that every intervention will have a different and special meaning for each gender.

2.9.4 Summary

This section of the literature review contrasted the Family Therapy section of the literature review with feminist theory. "Mother-blaming" themes occur throughout the literature of family therapy and it is important that a feminist perspective be integrated into therapy in order that this blaming does not occur. Donaldson-Pressman and

Pressman (1994) stress that those individuals who come from a "dysfunctional" family are afraid to "blame" their parent because they do not want to acknowledge their anger towards them. It also seems to them that blaming their parents is too easy and may somehow backfire on them and leave them feeling worse. Unfortunately they are more likely to blame themselves for everything, including failed relationships, indecisiveness, and their parents' difficulties. They stress (and I agree) that it is important to explore one's family of origin and recognize its effects on one's development. While a child is not responsible for what happened as a child, as an adult one is responsible for one's own recovery. Though this is similar to feminist values, the issue of anger and the need for an individual to have permission to acknowledge the reality of past behaviours and limitations of her mother (and at times have feelings of blame particularly towards the mother) at some point does not seem to be recognized as important from a feminist perspective. In contrast, I think the need to acknowledge feelings of blame and anger toward one's parent can be a very important aspect in the process of one's healing.

2.10 SMALL GROUP THEORY

The following section of the literature review provides information which has guided me in initiating, developing and analyzing the group intervention. I believe that issues of childhood abuse and caregiver issues can be combined and worked upon in a complementary fashion in the context of a group.

For the purpose of this practicum I chose a psychoeducational group format as the most suitable form of intervention to meet the stated objectives and attain treatment goals. "The primary purpose of educational groups is to help members learn about

themselves, their community, and their society". They are aimed at "increasing members' information or skills" (Toseland & Rivas, 1995, p. 25).

Toseland and Rivas (1995) defined treatment groups as meeting members' socioemotional needs through education, growth, remediation and socialization. Within this typology, this group can be further categorized as a "growth group", providing "opportunities for members to become aware of, to expand, and to change their thoughts, feelings, and behaviors regarding self and others" (Toseland & Rivas, 1995, p. 22).

Schultz and Schultz (1990) have developed a model for caregiving which has been used as a framework for psychoeducational groups for caregivers (see Figure 1). The model emphasizes empowerment and positive adaptation through awareness, problem-solving, and skills development. It is based on a blend of phenomenological-psychodynamic and cognitive-behavioural approaches. The phenomenological-psychodynamic approach encourages introspection to gain dynamic self-understanding and clarification of options. The cognitive-behavioural approach enables the caregiver to find additional coping resources through acquiring skills to gain control over "mood, activities, and thinking patterns" (Gallagher, 1985, p. 264).

"The starting point in this Symbol of Growth is the personal, individual world of the caregiver" (Schultz et al., 1993, p. 8). An increased self-awareness clarifies understanding about circumstances surrounding the person and significant others, and about the input of environmental factors. Once personal strengths and available resources are identified, there is a progression to the level of problem-solving.

> With a renewal of energy comes the fuller use of existing skills and strategies and an eagerness to explore new options. Thus personal growth, skills-development, and resource utilisation emerge, leading to appropriate caring action for self and others (Schultz et al, 1993, p. 9).

The Schultz and Schultz (1990) model for caregiving is used as the basis for developing group topics which include the pressures and tensions of caregiving, loss and grief, family dynamics, communication skills, community resources, and stress reduction. "The emphasis is on experiential learning with much group interaction interspersed with didactic input from the leader" (Schultz et al, 1993, p. 9).

Figure 1. SYMBOL OF GROWTH

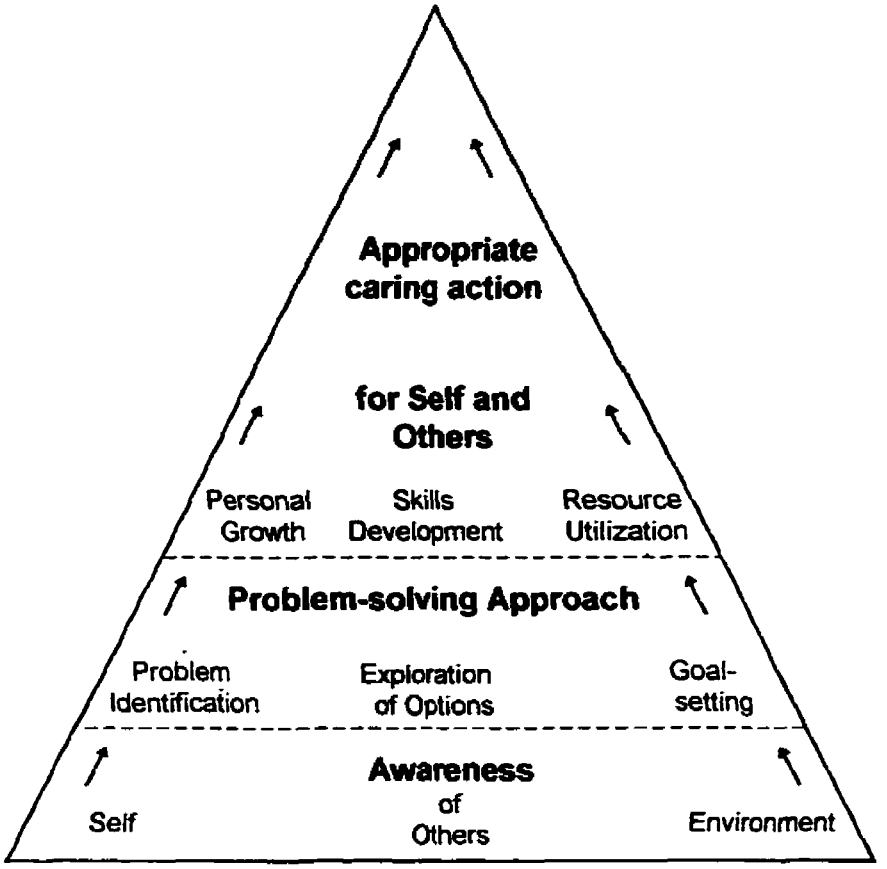


Figure 1. A model for caregiving. (copyright Cynthia L. Schultz and Noel C. Schultz, 1990).

2.10.0 Benefits of a Group Format

Eliana Gil (1988) identified the lack of existing support groups for the Adult child who has experienced physical and emotional abuse, or for the adult who was neglected or abandoned as a child.

The benefits of utilizing a group format are many and support for this is provided by researchers in child sexual abuse such as Courtois (1988), Gil (1988), by group treatment theorists such as Toseland and Rossiter (1989), and Goodman (1991). Although this is not an exhaustive list, the reasons for utilizing a group format include the following:

- to provide an opportunity to share feelings and experiences in a supportive environment with peers who share similar concerns;
- to provide members with mutual support, understanding, affirmation and validation of their perceptions thoughts and feelings;
- to universalize and normalize members' experiences;
- to encourage mutual sharing of information about effective coping strategies;
- to reduce isolation and loneliness, through the experience of "being in the same boat" with other group members;
- to help members identify and examine problems and concerns and to use systematic problem-solving procedures to resolve specific concerns;
- to experiment with issues of safety and trust; and
- to develop cohesiveness, and enhance self-esteem.

Goodman (1991) refers to Lieberman who also notes that groups make available the opportunity to "share concerns, participate in the struggles of others, to feel normal in spite of stress, to express feelings and fears, to share a reference group with others, to

exchange ideas about coping, and to provide an opportunity to help others" (Goodman, 1991, p. 164). Another important component of the group process is to create an atmosphere which enhances personal discovery in group members.

Courtois (1988, p.178-182) identifies further benefits of group treatment with the Adult child who has been abused. These are:

- to break secrecy and acknowledge abuse;
- to act as a support network and new or "surrogate family";
- to provide a context and catalyst for the challenging of beliefs and childhood messages;
- to offer a unique forum for grieving; and
- to offer an opportunity for observation and exploration of interactional patterns and client dynamics.

2.10.1 Open or Closed Group Membership

Short-term groups are those which usually meet from between three to a dozen sessions. The short-term group is usually developed by the agency around a particular theme, or to deal with a special issue (Cohn, 1974; Drum & Knott, 1977). Many of these groups are oriented towards education or growth rather than remediation. Poey (1985) stresses the importance of using specialized time-limited techniques to facilitate groups which last from ten to twenty sessions.

The open group maintains a constant size by replacing members as others leave. Members enter and terminate throughout the duration of the group. There are both advantages and disadvantages to an open group composition. Open groups allow for new ideas and new resources to be brought to the group through new membership, which can make the group more creative. The disadvantage to the open group is the "instability of

the open group, which results from loss of leadership, turnover in personnel, termination of certain members, and loss of group identity" (Hartford, 1971, p. 135).

The closed group "accepts no new members and usually meets for a predetermined number of sessions" (Yalom, 1975, p. 277). An advantage of a closed group is that members are more likely to form a greater sense of cohesion because they have all attended the group since its beginning. There is usually greater stability in roles and norms in a closed group. The advantages of closed exclusive membership include "higher group morale, more predictability of role behaviours" (Toseland & Rivas, 1995, p. 163) and more cooperation among members. Eliana Gil (1988) states that it may be easier for the Adult child who has experienced abuse to make a short-term rather than a long-term commitment to attending a group. Once a person has experienced the benefits of the group experience she may be more likely to commit for additional sessions. Flegenheimer (1982) also indicates that brief treatment modalities are preferred by many clients and are often the only effective form of treatment that an individual will accept. A disadvantage of a closed group is that "when members drop out or are absent the number of members in the group may fall below that required for meaningful group interaction" (Toseland & Rivas, 1995, p. 129).

Poey (1985) has reviewed Yalom's understanding long-term groups and sees the following as important, as well, in brief group work: interpersonal learning, cohesiveness, catharsis and insight. Poey adds to this list (1) "acute awareness of time and the sense of urgency that pressures members and leaders to participate less hesitantly and more courageously than they would have expected" (Poey, 1985, p. 350); (2) the

member's appreciation of the structure provided by focusing on several problem areas and being brought back to the task of working on those issues until there were results; and (3) the members' appreciation of the therapist's facilitating skills of active involvement, modeling, self-disclosure and supportiveness.

Eliana Gil has found that short-term groups ranging from ten to fourteen sessions are useful. She will recontract with the same clients, if necessary, for additional sessions. Toseland and Rossiter (1989) who reviewed groups for caregivers indicate that most caregiver support groups run six to eight weekly sessions from one and a half to two hours. Toseland and Rossiter report that there have also been groups which meet for more than eight sessions and some use an open-ended, long-term format.

Lovett and Gallagher (1988) have facilitated groups which included ten weekly, two hour sessions, and this is essentially how I have structured my group intervention. However, I have found Schultz, Smyrnios, Grbich, and Schultz (1993) group structure very interesting as well. They have developed a caregiver group where participants meet two to five hours on a weekly basis for six weeks and then meet three more times on a monthly basis. The last three sessions are structured in a way which helps to strengthen group ties and gradually diminish the leader's role.

2.10.2 Homogeneous and Heterogeneous Groups

The concept of homogeneous groups as discussed by Toseland and Rivas (1995) indicates that members of a group should have some goals and personal characteristics in common. This aids in the facilitation of communication and enhances members' ability to identify with each others' issues. Commonalities between members also assists them

in building relationships with one another. The authors state that it is important for members to share similarities of age, level of education, cultural background, degree of expertise relative to the group task, communication ability, or type of problem in common.

Heterogeneity or diversity is useful in areas of differing coping skills, life experience, perspectives, and communication skills. Differences in members' coping patterns can help them learn from one another and broaden their views of options, choices, and alternatives (Toseland & Rivas, 1995).

The composition of the treatment group according to Toseland and Rivas (1995), should be homogeneous in that members have common concerns and goals, but can be heterogeneous in their coping abilities, life experiences, and learning.

2.10.3 Size of Group

Small groups generally range anywhere from three to fifteen members. Toseland and Rivas (1995) report that in general the literature suggests that a treatment group size of seven members is ideal.

2.10.4 Group Format

Several sources were explored in considering the development of the group format. Eliana Gil (1988) suggests a group format for the Adult child who has been abused which lasts for ten sessions and is divided into six segments listed below.

Sessions One and Two: Group rules, group structure and goals

Sessions Two and Three: Priorizing goals

Sessions Four and Five: Self-Image

Sessions Five and Six: Self-Esteem (identifying ones strengths and weaknesses)

Session Seven and Eight: Intimacy

Session Eight through Ten: Childhood abuse

This format became a basic guide for my group intervention. Additionally, I incorporated Boszormenyi-Nagy's (1986) contextual family therapy model dimensions into the format. As well, I incorporated some of the topics identified in the group format developed by McClelland (1993) which utilized a feminist approach. This format is listed below.

1. Introduction of group and members
2. The aging process and stresses associated with caregiving
3. Self care and stress management
4. Emotional responses to caregiving
5. Women as caregivers
6. Formal and informal care
7. New ways of coping and achieving increased wellness
8. Closure of group

2.10.5 Stages of Group

Published group work material in the last twenty years seems to suggest a strong emphasis on the intervention-focused stages of group development and the concomitant tasks of the worker. Less emphasis is given to a group's natural stages of development. Useful material regarding the latter issue was achieved by accessing the research

completed by Garland, Jones, and Kolodny (1965) as cited and discussed by Charles Zastrow (1989).

Whittaker (1970) has reviewed a number of models of group development. I focused on the Garland et al. (1965) model of group development, and made reference to Henry Maier's (1965) four stages of group development

which is very similar to the Garland et al. stages of group development (Whittaker, 1970, p. 134). Garland et al. identify five stages of growth in group development and Maier identifies four stages. Maier chooses not to look at termination as an actual stage of group development. The five stages are identified and briefly described as follows:

Stage 1 - Pre-affiliation - Approach and Avoidance (Garland et al., 1965)

Locating Commonness (Maier, 1965)

This stage of group development involves members becoming familiar with each other and their situations. Some members may demonstrate ambivalence toward involving themselves in the group's activities as they begin to trust and decide on their level of commitment to the group. Members may also feel the need to protect themselves as a group situation can be frightening. They may be attracted to the benefits of being part of a group but may require some distance at the start. Garland et al. (1965) suggest that this "arms length", "non-intimate" involvement at this stage is, on the whole, a healthy process.

Stage 2 - Power and Control (Garland et al., 1965)

Creating Exchange (Maier, 1965)

Once members have established that the group experience may be safe and rewarding, they will begin to invest emotionally. As this occurs, members may lock horns and test each other as well as the facilitator. Norms, roles and patterns of communication begin to develop at this stage. Cliques and alliances may also develop as a way to protect oneself from a more "powerful and aggressive" member. Scapegoating may first appear at this stage of development and the drop-out rate is usually highest at this stage.

Stage 3 - Intimacy (Garland et al., 1965)

Developing Mutual Identification (Maier, 1965)

The third stage of group development involves an intensification of individual investment. It also involves more of a willingness to express feelings towards group members and the facilitator. Clarification of power relationships in the previous stage allows for freedom to express autonomy and intimacy in this stage. The facilitator is sometimes referred to as a parent. There is a striving for satisfaction of dependency needs, and sibling-like rivalry or transference may be demonstrated between group members. "There is a growing awareness and mutual recognition of the significance of the group experience in terms of personality growth" (Garland et al., 1965, p. 34) and making changes in their personal lives.

Stage 4 - Differentiation (Garland et al., 1965)

Developing Group identification (Maier, 1965)

Stage 4 is described as the stage of group development which involves a growing ability of members to accept each other as "distinct individuals". "Clarification of and coming to terms with intimacy and mutual acceptance of personal needs brings the freedom and the ability to differentiate, and to evaluate relationships and events in the group on a reality basis" (Garland et al., 1965, pp. 37-38). Members are increasingly cohesive as they communicate more openly and provide mutual support. Leadership is more evenly shared and members are also more open to experiment with new and alternative behavior patterns (Zastrow, 1989).

Stage 5 - Separation (Garland et al., 1965)

The final stage of group development involves members beginning to move apart and accessing "new resources for meeting social, recreational and vocational needs" (Garland et al., 1965, p. 41). Members may demonstrate such coping behaviours as regression, denial, and recapitulation. Garland et al. write that recapitulation serves as an evaluating function, which can help the group to explore the meaning and value of the overall experience. "If the group experience has made a significant impact on the group members, the assumption is that it now becomes the frame of reference for approaching new social, group and familial situations (Garland et al., 1965, p. 41).

Tasks of the Worker

"Tasks of the worker" have been identified by Garland et al., (1965) as well as Maier (1965). I have attempted to incorporate both the Toseland and Rivas (1995)

framework of group development and the Garland et al. (1965) stages of group development in relation to the tasks of the worker.

Toseland and Rivas (1995) provide a framework for understanding group development in relation to the tasks of the worker. They divide the framework into four main stages: the planning stage, the beginning stage, the working stage and the ending stage.

The planning stage of group development includes establishing the purpose of the group, recruiting members, composing the group, orienting members to the group, contracting, and preparing the group's environment (Toseland & Rivas, 1995). This stage does not coincide with any stage which Garland et al. (1965) have identified as they focus on group development and Toseland and Rivas look at tasks and intervention stages.

The initial group meeting involves discussing the purpose of the group, contracting with respect to ground rules for the group and setting group goals. This beginning stage coincides with the Garland et al. (1965) pre-affiliation stage. The authors identify the tasks of the worker as providing program structure and initiation. Other tasks of the worker identified by Garland et al.(1965) include an acceptance of the process of "approach and avoid", gently encouraging trust between members, facilitating exploration of commonness and differentness.

The working stage as identified by Toseland and Rivas (1995) involves the preparation, structuring and evaluating of group process. In planning group sessions, the facilitator creates a plan of weekly topics and structures, to a certain degree, the process

of group interaction. The weekly agenda of group sessions involves a "checking in" time to break the ice, followed by the topic of discussion and an open group discussion of the topic. The group facilitator also assists members in meeting their goals through enabling, brokering, mediating, advocating, and educating. Toseland and Rivas (1995) suggest that intrapersonal intervention in a treatment group should utilize cognitive restructuring through stopping, reframing, and relaxation techniques such as creative visualization and progressive relaxation to assist members in changing thoughts, beliefs, and feelings about life's stresses and creating a positive group climate.

Several of Garland et al.'s stages of group development coincide with the working stages described by Toseland and Rivas (1995). Stage 2: Power and Control, as described by Garland et al. (1965), outlines the tasks of the group worker as allowing for rebellion, protecting the safety of individuals, and clarifying power struggles. In Stage 3: Intimacy, the worker focuses on clarifying negative and positive interpersonal feelings. The tasks of the worker in Stage 4: Differentiation include helping the group to operate on its own, facilitating opportunities for the group to act as a unit, and facilitating the evaluation process.

The ending stage focuses upon both a formal (written) and informal (verbal) evaluation of the group in terms of members' learning, meeting stated goals, and looking toward the future. This stage coincides with Garland et al.'s (1965) Separation stage. The tasks of the worker at this stage include letting go, focusing on group and individual mobility, the achievement of personal needs in the future, and facilitating evaluation.

Poey (1985) identifies four stages of a group as well, where both the tasks of the worker and the stages of group development are combined but not clearly identified separately. Stage one (sessions 1-3) includes the introduction of members and leaders, therapeutic milieu building, and problem-focused contracting. Stage two (sessions 4-6) involves orienting members to the therapeutic modalities and the establishment of cohesiveness. Stage three (sessions 7-9) involves increased mutuality and functional role-relatedness. Stage four (Session 10-12) is the closing stage of the group . This involves summarizing what has and has not been accomplished and saying good-bye.

2.10.6 A Model of Group Leadership

Three leadership models of social group work have been identified by Toseland and Rivas (1995). These are the social goals model, remedial model and reciprocal model. I have chosen the reciprocal leadership model for the purpose of my intervention. In this model, the leader's goal is to form a mutual aid system among group members to achieve optimal adaptation and socialization. The focus of the work is to create a self-help, mutual aid system among all group members. It is the facilitator's role to act as a mediator between needs of members and between needs of the group and the larger society. This style of group leadership is in keeping with a feminist approach. The facilitator also contributes data not available to the members. Group members are those who share common concerns. One of the methods used in the group includes sharing responsibility, whereby members discuss concerns, support each other, and develop a cohesive social system benefitting all those involved (Toseland & Rivas, 1995).

2.10.7 Summary

This section of the literature review has provided a rationale for the value of group interventions. It also highlights information regarding useful structure, content and development of groups which provided the basis for the development of this intervention.

CHAPTER 3 - INTERVENTION

The purpose of this practicum was to develop, implement, and evaluate an intervention which would assist the Adult child to improve her ability to cope with a parent whom she perceived as having a "difficult personality" . In particular, the aim of the intervention was to facilitate improved ways of coping through the reduction of feelings of burden, and/or the improvement of social support networks, and/or the improvement in attitude toward the parent, and/or the improvement of self-esteem. I chose a short-term group facilitation intervention based upon intergenerational and feminist theory.

The intervention for this practicum was comprised of eleven group sessions. Pre- and post-group individual interviews were conducted to provide additional background and contextual information. These interviews were used to enrich the data base and to evaluate the effectiveness of the group.

The group was initially comprised of eight members and was closed to new referrals once pre-group interviews had begun. Potential members were interviewed for the purpose of sample selection and to collect information prior to the commencement of the group. The individual became a group member if she met the stated criteria, signed the consent form and agreed to be a member of the group.

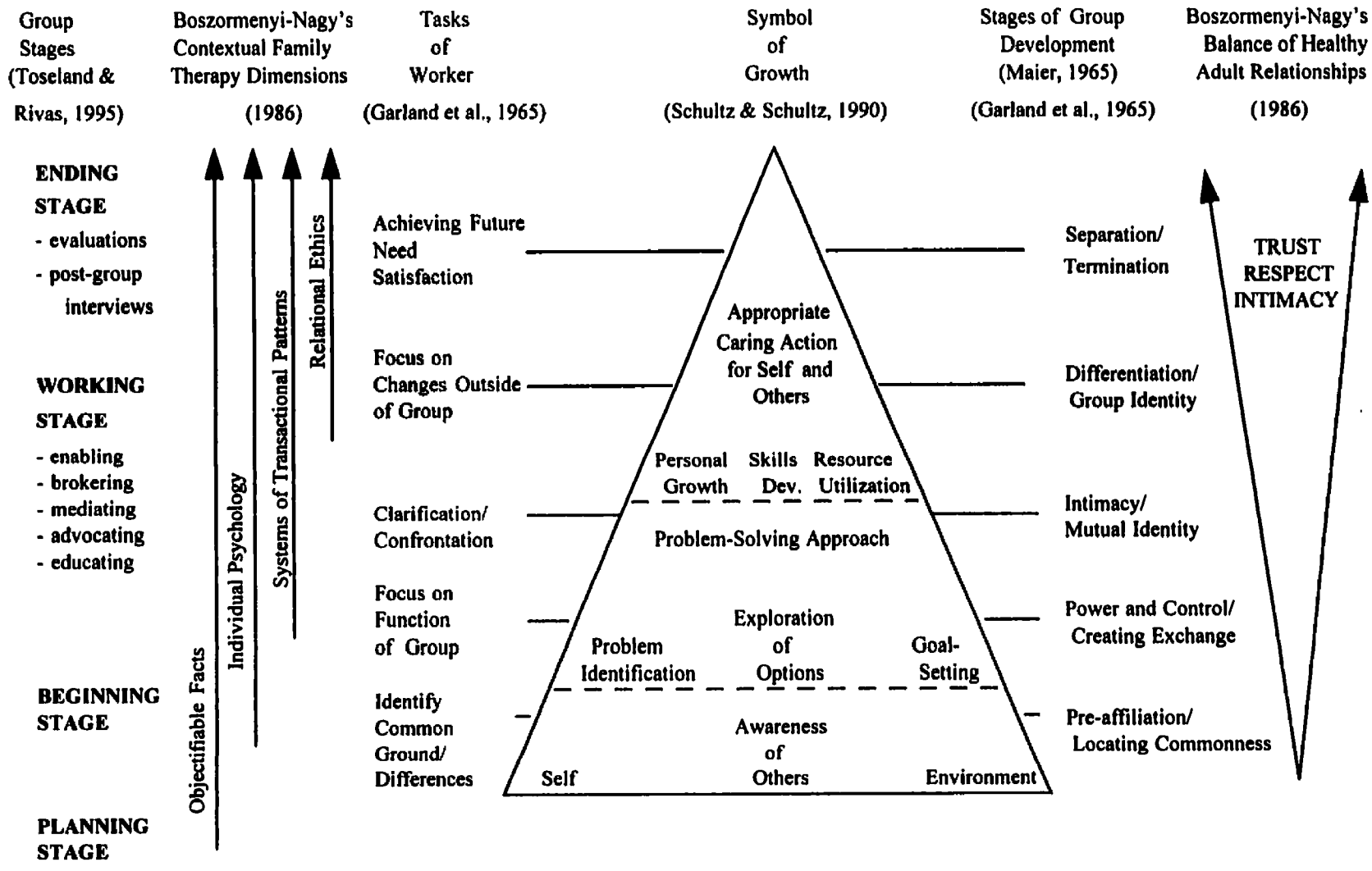
3.0 MODEL FOR INTERVENTION

The model for intervention utilized for this practicum was developed through the compilation of theories described in the literature review section of this practicum report. Figure 2 provides a visual representation of this model.

As presented in Figure 2, the planning stage for the group occurs before the group actually begins. This involves locating members for the group and coordinating where, when, and how long the group will meet. It also involves pre-group interviews with each individual member of the group. Pre-group interviews prepare the prospective members for the group. They are asked to sign a consent form and asked some questions about their parents' as well as their own health problems and supports. They are also asked questions about the behaviours of their parents with which they have difficulty coping and what coping strategies they use to deal with the stress resulting from the situation/relationship with their parent. It is also at this time that quantitative measures are administered. Each group member may begin to think more about her past life experiences in relation to her parent, and naturally begin the process of a life review. As presented in Figure 2, Boszormenyi-Nagy's (1986) contextual family therapy dimension of Objectifiable Facts, or life review, has already begun.

The initial stage of the group intervention involves identifying common ground and differences among group members. The worker facilitates the process of individual members describing themselves and their situations. Through the process of information

Figure 2. " FAMILY THERAPY" WITHOUT THE FAMILY: A MODEL OF GROUP INTERVENTION



voluntarily shared between individuals, group members begin to get to know one another. This is the time when group members are beginning to become more aware themselves, their environment and the situations of others as identified in the Schultz and Schultz (1990) Symbol of Growth model identified in Figure 1. Boszormenyi-Nagy's (1986) contextual family therapy dimension of individual psychology is integrated into the first part of the Symbol of Growth model.

The working stage of the group intervention involves tasks of the worker which include enabling, brokering, mediating, advocating and educating (Toseland & Rivas, 1995). Other tasks of the worker include focusing on the function of the group, clarifying and confronting, and then focusing on changes outside of the group (Garland et al., 1965). It is during the working stage that systems of transactional patterns and relational ethics (Boszormenyi-Nagy, 1986) are introduced and discussed with group members. Intervention strategies identified by Boszormenyi-Nagy and outlined in the literature review section of this practicum report are also utilized by the worker.

Schultz and Schultz (1990) identify the problem-solving approach which becomes integrated into the middle stage of group development. This is where members identify problems, explore options, and set goals for themselves. Through this process members begin to experience personal growth, skills development and resource utilization. It is during the working stage as well that the group goes through stages of power and control/creating exchange, intimacy/mutual identity, and differentiation/group identity.

The ending stage of the group intervention involves members integrating the contextual family therapy dimensions (Boszormenyi-Nagy, 1986) and moving forward

after the group terminates. As identified by Schultz and Schultz (1990) in their Symbol of Growth model, members will have learned appropriate caring action for themselves and others and are helped to recognize that these skills take practice to develop, maintain, and improve. The task of the worker involves facilitating discussion around how members can achieve their own future needs and continue to develop personal growth, to develop skills, and to maintain or increase their personal resources. It is at this time that group evaluations are completed and post group interviews are conducted by the worker.

Throughout the process of the group intervention group members learn the features of healthy adult relationships (Boszormenyi-Nagy, 1986) which are identified in Figure 2 as being trust, respect, and intimacy. Group members are encouraged to explore and evaluate the quality of the current relationships in their lives as the worker facilitates the actual development and growth of healthy adult relationships among group members.

The following section outlines the purpose, goals, ground rules, and agenda for the eleven-week group.

3.1 PURPOSE OF THE GROUP

The overall purpose of the group was to assist Adult children to cope more effectively with a parent whom they perceived as having a "difficult personality" . A variety of techniques were used including providing mutual support, facilitating problem-solving skills, and introducing experiential exercises such as anchoring, relaxation, assertiveness-training, practicing stress management skills, and providing emotional validation. Through these interventions, the aim of the group was to assist members in

reducing perceived burden, and/or developing social support, and/or facilitating positive changes in their attitude toward their parent and/or improving their self-esteem.

3.2 GROUND RULES OF THE GROUP

The following ground rules were shared with group members by the facilitator at the beginning of the first session. They are listed below.

1. All discussions within the group are kept confidential in order to respect the privacy of group members.
2. Each group member has the right to express herself and to be heard by group members.
3. Feelings or opinions expressed by each group member are to be respected and accepted.
4. Each group member is expected to bring up concerns in group sessions in order to deal with them openly.
5. If a member is unable to attend a session, or decides to terminate group involvement, she will notify the group facilitator.

Members added one more group rule and that was to have a 10-minute smoking break during the two-hour session. Interestingly, this rule did not continue after the first session because once future sessions began, the group did not care to stop for a break.

3.3 GROUP GOALS

The facilitator raised the following group goals for discussion with the group members at the first session:

- to provide a safe environment in which the group member shares common experiences and feelings, and gains support and validation from others;
- to regain a sense of balance in one's life;
- to promote control and mastery over one's feelings, thoughts, and behaviours;

- to promote education and understanding about current problems and caring for oneself;

- to gain new ways of perceiving relationships each member has with her parent, herself, and others in her life;

- to assist the group member in making changes in her own support network and in gaining further support and recognition for her struggles in dealing with her parent; and

- to form the basis for possible ongoing mutual support among group members.

Members were asked to decide for themselves which of these goals were the most meaningful to them, and were asked if they had any to add. I advised the members that they did not have to share which goals were the most important for them. They did not share the goals most important to them and did not add any goals to the list.

Members were also asked to think about whether they wanted to focus particularly on any of the areas outlined by Kent Poey (1985), i.e.

- autonomy;
- identity formation;
- interpersonal skills;
- assertiveness; and
- intimacy.

Given this opportunity, members still did not add to the list of group and/or individual goals.

3.4 OUTLINE OF GROUP SESSIONS

All but the last two group sessions began with introductions and the sharing of current issues with group members. Group sessions were pre-planned for members, informed by intergenerational/feminist theory. However, the needs of members (and feminist practice) supported flexibility in implementation and therefore, sessions were

revised as necessary to focus on the current needs of the group members. Some portions of group sessions focused on topics which were identified by group members.

Session #1 Introduction, education, life review

- Introduction of group and members

-Solicit input from group members about what they hope to achieve

- Review ground rules

- Review purpose and goals of group

- Members begin to share their personal experiences.

Session #2 Life review: Coping and roles in one's family of origin

- Mini-lecture on the roles different members play in their family of origin

- Group discussion

Session #3 Life review: Roles in one's family of origin and in one's present relationships

- Further exploration into coping and roles in one's family of origin and in one's current living arrangement

- Utilizing genograms to illustrate roles and patterns

- Group discussion

Session #4 Feelings: Guilt and setting limits

- Focus of discussion focused on feelings of guilt and setting limits as identified by group members in previous sessions

- Members divided into dyads to discuss their experience with guilt

- Group discussion

Session #5 Setting limits

- Focus of discussion continued with setting limits with one's parent and/or other individuals in one's life

- Group discussion

Session #6 Feelings: Addressing fears of being like one's parent

- Focus of discussion centered on fear of being like one's parent. Commonalities between parent and child were identified and discussed

Session #7 Communicating feelings and taking charge of one's current situation

- Focus of discussion centered upon information brought by a group member on how to take charge of one's life

- Group discussion

Session #8 Relational Ethics and taking responsibility for change

- Mini-lecture on Boszormenyi-Nagy's "Relational Ethics" and the balance of fairness in relationships

- Group discussion

Session #9 Relational Ethics and taking responsibility for change

- Further exploration into the relational ethics in one's family of origin and how they continue to be played out in current relationships

Session #10 Care for the caregiver and planning for future need satisfaction

- Focus of discussion was on individual needs of group members and ways of meeting those needs in the future.

Session #11 Evaluation and Termination

3.5 SOURCE OF REFERRALS

Referrals were made through the Psychogeriatric Outreach Team at Deer Lodge Centre in Winnipeg, Manitoba. Team members agreed to identify potential participants who were Adult children of a parent who was perceived by the Adult child or the team member as having a "difficult personality".

3.6 SAMPLE SELECTION CRITERIA

It was necessary for potential members of the group to fit the following criteria:

1. be an Adult child of an elderly parent who was perceived as having a "difficult personality";

2. that the Adult child's parent or the Adult child was referred to the Psychogeriatric Outreach Team at Deer Lodge Centre;

3. that the Adult child was motivated to change her relationship with her parent;

4. that the parent was unmotivated to change his/her relationship with one's daughter, from the Adult child's perspective or that the Adult child was not yet prepared to engage in therapy with her parent; and

5. that the Adult child may or may not have perceived herself as a caregiver to her parent; and

6. that the Adult child was not exhibiting behaviours which would be disruptive to the group process.

3.7 SETTING

Group sessions took place at Deer Lodge Centre, 3 North Pavilion every Wednesday, from September 18 to November 27, 1997. The group ran from 6:00 p.m. until 8:00 p.m. This time was chosen in an attempt to simulate a typical family gathering which generally occurs over the meal hour. Coffee and snacks were provided.

3.8 DATA COLLECTION

Data collection included quantitative and qualitative techniques, which are described more extensively in the evaluation section of this chapter.

Pre- and post-group interviews with members allowed me to gather important descriptive data in a case study format. Many of the variables studied around the issue of differentiation could not be measured by quantitative methods. Thus, questions in the interview attempted to gain such information as the burden and stress of caregiving, and characteristics of the parent-child relationship. These issues factor into coping abilities of the Adult child. Possible outcomes experienced by the Adult child in coping with caregiver stress may be more accurately measured by self-report and therapist assessment than quantitative measures. Scales can also be obtrusive and do not always contribute to the therapeutic relationship. I decided that, in balance, gathering data should not override the importance of providing services.

Quantitative data was collected through measures of burden, child's attitude toward mother/father and perceived social support for caregiving and social conflict. These self-anchored scales are described more thoroughly in the evaluation section of this chapter.

Group sessions were audiotaped and analyzed for the purposes of collecting information and clinical supervision. A record of my observations of the group process, and individual treatment progress reports, also provided further data.

3.9 EVALUATION

Evaluation of the group intervention was measured by both quantitative and qualitative analysis. Quantitative analysis is defined by Earl Babbie (1986, p. 558) as "the numerical examination and interpretation of observations, for the purpose of describing and explaining the phenomena that those observations reflect". Qualitative analysis (Babbie, 1986) is defined as the "nonnumerical examination and interpretation of observations, for the purpose of discovering underlying meanings and patterns of relationships" (p. 558).

The quantitative data in this intervention was gathered using the basic "AB" Single System evaluation model. This model directs the administration of scales to the Adult child both on a pre- and post-test basis. Measurement before the intervention provides a baseline and measures specific dependent variables before the intervention (an independent variable). The post measurement provides data on any changes of the same specific dependent variable.

Qualitative data in this intervention was obtained from individual pre- and post-group interviews. A written open-ended evaluation was also filled out during the final group session (see Appendix B). Information gathered throughout group sessions was also an avenue by which qualitative data was obtained. This data was compiled in the form of comparative case studies and will be discussed in Chapter 4 of this practicum report. Although comparative case studies have been criticized as lacking validity, a number of other authors have suggested that using the method of triangulation can

increase internal validity and that findings can be generalized (external validity) in a more confident manner if the findings apply to a number of cases (Stoecker, 1991).

As indicated, combining both quantitative and qualitative measures is known as "triangulation". This method provides richness and detail in that one type of data can elaborate the findings of the other (Rossman & Wilson, 1985).

The benefits of using triangulation as described by Jick (1979) include:

- increasing confidence of results;
- assisting in an integration of theories; and
- providing a context in which the behaviour can be understood.

Patton (1990) notes that triangulation of quantitative and qualitative data provides a type of comparative analysis which strengthens the reliability of the data gathered.

3.10 SCALES

Four self-anchored , standardized scales were administered to members involved in the group intervention. They were administered in the following order, pre and post group:

1. Child's Attitude Toward Mother/Father (CAM/CAF)
2. Caregiver Burden Inventory (CBI)
3. Perceived Social Support for Caregiving and Social Conflict Scale (PSSC/SC)
4. Index of Self-Esteem (ISE)

1. Caregiver Burden Inventory (CBI)

The Caregiver Burden Inventory is a standardized, empirical measure which was developed by Dr. Mark Novak and Carol Guest. It was originally developed in 1987, and was revised and expanded in 1989. The scale is a multi-dimensional, 24 item questionnaire developed to measure specific areas of burden in caregivers' lives. It is classified as a self-anchored rating scale and is quite easy to administer. The scale consists of five factors: (1) Time Dependence; (2) Developmental Burden; (3) Physical Burden; (4) Social Burden; and (5) Emotional Burden. Scores for each factor range from 0-20, except for physical burden, Factor 3 which ranges from 0-16. Physical burden scores are mathematically adjusted by multiplying the score by 1.25 which gives the equivalent score out of 20.

Novak and Guest (1989) found the internal consistency reliability (Coefficient Alpha) high at .89 for the overall scale, with alphas ranging from .73 to .86 for the factors.

The Caregiver Burden Inventory has been used primarily on caregivers of those who suffer from dementia. Further research with caregivers of the aging person who has a "difficult personality", for example, may expand its applicability.

2. Perceived Social Support for Caregiving and Social Conflict Scale (PSSC/SC)

Catherine Chase Goodman (1991) developed these two scales . The first nine questions relate to perceived social support for caregiving and they include aspects of self-help support as well as information exchange and emotional support. The next three questions make up the social conflict scale which was developed to measure negative aspects of supportive relationships. The scales were developed through factor analysis on a sample of 206 caregivers. Goodman (1991) reports good internal consistency and a coherent factor structure.

Goodman notes that the scale can be easily adapted for use with other populations participating in self-help and support groups. She believes that because the PSSC and SC appear to reflect support from peers, family or friends, it is an ideal tool to evaluate outcome or compare benefits from groups.

3. Child's Attitude toward Mother/Father (CAM/CAF)

The Child's Attitude Toward Mother (CAM), or Father (CAF) scale (Walmyr Publishing Company, 1992) were designed to measure the "degree, severity, or magnitude of a problem" a child has with his/her mother or father. These scales can be used with adolescents or adults. It is generally not recommended that they be used with individuals under the age of 12.

Scores for the CAM and the CAF range from 0-100. These scores can be regarded as true ratio scale values, in that 0 would indicate that the individual has no

difficulties with his/her parent and a score of 100 would represent the highest possible level of distress that the scale is capable of measuring.

The CAM and the CAF have two clinical cut-off scores. The first is 30 and the second is 70. Individuals who score below 30 can be presumed to be free of a clinically significant problem in this area. Scores above 30 indicate a clinically significant problem in this area. Scores larger than 70 indicate that the individual is nearly always experiencing severe distress. Scores this high indicate that the individual may use forms of violence to deal with the ongoing problem.

The CAM and CAF scales have Alpha coefficients of .90 or larger. Content, construct, factorial, and known groups validity nearly always achieve validity coefficients of .60 or greater (Walmyr, 1992).

4. Index of Self-Esteem (ISE)

The Index of Self-Esteem or ISE (Walmyr, 1992) was designed to measure the degree, severity, or magnitude of a problem an individual has with self-esteem. Self-esteem, as conceptualized and measured by the ISE, is the evaluative component of self-concept. The ISE scale can be used to obtain context specific measures of client problems with respect to self-esteem. Therefore, the scale can be completed by asking the client to fill it out, for example, in terms of their social life or their family life.

Scores for the ISE range from 0-100. The scores can be regarded as true ratio scale values, 0 indicating the individual has no difficulties and 100 indicating the highest possible distress level that the scale is capable of measuring.

Cut-off scores for the ISE are the same as for the CAM and CAF. A score below 30 indicates no significant problems and a score over 30 can be presumed to have clinical significance in the area of self-esteem. The second cut-off score is 70, and scores higher than 70 indicate that the individual is nearly always experiencing severe distress. As with the CAM and CAF when scores reach this level there is a possibility the individual may use some form of violence to cope.

Reliability and Validity are similar to the CAM and CAF. Internal consistency reliability scores is reported to be .90 or larger (Walmyr, 1992). Content, construct, factorial, and known group validity achieves validity coefficients of .60 or greater.

I chose to use a number of quantitative measures to explore various characteristics of individual members. Pre-group results demonstrated a variety of scores on these scales which indicated to me the wide range of needs of this particular group. I did not necessarily expect to see drastic improvements in the scores of the CBI, CAM, or ISE post-group. There are many reasons for this. First, the length of the group (11 sessions) was not expected to address deep seated issues of self-esteem or of one's attitude to one's parent. Second, scores on the CBI, CAM, and ISE may indicate little change or even regression in post-test scores. This, however, may be more realistically indicative of progress as the Adult child may have become more aware of her feelings and attitudes about herself as she began to process these issues in greater depth. Third, issues such as self-esteem, attitude toward one's parent and caregiver burden can be

expected to fluctuate regularly depending on one's current overall living situation at the time of testing.

I was also interested in the changing qualitative perceptions of group members and how the members perceived the group as having helped them to cope. To access information about their perceptions I developed a qualitative questionnaire which was administered at the eleventh session, the final meeting.

CHAPTER 4 - OBSERVATIONS

Potential members for the group intervention under study for this practicum report were recruited through the Psychogeriatric Outreach Team at Deer Lodge Centre. Team members agreed to identify potential participants who were Adult children of a parent who was perceived by the Adult child or the team members as having a "difficult personality". The team members who identified potential group members also contacted these individuals and advised them of the up-coming group. If they were interested the team member requested permission to release their name to me. The initial referral list consisted of 26 names of potential group members (2 men, 24 women) whom I contacted by telephone (or left a message) to confirm their interest in the group. If the person was still interested I sent them a letter of introduction in July, 1996, which explained the scope and purpose of the group. Thirteen letters were sent out, all of them to women.

In August another letter was sent to interested individuals requesting that they contact me to schedule a pre-group interview for September. Of the thirteen individuals, eight were recruited for the pre-group interview.

Some prospective members of the group advised me that they could not attend due to time constraints. Other prospective group members did not feel that a group setting was an environment where they wished to discuss their problems they were having with their parent. Still other members did not inform my why they were not attending the group, and I did not ask them specifically. I do know that many of my conversations with these individuals gave me the impression that they felt that they already had enough to deal with, without adding yet another commitment of attending a

group. These Adult children sounded very tired and did not want to engage in any further discussion about their parent.

Pre-group interviews were scheduled the week before the group sessions began. The purpose of the pre-group interviews was to pre-screen potential participants for suitability, to gather demographic, contextual, and baseline information, and to discuss the potential benefits involved in participating in the group intervention. The practicum was also discussed and individuals were asked to sign a consent form (see Appendix A). Of the eight women interviewed, all of them were suitable for the group, and they maintained their membership until termination. These women were all daughters of a parent whom they perceived as having a "difficult personality".

The daughters in the group ranged in age from 40 to 65 years with a mean age of 52. They came from a range of socioeconomic and educational backgrounds. Five of the eight members in the group were married and considered themselves to be in relatively stable relationships with their partners. One member had been married twice and both marriages ended due to her husbands' deaths. Throughout the duration of the practicum she was in a relationship with a man with whom she did not live. Another member had been married and was divorced. Another member was single. All group members except one had at least one son or daughter.

There were seven parents who were identified in the group as having a "difficult personality" (two of the group members were sisters and both identified the same parent as having a "difficult personality"). Of the seven parents, six were mothers and one was a father. The ages of the parents ranged from 73 to 85 years, with a mean age of 81. Six

of the seven parents with a "difficult personality" were widowed. Five of the seven were living alone when the group commenced. One (who had two daughters attending the group) lived with her husband, another lived with her only daughter who attended the group, one lived in a personal care home, and one was admitted to hospital just before the group had begun. Five of the seven parents received home care services.

The focus of this chapter is to present a profile for each of the group members, describe the focus and process of each group session, and introduce the findings of both quantitative and qualitative data. This provides the reader with contextual information which will be referred to and evaluated in the next chapter.

The client profiles contain self-reported information that was gathered from members during the pre-group interview. All group members names have been changed and personal circumstances altered in this practicum report to protect the identities of group members. The narrative is presented in the present tense.

4.0 INFORMATION COLLECTED PRE-GROUP

4.0.0 #1 Alice

Alice was born in Winnipeg and comes from a European background. She is 56 years old and has 3 children who are all over the age of 30. She is married and lives with her husband and one child. Alice received a grade 12 education and works part-time. She is affiliated with a church. Two weeks before the group began Alice became a grandmother for the first time. She feels quite positive about her situation, in general.

Alice is the eldest of five children and is the only child living in Manitoba. She thinks that although her siblings are far away they are relatively supportive. One sibling, however, can be quite opinionated.

Alice thinks that her father was very strict and did not tolerate any disrespect towards her mother. She reports that in his eyes "Mom could do no wrong". She also thinks her father protected her mother because she had apparently had a hard life. She believes that he did not do her mother "any favors" by protecting her.

Alice feels that she "was expected to grow up right away". She says that her mother "always had pneumonia" and she felt that she "was the cause of the pneumonia". She thought this because she believed her mother would not have been so sick and overworked if it were not for her and her siblings.

Although Alice thinks that she is not like her mother she says "I hope I'm not like that when I'm old". She also finds it difficult to hear from others "what a sweet person" her mother is, as her mother has never been "sweet" to her. She does not remember her mother kissing her and remembers being told that "she was too old for that". Now that her mother is older she wants to be kissed by Alice but Alice does not kiss her mother.

Alice's mother is over 80 years old and lives independently in her own home. Alice has "just watched over" her mother for the past eight years. When Alice's father died her stress increased with respect to her mother. According to Alice, her parents had depended on Alice and her husband for their social life.

Alice's mother receives no home care or other outside support. She describes her mother's health problems as "old age", "nervous" and a "scared person". She states that her mother's memory is quite good but that she is "hard of hearing".

Alice reports that the behaviours she has difficulty coping with in respect to her mother are the inappropriate statements her mother makes when she is with her. She also makes indirect comments about what needs to be done around the house but never directly asks for help.

In her interactions with her mother, Alice copes by not saying much. She says, however, that she is becoming more assertive with her mother. She says "if she [mother] had cataracts it would be easier" and "I could blame something for why she behaves as she does", but Alice feels that her mother is physically healthy for her age.

Alice's healthy ways of coping include golfing, playing keyboard, playing badminton, working, and going out for lunch with friends. Less healthy ways of coping include smoking, keeping her thoughts and feelings about her mother bottled up, taking out her frustrations on her husband, and blaming herself for things. She states also that she rarely cries and does not take well to criticism.

4.0.1 #2 Pat

Pat was born in Winnipeg and is from a European background. She is 65 years old and has one child. She received a grade 11 education and worked in accounting before she retired. Pat has no siblings. She attends church on a regular basis.

Pat was married and has divorced. She separated from her husband when her child was one year old. Her child lives in an institution due to congenital mental and

physical deficits. Pat's husband, and parents, suffered from alcoholism. Her parents separated when Pat was a pre-teen.

Pat herself suffers from high blood pressure and also takes an anti-depressant. She has seen a behaviour therapist in the past to help her overcome her fear of flying.

Pat has few friends. She says that she does not seek out relationships with others for "fear of getting hurt". She confides in one family member who she sees as a close friend.

Pat's mother is over 80 years old and her father is no longer living. Pat's mother moved in with her several years ago, when Pat began caring for her. Her mother suffers from a variety of chronic, degenerative conditions and requires a walker for ambulating. She also suffers from high blood pressure and has had a number of small strokes which have resulted in word-finding difficulties. Pat's mother continues to drink alcohol, having 2 to 3 beer each day. Pat cooks most of the meals and does all of the grocery shopping. Her mother takes Handi-transit to various appointments, but still manages to wash dishes and do the laundry. She also manages her own finances.

Pat reports that she has difficulty coping with her mother's ambivalence about making decisions. Her mother shows no recognition for things that Pat does but requires to be constantly "patted on the head for everything". Her mother is not happy for Pat and is often jealous; she is great at giving advice or criticizing others but cannot accept when others do it to her. Pat says "I feel like I'm tied down to something that she wants". She also recognizes that her mother is "always charming to everybody else".

Pat responds in her interactions with her mother by usually not saying anything indicating "When I should confront her I just don't". She feels that her mother often says things to her when she isn't expecting it and, therefore she does not always respond the way she would like.

Pat copes with the stresses of caring for her mother by taking courses. She has recently joined a goal-setting class and is considering joining Al-Anon. She also reads, sleeps and takes time for herself. She says that she does not talk about herself very much and often isolates herself as a way of coping. She feels she is a procrastinator, does not exercise regularly, and is a binge eater. She recognizes her accomplishment of having quit smoking several years ago.

4.0.2 #3 Ann

Ann is 53 years old, lives with her husband, and does not work outside of the home. She was born in Winnipeg and received a grade 11 education. She has been married to her husband for many years and the couple have a set of twins who live on their own. She comes from a European background and has one brother who lives outside of the province. She attended a church as she was growing up but no longer is affiliated with a particular church.

Ann's mother is over 80 years old and has lived alone since the recent death of her husband. Ann has cared for her mother over the past few years. Her mother has a number of medical conditions. She is cognitively well. Ann is trying to reinstate homecare for two hours each day to cook meals and do the cleaning. She states however, that her mother is very resistant to accepting help from those other than family members.

Ann helps her mother with major grocery purchases and takes her mother to various appointments.

Ann says that she has difficulty coping with her mother's "whining", stubbornness and constant phoning. She also says "she never ever listens to what you tell her", "she has always been a control freak" and was "spoiled". Ann also says that "my mother likes to cry wolf", she "rarely apologizes" and things Ann does are "never good enough". Ann does not know how her father ever lived with her mother.

Ann says that her mother "drives me crazy". She indicates that her mother is very self-centered. When Ann gives her an answer to a question "she doesn't want to hear it" or "doesn't like the answer". She describes her mother as "never a social person" but very attention seeking and jealous of others who were receiving attention. After Ann's father died her mother said on a number of occasions "I'm going to sit in this house and die".

Ann copes in interactions with her parent by screaming or arguing. Coping strategies she uses are walking, talking, keeping busy, reading, throwing things, and screaming. She worries that when she talks about her problems, others will think "My God, she's just like her mother".

4.0.3 #4 Beth

Beth is 55 years old and is French Canadian. She was born in a small town in Manitoba and went to college for a number of years. She lives with her husband in an apartment and has two children who are over the age of 30. Beth was married at the age of 18 and worked for a local company, first as a steno and then as a financial analyst.

She took an early retirement package at the age of 50. She went to church as a child and still attends.

Beth is the second eldest in the family and has four siblings. She has two siblings who live in Winnipeg, and two siblings living outside of the province.

Beth was raised by her grandmother, and moved in with her parents when she was a teenager. She basically raised her brother and younger sister. She says that she also did most of the laundry, cooking , and housecleaning growing up. Her mother often went to bingo and was rarely home, and her father worked long hours.

Beth suffers from deteriorating back disks and muscles which are myofascial. Her husband had a heart attack in the past and presently has a disease which requires frequent surgery.

Beth has cared for her parents for several years. Her mother came from a family of 10 children. She was the second eldest in the family and now only has 2 sisters who are alive. There was a period of several years when Beth's parents lived on the same property. Beth found this very stressful and says that she would never do this again.

Beth's mother is over 80 years old and lives with Beth's father who is older than she. Her mother is hard of hearing, suffers from depression, arthritis, and high blood pressure. She says that her mother has "very bad nerves", is easily depressed and is "scared to be alone". She is cognitively well. Her mother uses a walker for ambulating and does not really require any help around the house but does not do much anyway. Beth's father does "everything" for her mother including cleaning, laundry, washing dishes. Beth believes that her father has not done her mother any favours by doing things

for her (Alice also had made this comment about her father). Beth or her sister will take their mother to various appointments and Beth cooks some meals to take over to her parents. Home care comes in to do cleaning and help Beth's mother bathe.

Beth has difficulty coping with her mother's inappropriate comments. If her mother is in the same room as someone who is overweight, she will ask them "why are you so fat"? Beth says that her mother used to "tattle on my son", however, when this happened Beth told her mother "he's my son not yours, and I don't want to hear it".

Beth copes in interactions with her mother by setting limits, walking away, and will sometimes argue but then back off. She also says that her mother is nice to other people but nasty to her father and siblings (Alice and Pat also made reference to this). Beth says that her mother was "spoiled" while she was growing up and was "always very manipulative". Other coping strategies include golfing, reading, talking to friends, eating, travelling, doing crafts, and cooking.

4.0.4 #5 Karen

Karen and Beth are sisters. She is the youngest daughter in the family and is 40 years old. She has four siblings. Karen has been married for eleven years and she has 2 children. She is a graduate from a community college and is presently working as a manager. Karen went to church as a child but is not affiliated with any church at this time.

Karen does not consider herself a caregiver. She says that she visits her parents when she can which is no more than once a week. Her mother had tuberculosis and also suffered a "nervous breakdown" (see Beth's profile for more information). Her mother

has never been on her own and never worked outside of the home. In fact, although her mother says that she worked very hard and "had a hard life" as a child, many of Karen's aunts say that she worked very little. Karen remembers that her mother "was always sick" but at this point in her life "has never been healthier".

Karen has difficulty coping with her mother's "condescending tone of voice". She also describes her mother as being impatient and inappropriate. She says that her mother has a habit of exposing herself in the living room. She also changes her top in the living room when family and friends are around. Karen sees her mother as "very demanding" and that her "Dad was my Saviour". There has "never been good communication" between her and her mother and she says "she's not a giver, she's a taker". Karen's mother "has always favored the boys" and one brother in particular "could do no wrong".

Karen copes in her interactions with her mother by "usually ignoring her". She says that if a person acknowledges her mother's position "she'll go on and on". Karen deals with her stress by taking stress management courses, baking, working on her computer, television, golfing, and not "eating right". She also says that "working is a way of dealing with the stress". Karen has a very supportive husband and this has also been a great help to her.

4.0.5 #6 Carol

Carol is a 53 year old French Canadian woman whose mother was of a European background. She is a second cousin to Beth and Karen and an only child. Carol was born in a small town in Manitoba. She has been widowed twice in the past and is

presently seeing a gentleman. She lives alone in her apartment and has an adopted child who is married.

Carol has a grade 10 education and works outside of the home. She went to church as a child and continues to attend church regularly. She suffers from a sore back, hips and hands. She also has "bad nerves" and high cholesterol.

Carol's father is over 80 years old and her mother is no longer living. Her father recently lived with her for seven months. He walks independently and now lives in his own apartment suite in the same block as Carol. Carol does all the cooking, cleaning, washing, ironing, paying extra bills, grocery shopping, escorting him to various appointments. Carol's father has a number of health problems. They include hardening of the arteries, hearing problems, ulcers, borderline cataracts, aging of the retina, and eczema. He has a pacemaker and has had two heart attacks. Carol's father has a history of misuse of alcohol. However, over the past year he has had very little to drink. Her father smokes, but has cut down on this as well. Home care services have been coming in weekly to give her father a bath.

Carol has difficulty coping with her father's behaviour of being what she calls "a very poor listener". He has always had a tendency to talk over people, and this has worsened due to his deteriorating hearing. His attitude is that "he knows best" and "he's always right". Carol says if you make a suggestion he does not listen and if you say "do whatever you feel is comfortable" he responds by saying "well do it yourself". He has a strong tendency to blame others and Carol often feels in a no-win situation. She recognizes that her father has trouble with intimacy and gives Carol the mixed message

of "I want you, but I don't want you". Her father is also very self-centered and it's "always I, I, I,". He does not know how to give a compliment but is "a good flirt" with the nurses when he is in hospital. Carol says that "as long as this man has control he's okay". If not, there are problems. Carol feels that "at all times he has me on a guilt-trip" and that she needs to learn how to control herself when it comes to her father's behaviour. Carol recognizes that she does protect her father and realizes to some extent that she can be verbally abusive to others as she has learned this from her father.

Carol says that she copes with the stresses of her father's behaviour by going out dancing. She also swims, does crafts, goes shopping and talks to friends. She has at least 5 friends who call her everyday to see how she is doing.

4.0.6 #7 Marie

Marie is 49 years old and lives alone. She was born in rural Manitoba and grew up in Winnipeg. She left home when she was in her pre-teens and lived with her grandmother. Her parents come from a European background. She has one younger sister who also lives in Winnipeg. Marie has a University education and is presently working in a helping profession.

Marie's mother is in her late 70's and lives alone. She has become less mobile and more weak as she has aged. She suffers from a heart condition as well as depression. Marie says that "her memory is very good" but that "she needs a lot of things that she refuses to acknowledge". Her mother refuses to accept homecare but phones Marie "every day".

Marie feels guilty when she says no to her mother. She copes with this by being straightforward with her mother. She also reads, sings, walks her dog, vacations, and accesses her support system to cope.

4.0.7 #8 Ruth

Ruth is a 47 year old woman who was born in Winnipeg. She also comes from a European background. She does not affiliate with a particular church at this time. Her one and only sibling lives in Winnipeg. She has been married for 26 years and has two children. The younger child lives with Ruth and her husband. Her older child, who lives nearby, refuses to see or speak to Ruth. Ruth, however, does see and talk to her three grandchildren. Ruth has a college education and presently works outside of the home. Ruth suffers from depression and takes an anti-depressant. She says that the medication is "a cover-up" which masks the problems she has in her life.

Ruth was raised in an environment where "you were to be seen and not heard". She remembers that her parents were "very good in bribing me". She remembers playing her mother's game that if her mother was angry and going to "beat" her she would cry so that her mother would not hit her "quite so hard".

Ruth's mother is in her early 70's. She presently lives in a personal care home due to progressive dementia. Ruth has cared for her mother for several years and currently visits her mother every day. Before she moved into the personal care home her mother lived with Ruth and her family for twelve years. Ruth also says that her father "made me promise I'd take care of my Mom".

Ruth has difficulty coping with her mother's memory loss and the telephone calls during which she is accused of being "such a poor daughter". It is also difficult to hear the messages on the telephone and then when Ruth visits her mother, she is "lovey dovey" towards her.

Ruth copes in her interactions with her mother by "ignoring it". In general she copes by working, smoking and trying not to remember things. Before she left home she cried everyday and says she has "never cried since I left my Father's house". She feels that "working is my life". She also copes by using distraction, which involves protecting others; in fact she says "I protect everybody". Ruth also does community volunteering by visiting an elderly woman.

4.1. GROUP SESSIONS

Table 4.1 provides a visual representation of group sessions which are described in this section of chapter 4. The focus of this section is an exploration of issues which were addressed within the group context, and themes which were raised during the group sessions. Each group session will be identified in terms of the focus of discussion, significant themes arising out of the sessions, and a discussion of the group process in terms of tasks of the worker and stage of group development.

All but the last two group sessions began with introductions and the sharing of how each member's week had gone. Members were also encouraged to raise any issues from the week before which required clarification or more discussion.

Table 4.1 - Outline of Group Sessions

Session	Number Present	Focus of Discussion	Themes	Stage of Group Development
1	8	Introduction, Education, Life Review	guilt, blame, protecting a parent, high expectations, verbal abuse, meal times, "Honour Thy Father and Thy Mother", fear of being like one's parent	Pre-Affiliation/ Locating Commonness
2	8	Life Review: Roles and Coping	meal times growing up, boys being favored over girls, coping, fear of being like one's parent	Power and Control/ Creating Exchange
3	6	Life Review: Roles and Present Situation	parents' use of pills, parents' relationship with each other, lack of appreciation, fear of being like one's parent	Intimacy/ Mutual Identity
4	5	Feelings: Guilt and Setting Limits	resentment, anger, parents' needs overriding childrens' needs, difficulty setting limits, fear of being like one's parent	Intimacy/ Mutual Identity
5	8	Setting Limits	self-esteem, personal growth, fear of being like one's parent	Intimacy/ Mutual Identity
6	8	Feelings: Fear of being like one's parent	passivity, being uncaring, ineffective communication, anxiety, controlling others, sarcasm, blurred boundaries, overprotectiveness, dependency	Intimacy/ Mutual Identity Differentiation/ Group Identity
7	5	Communication and Taking Charge	being centered, getting over being "nice", setting goals, taking yourself seriously, building alliances, fears of being "too happy", confidence building, learning to say no, caring for oneself	Differentiation/ Group Identity
8	4	Relational Ethics	interest in parents' childhood, fear of success, fear of being "too happy", boundaries, social support, trust, communication	Differentiation/ Group Identity
9	7	Relational Ethics	interest in parents' childhood, communication	Differentiation/ Group Identity
10	6	Care for the Caregiver	communication, friendships, mutual interests, maintaining contact	Separation/ Termination
11	7	Evaluation and Termination	individual strengths, enjoying each other's company	Separation/ Termination

4.1.0 Session #1 - Introduction, education, life review

The main purpose of the first session was to facilitate group discussion and to discuss and gain feedback about the group's rules, purpose, goals, and focus of discussions. Members began to talk about themselves with each other. This facilitated the process of a life review which is similar to Boszormenyi-Nagy's (1986) first contextual therapy dimension of Objectifiable Facts. Although I validated members' frustrations with their parent I also began to provide education through alternative considerations and feedback in order to reframe their parents' behaviours as being ineffective coping styles.

Themes

Members began by introducing themselves and indicating what they hoped to achieve by coming to the group. Several significant themes emerged through this process. Themes of guilt instilled by a parent, relatives, society in general, and religion ("Honour Thy Father and Thy Mother") were highlighted. Other themes included numerous phone calls, feeling blamed, members having "their buttons pushed", protecting a parent's feelings, being expected to perform tasks that a parent was capable of doing, and being spoken to in an abusive manner. Members also discussed the anxiety about feeling that they would end up like their parent. They raised the issue of feeling apprehensive about talking about their parent, feeling that they would not want their own children blaming or speaking negatively about them. It was stressed that the goal of the group was not to blame the parent, but to acknowledge the behaviours of the

parent and attempt to understand how it has affected them, and what they as adults, can do about it now.

Stage of Group Development

The group quickly engaged and displayed cohesion as the first session progressed. To facilitate cohesion I identified similarities between parents and Adult children but also acknowledged that all members had unique experiences. Interactions between members became more spontaneous as the session progressed. This led to the sharing of common experiences, and suggestions of dealing with certain situations. Beth emerged as a natural leader in the group by engaging in a leadership role at various times throughout the session.

Garland et al. (1965) describe the first stage of group development as the Pre-affiliation stage. Maier (1965) identifies it as locating commonness. In the first session, most group members found it very easy to identify and discuss common issues and in my opinion this was indicative of members operating at the first stage of group development. Alice said "I just can't believe what I'm hearing here because each one has similar [situations] makes me feel that I'm not the only one".

According to Garland et al. (1965) the first or initial stage of group development also involves vacillating responses to program activities. One example of this occurred during the first session with Ruth. She was very quiet during the first half of the group session. At the break she advised me that she did not know if the group would meet her needs as she saw herself as very different from the others. I asked her if I could share some of her situation with the group members during the second half of the group. She

agreed with this and when I did share this information and Ruth began to speak more openly, commonalities were identified between the members and differences were also recognized. At the end of the group session she said that she would come back the next week.

Prior to the group's beginning, I had hoped that the subject of meal times would be raised, and by providing snacks over the dinner hour I hoped that eating together would facilitate a positive experience in which individuals could share equally and actually enjoy themselves, something they may not have experienced as children. The subject of meal times was brought up spontaneously by Ruth, who remembers that there was "never a supper where I could sit down: I would take one bite and I'd be up in my room crying", "one word from that man, it was worse than the physical abuse". Carol and Alice could also relate to similar negative experiences at meal times.

At the end of the session all eight members were eager to fill out a measure (Family of Origin Scale, Fischer & Corcoran, 1994) to help them understand their family of origin more clearly. As the members left Deer Lodge Centre they all rode down together in the elevator, interacting with ease.

4.1.1 Session #2 - Life review: Coping and roles in one's family of origin

This session began with members introducing themselves, discussing their week and raising issues from the last week. Throughout this session, individual members were encouraged to discuss their perceptions of their own situations along with their feelings associated with them. Boszormenyi-Nagy's (1986) contextual family therapy dimension of Individual Psychology guided me in this way as this dimension specifically focuses on

a person's own perceptions and feelings. During this session I provided a brief mini-lecture on coping and coping strategies. Members then divided up into pairs to talk together about how their parents coped with stress and how their parents' coping strategies affected them as children. After this exercise we discussed these coping strategies and members began talking about the various roles which they played in their families. This discussion gave members an opportunity to continue with a life review, as they explored events in their personal lives. The life review or Objectifiable Facts represents Boszormenyi-Nagy's (1986) first contextual therapy dimension. I facilitated the exploration of this dimension at every group session, as I think it is an ongoing process which provides the context for Boszormenyi-Nagy's other therapy dimensions.

Roles such as placater, blamer, computer, distractor and leveller (Satir, 1988) were also explained and discussed. Boszormenyi-Nagy's (1986) third contextual therapy dimension titled Systems of Transactional Patterns guided me in this way because one of the components involves the exploration of roles in one's family of origin.

Themes

One of the themes at this session was revisiting what meal times were like in one's family of origin. Ann recalls meals when her mother was significantly absent from the table. Ann said "she was never there for me". Pat said that she "had a great childhood" where there were very little restrictions. She said that meals were relatively fine until her mother started to date a particular gentleman, and when he was present at meals there would be arguments. Pat said that she and her mother no longer eat together even though they live together.

Beth and Karen both recall that when their father was not at home they would have to fend for themselves at meal time. The sisters do not recall their mother ever cooking and remember that when they were old enough they did much of the cooking.

Carol, Alice and Ruth reiterated their experiences of meal times. Alice said that meals were very tense and were "no fun at all". She said that when she had friends over she was very afraid that her father would embarrass her in front of them. Marie said that she was served "beautiful meals at lunch" and would have to fend for herself at dinner time. She had positive memories about meal time.

A theme which was identified by Ruth, Ann, and Pat was growing up in a family where boys were favoured over girls. Ruth said "My brother was a king and I was a nothing". This resulted in discussion about how men and women are raised differently and what injustices have occurred as a result of this socialization.

Conversation began about roles in one's family of origin and the roles each member played in her own family. Pat was able to see that her mother coped by placating after having been told by a friend of hers that Pat herself had a tendency to placate. Alice could identify this as well. Other group members identified that many of their parents' way of coping involved blaming others.

Stage of Group Development

When members introduced themselves at this session they also relayed their impressions of the last group session. In general, these comments were very positive. Alice said that after the last group session she did not feel elated but felt very peaceful. Marie said that she felt very different after the first group. She said that she went home

and watched comedies on the television and "laughed longer and harder" than she usually did. She said that when she speaks with her friends about her parent, the discussion is usually very "cerebral". She said that in the group she thought that people discussed the issues at more of a gut level. Marie said that it also helped to put her situation into perspective.

Pat said that after the last group she did not know how she felt. She indicated that through therapy in the past, she has learned that she has difficulty recognizing how she feels. Ruth said that after the group last week she felt the same as when she came in.

Karen said that she felt "pretty good" after the last session. She agreed with Marie and said that she does not normally "get jokes" but when she went home the week before she watched comedies as well and said that she laughed at jokes she normally would not get. She said that she was relaxed and euphoric, feeling better about her current situation. Carol said that after the last group she felt more in touch with the degree to which she felt guilt in her relationship with her father.

Beth did not have anything particular to add and Ann said that last week felt like a beginning session.

I began challenging some of the individuals in the group at this session, because I thought that some group members were ready because of the natural cohesion that developed the week before. I asked Ruth to think about her caregiving role and what purpose it was serving. Ruth was able to identify that she sees herself as "a very caring person" but wondered why she was so compelled to visit her mother. I introduced the idea of her need to explore her caring role and the need to take risks sometimes in order

to feel better. She was somewhat apprehensive about hearing this but did acknowledge that there may have been more to her caring than she saw at the moment. As a group facilitator I felt that Ruth was wanting to maintain control and as a result was testing my skill. It was my impression that this example was a demonstration that the group had moved into the second stage of group development, that of power and control (Garland et al., 1965). Maier (1965) has identified this stage as creating exchange. Another example which demonstrated this second stage of group development was Ann's expression of strong feelings about what her mother "made" her do. When I gently challenged her, suggesting that she had some control over this, she looked uncomfortable and non-verbally responded in a way that indicated she was unreceptive to hearing this.

Group members were very interactive and supportive to each other during the group session. Group members gave each other feedback and assisted in problem-solving certain situations. Ruth recalled a number of traumatic experiences from her childhood. Group members were very supportive to her. Particular feedback was given to Ruth with respect to the number of times she visits her mother and she had some difficulty hearing this. Some members made suggestions which Ruth was not ready for, for example cutting down on how often she visits her mother. I played mediator in this situation and stressed that perhaps Ruth had to feel better about herself before she could consider this and Ruth agreed.

4.1.2 Session #3 - Life review: Roles in one's family of origin and in one's present relationships

Alice, Pat, Ann, Beth, Karen, and Carol were present at the third session. Pat made the suggestion that members re-introduce themselves every week, and members agreed with this.

This session was used to assist members in continuing to explore the roles in their families of origin and in their relationships at present. Genograms were utilized to clarify and demonstrate the dynamics of particular relationships. Boszormenyi-Nagy's contextual therapy dimension of Systems of Transactional Patterns was discussed in more detail. Components of this dimension which were discussed included roles, power alignments, family structure, belief systems, and boundaries. These components were also discussed within the framework of feminist theory. The Family-of-Origin scale results were also returned to those members who had filled them out. Some discussion took place about the meanings of the scale.

Themes

A theme which arose as members checked in at this session was their parents' use or overuse of medication. All of the mothers with the exception of Carol's had been prescribed valium at some time in their lives. Members discussed their frustrations with doctors who had prescribed medications to their parents but also recognized that doctors were often at a loss in terms of how they could help their parents. At that time Alice's, Ann's, Beth's and of course Karen's mother were all taking an anti-depressant, which was showing more positive results than the valium ever had.

Other themes which came out of the group session included being told by others not to cry, lack of affection or over-affection between parents, lack of positive compliments about one's physical appearance while growing up, a parent's tendency not to say please or thank-you when their children do something for them, and the fear that they would turn out like their parent.

Stage of Group Development

Karen indicated that since she had been attending group sessions she was much more attentive to how she deals with her own children.

Members were quite involved in giving feedback to other group members about their genograms. Conversation was also very spontaneous as members discussed their experience with their parents on particular medications. Beth and Karen seemed to have gained particular insight into their mother's behaviour based on the kind of person their father had been. Pat spoke the least this session and a number of group members went up to her at the end of the session telling her that they also wanted to hear from her.

Beth brought a note pad and pen to this session and took down notes for herself. Carol joked that Beth was the note taker for her as well. I encouraged other group members to write in a journal to help them in working through some of the issues which were raised in the group.

Group members continued to explore their own experiences and became more free to disclose abusive situations in their past. I believe that this increased disclosure placed the group at the stage of intimacy and mutual identity (Garland et al., 1965; Maier, 1965): Carol spoke of many difficult experiences in her childhood, particularly

with respect to her physical appearance. She said that because of her dark complexion, she had worn make-up since she was 7 years old. Her grandmother used to scrub her knuckles in hopes to remove the darkness of the skin. She also wore a big straw hat in the sun so as not to darken her skin. Carol said that her mother treated her as a friend and that she knew all the facts of life by the time she was ten years old. Carol also said that she was always able to talk about these experiences but was able to do it now without becoming as angry. She thought that this was happening as a result of attending the group.

4.1.3 Session #4 - Feelings: Guilt and setting limits

Five members of the group were present at the fourth session. Carol's father was in the hospital and very ill, Marie was sick, and Pat was out of town. Discussion at this session was focused around guilt and setting limits. I utilized Boszormenyi-Nagy's contextual therapy dimension of Individual Psychology for the focus of this particular session. This involved members continuing to explore their feelings and perceptions at a deeper level.

Themes

Themes of resentment, anger, difficulty in setting limits were highlighted. Particular resentment was experienced by Marie and Ann in that they felt the roles had been reversed and they were now parenting their parent. Many other members expressed resentment about feeling that they had to make decisions on behalf of their parent, even though their parent was often capable of doing so on their own. Conversation also

diverted to a discussion about how the members' mothers used to dress them and make decisions based on what their mother liked rather than their own wants and needs.

Stage of Group Development

Before introductions began at this session Ann stated, "I was told today I was not responsible for my mother". It was my impression that this reality was starting to sink in for her.

This session clearly indicated the group's movement towards personal involvement and a willingness to bring feelings out into the open. This session represented to me that the group was in the stage of intimacy and mutual identity (Garland et al., 1965; Maier, 1965).

My role as facilitator was minimal during this session. Members gave each other a number of suggestions and even confronted each other in a constructive way.

Beth and Karen gave a number of examples of how they set limits with their mother. Alice was particularly interested and said a number of times how she admired them for being able to be firm with their mother. She also expressed the fear that if she did set a limit with her mother she may never see her again. Karen and Beth made a number of statements which suggested ways of setting limits without being "nasty". Beth said that she did not respect her mother nor could she because of her behaviour. She did say however, that she did not want to be mean to her either. Ann also commented that if you respond to your mother with meanness "you're just stooping to her level". Ann also spoke of her mother who made few decisions, and was beginning to realize that the more she did for her mother the more dependent she became.

Ruth spoke of her lack of outside interests. She identified that she enjoyed exercise and Beth basically told her that she should begin to visit her mother every other day and on the opposite days, exercise. When Ruth heard enough from Beth, she held up her hand and said "wait". She then began to talk about the depression she had been struggling with over the winter. Group members were very attentive and supportive to her. Ann very supportively commented that Ruth needed to have something else in her life, and Ruth agreed.

I commented that I thought Ruth had changed since the first time I met her. Other group members agreed and Ann said that she found Ruth to be more open. Ruth managed a smile which she almost seemed to be trying to hold back. It was my perception that Ruth was really beginning to look at herself and explore who she was. She continued to talk about how she had never planned for her life to end up "like this". She stated, "What are they going to remember me by?... I don't want to be remembered as, 'oh, she was good to her mother'....When I grow up I don't know what I want to be.... What's my purpose?...."I was a very selfish person[but] the good person in me has always been in there". Ruth raised the importance of people listening attentively to her, a comment which she had made before. She stated "A lot of people just don't listen". I facilitated Ruth's need to explore this further and asked her "how much do you listen to yourself". She said "very little" and laughed. She then changed the subject raising the issue of her younger child who was moving out the next week. Beth said that the empty nest would "be wonderful". Other members could relate to this difficulty, however Ruth was not convinced.

4.1.4 Session #5 - Setting limits

Introductions took a great deal of time at this session. Marie had not attended for 2 sessions due to illness and a work meeting. Members caught up with each other about what had been happening in their lives. Through the process of introductions, setting limits was raised again and actually practiced by some group members. Boundaries and setting limits are both components of Boszormenyi-Nagy's contextual therapy dimension of Systems of Transactional Patterns and guided me in this session. By this time members were beginning to integrate the components of Boszormenyi-Nagy's first three contextual therapy dimensions.

Themes

Themes which arose out of this session included accepting compliments, self-esteem, and the fear of being like one's parent.

Pat raised some interesting themes in two dreams that she had experienced. She said that two weeks ago she dreamt that her cousin died. This was the same week that I had told group members that my cousin had been diagnosed with a terminal illness. A week later she dreamt that she was walking down a road with over-hanging trees flowering with beautiful Spring blossoms. She related this to the death of her old self, new growth and personal development.

Stage of Group Development

Group members continued to demonstrate increased intimacy and mutual identity which indicated to me that the group continued to be at the stage of intimacy/mutual identity (Garland et al., 1965; Maier, 1965). Ruth spoke about the difficulty of having

her child leave home, and identified the difficulty both of them had expressing their feelings. Group members were very supportive. When I asked the group what could be done to help Ruth during this difficult time, Carol offered that she would call Ruth during the week. Other group members agreed and all members shared their phone numbers with Ruth. Group members also agreed that I could photocopy a list of phone numbers for all group members to have. This also showed evidence that the group was in the stage of intimacy/mutual identity.

At the end of the session I identified that the group sessions were at the midway point. Ann made a comment about having 20 instead of 10 sessions. I asked group members to think about whether they would like more sessions and it was agreed that this would be discussed at next week's group.

4.1.5 Session #6 - Feelings: Addressing fears of being like one's parent

I decided to devote this session to focusing on further exploration into one's fear of being like one's parent and cognitive behavioural techniques in dealing with one's feelings and behaviour. At this point members were continuing to integrate Objectifiable Facts, Individual Psychology, and Systems of Transactional Patterns which had been explored in the context of feminist theory.

Themes

The main theme of Session #6 was to discuss fears of "ending up like one's parent" or being like one's parent. This theme had been mentioned in all of the preceding sessions. Members spent some time thinking about their own personal characteristics which were similar to their parent's characteristics. Some of the

characteristics included passivity, being uncaring, ineffective communication, anxiety, controlling others, sarcasm, blurred boundaries, overprotectiveness, and dependency. One of the main characteristics which group members feared was that they might cope with anxiety the way their parents did. Beth said that she did not know what her anxiety was about, but was learning to control it. Beth also agreed with me that she has high expectations of herself and is a high achiever.

Karen initially could not identify characteristics in herself which were similar to her mother's. I facilitated further exploration into this by asking her whether her mother tended to be sarcastic, something Karen had been accused of being by others in her life. Karen said yes, and Beth agreed that Karen was sarcastic.

Other themes which were raised during this session included responding vs. reacting to one's parent, trust, struggles with autonomy, fear of being "too happy", "waiting for the other shoe to drop" and dreams not yet fulfilled.

Stage of Group Development

Karen pointed out that since she had been attending the group she had begun to look more at how she affects others. She gave an example of an incident with her husband when he had told her that she was sarcastic. She inquired further into his statement, accessing cognitive behavioural techniques of thinking, feeling, and behaving having learned this from a previous group session. Pat made some suggestions as well about how Karen's husband may have felt.

Alice said that she was able to tell her sibling that she had been attending the group even though she did not receive support for this. She also stated that the group was

helpful in that she was meeting more people and hearing how they were dealing with their problems. She said "I get a plus out of this and when I go home I feel really good".

This session demonstrated to me that group members were continuing in the stage of intimacy and mutual identity. At one point Ann teased Beth about taking the biggest piece of cake and this incident reinforced to me Garland et al.'s (1965, p. 34) suggestion that "sibling-like rivalry tends to appear" at this stage of group development.

Marie made occasional comments during the session but in general spoke very little. She continued to demonstrate strong personal control in group sessions and made comments which I found difficult to respond to as they were said in a superficial or joking way. When further inquiry was made about her comments she did not wish to elaborate at any deeper level. Marie's lack of participation may have been partly due to the fact that she had missed two sessions in a row and was not feeling as much a part of the group.

Group members showed continued insight into themselves and who they were. Ann stated that she was seeing more and more how she was a "hyper person" and was starting to practice relaxation techniques. I stated that I had noticed that she had become more open and calm since the group began. Other members agreed with me. Ann also spoke of her fear of being judged by others. Discussion ensued and Marie made further suggestions about relaxation and deep breathing exercises.

Pat told group members at this session that she had felt "badly jarred", and "out of kilter", with her "cheeks feeling heavy" after last session. She said "the trouble is I really don't talk to people and I don't say what I feel, maybe I'm just afraid of my

feelings. I don't know what they are in the first place". The group was supportive and this acknowledgement indicated to me that Pat was continuing to explore herself and her feelings at a deeper level. Pat then continued to speak about her adult child who was disabled. She said that she was able to show her child affection, which was something she had never received. She said that showing affection in return is now second nature to her child. The group gave her credit for this accomplishment.

Ann spoke again of her frustration with her mother, but acknowledged that she may have more control over this than she realized. She said "I think I realize that [I have more control] now, [but] it's going to take awhile".

Ruth spoke at length about her fear of finding out who she was, and the fear that many changes would take place in her life if she did find out who she was. She stated that, "one of these sessions made me realize something, that I go to see my mother not for her sake but for my sake...after I left that session I thought that's exactly what it is". All group members were supportive and agreed with Ruth. Beth also reinforced that it was okay to visit for Ruth's needs. Carol agreed. Ruth however, felt that this was uncaring, and other group members disagreed. This uncaring characteristic was explored and group members reinforced that many of Ruth's thoughts were not uncaring but were thoughts that many other group members had. Carol identified that some of the things Ruth was describing were a result of being shy rather than being uncaring.

At the end of this session, the group was asked to decide about the idea of extending the group. All members were actively involved in this problem-solving process. It was clear that most members wanted the group sessions to be completed

before they became too busy in preparation for Christmas. It was agreed that the group would be extended one more session.

It was at this session that each member received a list of all members' phone numbers. Members were also asked to think of adjectives which would describe other group members as a way of providing each other with constructive and honest feedback.

4.1.6 Session #7 - Communicating feelings and taking charge of one's current situation

Alice, Carol, Pat, Beth, and Ruth attended the seventh session. Weather conditions were less than ideal on the evening of this session as it was snowing and the roads were slippery. Discussion centered around communicating feelings and steps to having more control in one's life. The communication of feelings is connected to Boszormenyi-Nagy's contextual therapy dimension of Systems of Transactional Patterns which guided me in this session. Healthy and unhealthy ways of coping with anxiety were also discussed. Members were involved in role playing and the session ended with a relaxation exercise.

Themes

A major theme that arose out of the session was learning how to take charge. Beth initiated discussion about five steps to taking charge which she had heard about over the radio. This was discussed for most of the session. The five steps to taking charge were to: (1) be central; (2) get over being nice; (3) set goals; (4) take yourself seriously; and (5) build alliances. Other themes which arose from the group included responding vs. reacting, fear of being "too happy", confidence building, learning to say

no, caring for oneself, one's need for praise and encouragement, and giving oneself positive messages. It was interesting that after discussing the fear of turning out like one's parent last week, this was the first week where it was not identified.

Alice relayed a personal example which helped in demonstrating assertiveness and taking charge. This was explored through role playing. Group members gave each other constructive feedback after the role play and throughout group sessions.

Stage of Group Development

This session represented a transition from the intimacy/mutuality stage of group development to differentiation/group identity. I see this transition as occurring as members shared more about themselves but also appreciated differences between each other as Alice role played a scenario in which she learned to assert herself. Members respected her need to practice and were supportive but also recognized that not all group members had difficulty with assertiveness. It was interesting to watch group members during this role play. I had to discourage members from "rescuing" Alice a minimum of five times. Members continually wanted to provide her with answers which she was capable of coming up with herself. Group members demonstrated anxiety about Alice's anxiety. I raised this example at the next session for further discussion.

Group members identified a number of ways they coped with anxiety. Beth and Carol identified that they keep busy as a way of coping. We talked about what could happen if we were one day unable to utilize a particular way of coping, for instance how would one cope if one were no longer able to keep busy because of emotional or physical reasons.

Pat spoke of her difficulty asking for help. After she identified this issue, she gave an example of a situation with her mother indicating that she had gotten angry and felt "jagged" after the incident. This was the first time Pat described a personal situation with her mother. Carol and Alice said that they could relate to her situation and Beth reminded her that her mother was not going to change, but that she had every right to be angry. Pat was very open to suggestions which group members gave readily. She spoke of how her mother engaged in power struggles and recognized in herself her part in engaging in the struggle. Pat also disclosed the way she had treated her son as a result of the way she had been treated. She said "most of his life I treated him like my mother treated me except up until this past year, when I knew I had to be teaching him differently and not get angry all the time; it's made a big difference as far as he's concerned".

Carol spoke of her father's health problems. She recognized that she had some gifts from her father including a good sense of humour and a strong will. It was my impression that Carol was beginning to understand her father in a more positive way.

Beth spoke more about the constant anxiety she felt and said that she did not know where it came from. Carol was able to give her some insights because she had spoken with Beth's family's housekeeper when Beth was growing up.

Ruth talked about her continued insight into her own anxiety and relayed an example in which she had to ask her boss to be excused from a certain task. Excusing herself was difficult for her because, as she said, "I got stressed not knowing what was really stressing me, because I never get stressed". She said that she had not known what

was bothering her at the time but later realized she was feeling anxious about the fact that she had learned that her mother was being transferred to another personal care home. Ruth was able to work this through in her mind and as a result was relieved when she understood what her anxiety was about.

Ruth was also very relieved because her mother had just told her "You know you don't need to come here everyday". Pat asked her if she had mixed feelings about it and Ruth said, "yes...because I don't know what to do with my time now".

Ruth also said that, "since I have been coming here, I've been really questioning myself ... I'm starting to come into doing things, thinking different, and I've gotta become a person, a whole person on who I really am and if that means being vulnerable and showing people, then that's what I'm going to have to do. I'm starting to really dig and trying to bring out all my emotions and little by little... It's gonna be a slow process. It could take a long time because I've hidden it for so long, but hopefully I'll find out who I am . One thing you said to me, which had never entered my head 'the real me would love to go to England' ... and once you gave me that permission I felt better". This statement demonstrated to me Ruth's need to have external permission. This was discussed with the group and I suggested that we did not have to wait for others to give us permission but that we could give ourselves permission to do what we wanted.

I asked group members to think about their parent and themselves in relation to Boszormenyi-Nagy's balance of parent-child relationships for next week. I also asked that each member pick out a meaningful greeting card which they would like to receive, buy it, and bring it to the final group session.

4.1.7 Session #8 - Relational ethics and taking responsibility for change

Members present at the eighth session were Beth, Ann, Karen, and Pat. Weather conditions were very poor again as there was a big snow storm. The purpose of Session #8 was to discuss and understand Boszormenyi-Nagy's parent-child relationship ledger (relational ethics). I provided a mini-lecture on this dimension which was then discussed as a group. The group ended with a guided imagery exercise which was a strategy in helping members gain more competence and confidence (see Appendix C). The group members found this interesting, however I am not sure if members actually incorporated this strategy for future use.

Themes

Themes which arose out of the meeting were trying to understand a parent's childhood by asking him/her questions about it, fear of success/failure, fear of being too happy, boundaries, re-parenting oneself, importance of social support, and trust.

Stage of Group Development

Members shared more of their experiences growing up, making connections which they had not made before. I facilitated the exploration of childhood experiences and utilized Boszormenyi-Nagy's ledger to help members identify the needs that were not met in their own childhood and then in their parents' childhood. I also stressed that as adults we were responsible for finding ways that would meet our own unmet needs. Members were also differentiating themselves more from their parent as they explored how their own experiences growing up had been different from their parents' experiences.

In my opinion, members continued to demonstrate the differentiation/group identity stage of development. The following is an example of what I believe to be an indication of group identity, wherein members were almost overidentifying with each other. I utilized a group example from last week to demonstrate members' need to overprotect each other. I raised the role play which occurred and asked members of the group about their need to protect Alice as she was struggling to come up with a response in the role play. Discussion ensued about one's need to overprotect another. Karen related this to how she sometimes deals with her children and Ann also talked about her strong feelings about another group member's past life experiences. Ann said she was feeling that she wanted "to fix it" and Beth said to her that she had to back off. Group members in general felt free to give each other constructive feedback. I believe that this process was enhanced when I asked members to think of adjectives to describe each other in order to provide each other with feedback.

Group members identified improvements in their ability to express their feelings and deal with their parent. Pat said that she seemed to be responding more quickly and effectively with her mother. She also said that the suggestions she had received from the group the previous week were helpful to her. Pat was very verbal at this session and spoke at length about not feeling much like a "social character". All group members were supportive and encouraging. She said it was easier to talk in the group because "I know everyone and I feel protected here".

4.1.8 Session #9 - Relational ethics and taking responsibility for change

Beth, Carol, Ruth, Alice, Pat, Ann and Marie were present at Session #9. Marie arrived late because of a work meeting. The purpose of this session was to discuss family relational ethics again and assist members in learning ways to re-parent themselves. The group session ended with an guided imagery exercise (see Appendix C).

Themes

Themes raised during this session were similar to last week's session. Discussion focused more upon the experiences members' parents had growing up. Communication skills were also discussed and role played.

Stage of Group Development

Alice said that since she had been coming to the group she did not think about her mother everyday, although she still struggled when she talked to her mother. Alice gave an example of an incident which made her feel guilty and invited members to give her some suggestions/insights about it. Members were very ready to provide her with feedback.

Carol brought note paper with her to this session. It was in the third session that she had made reference to Beth as being her note-taker. I believe that this demonstrated that Carol was taking more responsibility for herself and for her learning.

It is my opinion that the stage of group development identified by Maier as group identification and by Garland et al. as differentiation was demonstrated by group members at this session. As suggested by Garland et al. (1965), the group becomes its own "frame of reference" and this was demonstrated by two examples, one given by

Carol and one given by Ruth. Carol recognized that when she was having difficulty communicating with her daughter, she thought of "the group" and this helped her to express herself more openly. This demonstrated , as well, that she was anchored in the group session. The second example occurred when Ruth told Alice that if she was having difficulty asserting herself to "think of us", "call us".

As members became more settled into the the of differentiation/group identity stage of group development my role as group facilitator became less necessary.

4.1.9 Session #10 - Care for the caregiver and planning for future need satisfaction

Alice, Carol, Marie, Beth, Pat, and Ann were present at the tenth session. Weather conditions were poor again for the third week in a row, and a snow storm was in progress before the session began.

The topic of the final formal session was caring for oneself. I asked the group members to think about what they needed to do to take care of themselves now and in the future. Members participated in another anchoring exercise to facilitate an increased feeling of autonomy and empowerment.

Themes

Themes arising out of this session included improving communication, friendships, a great appreciation for the group, and concern over maintaining contact with one another.

Stage of Group Development

Appreciation for the group experience was demonstrated when Ann said "It's good to sit in a group and just talk about what you've done all week, and you go from

there and you get stuff off your chest". She asked other group members for their opinions and Beth responded by saying that talking about events came naturally to her. A dynamic was starting to develop between Ann and Beth where Beth's verbal and non-verbal messages were indicating that she was setting limits with Ann who seemed to be seeking Beth out more than other group members.

Alice said that although friends were important, she felt that they did not really understand the way that members in the group understood her. Marie indicated that there was a common element with all group members and I reinforced that common elements are usually what friendships are based upon.

Much time was spent discussing opportunities for group members to get together as a group or as dyads. Members volunteered a number of their personal hobbies/interests and invited other members to join them. Telephone contact had already been occurring between members since the session in which members shared their phone numbers with each other. All members encouraged one another to call them in the future.

The tenth session focused largely on members' needs in the future when the group would no longer exist as it had up until this time. Beth and Carol seemed more withdrawn at this session, presenting as though they were beginning to distance themselves from the group. Ann and Pat were in particular need of knowing that although sessions would not be held at Deer Lodge Centre, members could still meet over coffee or at one of the members' homes.

It is my perception that group members were in the final stage of Garland et al.'s (1965) final stage of group development - separation. The authors write that as members anticipate the impending dissolution of the group, they find new resources for meeting their social, recreational, and vocational needs. In this group's instance they were already trying to meet these needs through establishing informal meeting times in the future or by withdrawing from intense involvement in group matters. Garland et al. also note that other reactions have been observed in groups who are in the process of termination. These reactions are: denial, regression, recapitulation of past experiences, evaluation, flight, and pleas from members who do not want the group to end. It was observed that some members were still wanting the group to continue, and others were ready to terminate. Because it was encouraged that members could continue to meet and members also reinforced the desire to meet, they did not see this session as being as final. It was interesting that Marie, who spoke very little during all of the sessions, began to raise issues about negative experiences as she was growing up. Up until this point she had said virtually nothing about the negative experiences she had experienced in her life.

Members participated in another guided imagery anchoring exercise at the tenth session. "Anchoring" as described by Grinder and Bandler (1981, 1979) includes visual, auditory, kinesthetic, olfactory, and gustatory components. It refers to the tendency for any one of these components to bring back the entire experience. For example, Carol said that on the weekend as she was saying good-bye to her daughter she was reminded of the discussion the group had held the previous week on the subject of Carol's discomfort with the way she hugged her daughter. Carol's memory of the group

experience suggests that this session provided an anchor for her the next time she expressed herself to her daughter. The memory gave her the confidence to hug her daughter the way she truly wanted to hug her.

The exercise which members participated in at this session involved members thinking and attempting to experience an unpleasant event which they wished they had dealt with differently. When they had a sense of the components outlined above, they were then asked to think about what resource they could have used that would have made the event more positive. Examples such as assertiveness, confidence and patience were given. Once members were in touch with that resource they were asked to "anchor" that feeling by pressing one of their finger nails. Once that had been completed they were asked again to recall the unpleasant event but live it out or imagine it again, this time taking with them the resource that would help them. Members were asked to press their finger nail ("anchor") to enhance the positive resource. They were also asked to imagine how the event would have turned out had they had that resource with them.

After this exercise Ann asked the group how one knows what assertiveness is if it has never been experienced. Discussion ensued and it was reinforced to Ann that she demonstrated assertiveness in discussions which took place in the group. Ann agreed and another anchoring exercise was introduced in which Ann agreed to participate. Members enjoyed and participated willingly in these exercises, however, I am unsure as to how effective anchoring was for this particular group of people, because they did not give me specific feedback about the exercise. I also did not experience being able to "see" the

physiological changes which might demonstrate that "change" had occurred for a group member.

4.1.10 Session #11 - Separation and Termination

All group members except Marie were present for this session. Carol's father had passed away the day before and Beth had contacted everyone but Marie during the day. Many of the members had sympathy cards for Carol and it was decided that the group would send Carol flowers. The death of Carol's father may have drawn members closer together during this session, as it too marked an ending to the members. It may have also prompted members to make plans to meet again in the future so as not to make the termination of the support group mean the end of still maintaining contact with each other.

This session marked the end of the group sessions. A written evaluation form was given to each member which they filled out during the meeting. Members were then asked to take out the greeting card that they had purchased and address it to themselves. After this was done members were asked to pass their card around so that everyone had the opportunity to write something on the card which they appreciated about that person. When this was completed each person had her own card back with everyone's personal message on it. Members went out for dinner to celebrate the end of the group's formal meetings.

CHAPTER 5 - EVALUATION

The purpose of this chapter is to present and discuss results gathered from quantitative and qualitative evaluation data. As discussed previously, quantitative measures utilized in this group intervention included The Caregiver Burden Inventory (CBI), Perceived Social Support for Caregiving/Social Conflict Scale (PSSC/SC), Child's Attitude toward Mother/Father (CAM/CAF), and the Index of Self-Esteem (ISE). These measures were administered to all group members pre-group and post-group. Pre-test scores were quite varied indicating a very heterogeneous sample. Scores on the CBI ranged from 9 to 50.5 with a mean of 31.16. The PSSC scores ranged from 13-37 (mean = 24) and SC scores ranged from 2 to 11 (mean = 7). The CAM/CAF scores ranged from 29.3 to 79.3 with a mean of 55.7. This mean indicates very elevated scores with respect to one's attitude towards one's parent, according to Hudson (1982). The ISE scores ranged from 20.8 to 62 with a mean of 38.4.

One qualitative measure utilized in this group intervention consisted of an open-ended questionnaire (see Appendix B) which was filled out by group members at the eleventh session.

5.0 QUANTITATIVE AND QUALITATIVE RESULTS FOR EACH GROUP MEMBER

5.0.0 #1 Alice

Quantitative Data

Data presented in Table 5.1 indicate improvement from pre-test to post-test on the social burden scale on the CBI, and on the PSSC, CAM, and ISE.

Table 5.1 - Results of Pre-test and Post-test Measures for Client #1

	Pre-test	Post-test
Caregiver Burden Inventory		
Factor 1 - Time Dependence	3	9
Factor 2 - Developmental Burden	10	19
Factor 3 - Physical Burden	2.5	7.5
Factor 4 - Social Burden	4	2
Factor 5 - Emotional Burden	16	18
CBI Total	35.5	55.5
Perceived Social Support for Caregiving Scale	25	33
Social Conflict Scale	8	9
Child's Attitude toward Mother/Father	62.6	59
Index of Self-Esteem	42	33.3

The total score on the CBI was much higher in the post-group interview than in the pre-group interview, indicating an increase in perceived burden. I believe this increase was partly due to a distressing incident Alice had experienced with her mother the day before the post-group interview. Alice told me that on the previous day she had

learned by chance that her mother had a severe case of shingles. Her mother had not advised Alice of this and had not seen the need to see a doctor about it. Alice said that she had never seen anything so infected. This ordeal also occurred shortly after her mother had broken her ankle days before. In addition, these things occurred just before Alice and her husband were to leave on a trip. It is my opinion that anyone experiencing the increased stress as described by Alice would be affected in terms of feeling guilty, responsible, burdened and resentful.

Perhaps Alice's perceived burden as measured by the CBI also increased because she had become more truthful about the actual burden she felt in caring for her mother. She had less difficulty filling out the questionnaire at the post-group interview, and in contrast to the pre-group interview, did not hesitate to answer questions in a way which might be viewed by others as negative.

Table 5.1 also depicts changes in Perceived Social Support for Caregiving and Social Conflict as indicated in the scale of the same name (PSSC/SC) (Goodman, 1991). Alice's score increased by eight points on this scale which indicates an improvement in perceived social support for caregiving as measured by the PSSC. Particular areas of improved perceived social support included the following three items: "Others I know have given me information about difficult personalities", "Others I know have helped me realize my problems are not unique", and "I've learned from others I know by watching how they manage stress".

Table 5.1 identifies pre- and post-test scores in one's attitude towards the parent as measured by the Child's Attitude toward Mother/Father Scale (CAM/CAF). Alice's

score on the CAM was slightly lower indicating improvement in her attitude towards her mother. However, although it had improved it still was in the range which suggests difficulty in one's attitude toward the parent. The significance of this score may be more meaningful, in that her attitude toward her mother had not worsened given the difficult day she had just experienced with her mother. As well, although Alice showed increased burden as measured by the CBI, her attitude toward her mother continues to indicate improvement as measured by the CAM. During the post-group interview, Alice was much more open with her feelings of anger, and did not speak of feeling as guilty about her feelings towards her mother.

As indicated on the table, Alice's score on the ISE shows a slight improvement in her self-esteem, however the score remained above the clinical cut-off. Alice also said that a number of people had come up to her at work and had noticed a positive change in her. They noticed that she seemed more calm and confident. Interesting changes from pre-test to post-test on items of the ISE were "I feel that others get along much better than I do", "I feel that I am a beautiful person" and "I am afraid I will appear foolish to others".

Written Evaluation

Alice indicated on the final evaluation that she found the group experience to be "very helpful and informative". The personal benefits and changes derived from her participation in the group were that "I believe I'm much calmer and more accepting of my dealings with my mother". What she found most helpful about the group was the camaraderie "with everyone", "because although each have different problems, they do

have similar problems, experiences etc. [and] just listening and being part of the group helped".

Alice indicated on the final evaluation that she believed the quality of her relationship with her mother had changed because of her "new" attitude. She said it was easier for her to ignore things that her mother said and not get as emotionally involved. She attributed this change to "maybe just the idea that people here understand me better than my friends". Alice wrote that she did not think any of her other relationships had changed since the start of the group.

Case Discussion

Alice attended ten of the eleven sessions. She indicated at the first session that she would like to learn more patience. She said "there must be a way of dealing with this that doesn't spoil your life". On her written evaluation she reported that she saw herself "much calmer and more accepting of my dealings with my mother". This statement as well as her improved score on the CAM indicate to me that to some degree she achieved the goal that she had identified at the first session.

Although Alice reported that she experienced no changes in other relationships in her life, I believe that some important shifts did occur, with respect to relationships at work and relationships with her children. People at work had noticed a positive change in Alice and Alice no longer felt as responsible for the quality of the relationship between her children and her mother.

The post-group quantitative measures were given to Alice the day after she had experienced a very difficult time with her mother and this may have affected the results.

However, I think that improved scores on the PSSC, CAM and the ISE in combination with positive qualitative data indicated meaningful and positive changes in these areas.

5.0.1 #2 Pat

Quantitative Data

Pat's scores as presented in Table 5.2 on the various quantitative measures indicate improvement in the area of physical burden, social burden and emotional burden on the CBI, which improved her overall score on the CBI. There was also improvement on the PSSC. Her CAM score showed a slight improvement as well.

Table 5.2 - Results of Pre-test and Post-test Measures for Client #2

	Pre-test	Post-test
Caregiver Burden Inventory		
Factor 1 - Time Dependence	7	7
Factor 2 - Developmental Burden	13	16
Factor 3 - Physical Burden	12.5	11.25
Factor 4 - Social Burden	4	2
Factor 5 - Emotional Burden	14	11
CBI Total	50.5	47.25
Perceived Social Support for Caregiving Scale	17	32
Social Conflict Scale	2	5
Child's Attitude toward Mother/Father	68	65.1
Index of Self-Esteem	62	65

Pat's score on the Social Burden subscale of the CBI suggest very little burden for Pat. Before the group began Pat said that her mother did not interrupt her social life because she really did not have a social life that could be interrupted.

Factor 5, "Emotional Burden" was very high for Pat pre-test. Her pre- and post-test score indicates that Pat's emotional burden was slightly less than it was before the group began. Pre- and post-test scores indicate some decrease in overall caregiver burden. When I reviewed these results with Pat she said that she does feel less burdened by the stresses of caregiving with her mother than she did pre-group.

Table 5.2 depicts improvement in perceived social support as measured by the PSSC. Items which showed particular improved support as measured by the PSSC included: "Others I know have given me useful advice about how to plan for the future", "Others have helped me gain insight into my behaviour and feelings as caregiver", "Others I know have given me information about difficult personalities", and "Others I know have helped me realize my problems are not unique".

Pat scores suggest a small increase in social conflict as measured by the SC. She said as she was filling out the SC pre-test that she did not have people in her social life, and as a result really had no one to be in conflict with except her mother. The fact that her SC score increased may be an indication that there were more people in her social life as a result of the group. This could be viewed as positive even though she may be dealing with more conflict.

Pat's scores indicate a slight improvement in Pat's attitude toward her mother as measured by the CAM. Pat recognized that her attitude toward her mother had become

more positive. Pat's scores indicate slightly decreased self-esteem as measured by the ISE.

Written Evaluation

Pat indicated on the final evaluation that her impression of the group was "that it is a worthwhile experience not to be missed". Pat found that "finding out that we share many common experiences" was the most helpful to her. She found that the group helped her to think of herself and her situation in "a more positive light".

Pat indicated that her relationship with her mother had improved since the beginning of the group in that they are "more communicative and listen to each other better". She believed that this had occurred because she had a better understanding of herself and her mother as well as her own behaviour and her mother's behaviour.

Pat also believed that the quality of her relationships have improved in general and wrote "I think it (i.e. the group) has given me more reception to others". Like Alice she recognized changes in her attitude and indicated that "insight into how we handle our problems was a revelation".

Case Discussion

Pat attended ten of the eleven sessions. Pat stated at the first group session that she wanted to learn how "not to upset myself" and "how I can manage how not to have my buttons pushed". Pat acknowledged at the eighth session that she was responding more quickly and effectively with her mother. She also identified improvement in the quality of the relationship with her mother on the written evaluation, and this was

reinforced by an improved score on the CAM. Pat's caregiver burden lessened as measured by the CBI, as well by her own self-reports.

Pat's self-esteem slightly decreased as measured by the ISE. Pat recognized that she had to continue to work on her self-esteem. She recognized on one level what she needed to do to increase her self-esteem but was having difficulty carrying through and fully appreciating this on a deeper level. She had already taken the initiative to take a course in self-esteem which was beginning in the next month. Pat had one suggestion for the group and that was that she "would like to keep on meeting".

Pat raised some interesting dream themes at Session #5. She relayed two dreams. First, she dreamt that her cousin died. This was the same week that I had told group members that my cousin had been diagnosed with a terminal illness. Second, a week later she had dreamt that she was walking down a road with over hanging trees flowering with beautiful Spring blossoms. She interpreted this to represent the death of her old self, new growth and personal development. Third, after the group ended on the evening of the eighth session, Pat informed me that since the previous two dreams she had been having a number of nightmares. She said that she thought this was perhaps her psyche trying to resolve those things she had not resolved from the past. She saw this as positive and I reinforced her view.

5.0.2 #3 Ann

Quantitative Data

Table 5.3 provides pre- and post-test scores for Ann.

Table 4.3 - Results of Pre-test and Post-test Measures for Client #3

	Pre-test	Post-test
Caregiver Burden Inventory		
Factor 1 - Time Dependence	5	15
Factor 2 - Developmental Burden	12	11
Factor 3 - Physical Burden	1.25	1.25
Factor 4 - Social Burden	0	3
Factor 5 - Emotional Burden	16.	16.
CBI Total	34.25	46.25
Perceived Social Support for Caregiving Scale	20	34
Social Conflict Scale	10	10
Child's Attitude toward Mother/Father	79.3	76.6
Index of Self-Esteem	37.3	50

Ann's score on the CBI greatly increased from pre-test to post-test, indicating increased burden. Time dependence increased more than any other factor. This is very interesting because not only did Ann have the support of the group for eleven weeks, she had also been receiving individual counselling from a social worker, and at the time of post-group testing her mother had been admitted to a facility for assessment and treatment for almost one month. Ann stated that when she was filling out the scales during the post-group interview, she found herself being more honest, and this may be a reason for the score results indicating increased burden deteriorated. Perhaps Ann's lack of control over the situation with her mother being in another facility, may have also increased her anxiety and perceived burden.

A very positive increase was observed in Ann's PSSC scores. She scored 20 pre-test and 34 post-test. Particular improvements in support as measured by the PSSC were noted on the following items: "Others I know have helped me deal with frustrations I have as a result of being a caregiver", "Others have helped me gain insight into my behaviour and feelings as caregiver", Others I know have given me information about difficult personalities", "I've learned from others I know by watching how they manage stress".

Interestingly, even though Ann's CBI score indicated increased burden her CAM score actually showed a slight improvement. This score however, was still concerning as Hudson (1982) reports that scores above 70 indicate a potential for violence towards oneself or others. However, two items on the CAM which showed important improvements were "My mother gets on my nerves" and "I feel violent toward my mother".

Ann's ISE score showed a decrease in her self-esteem. Again Ann attributed this to the fact that she was more honest in answering the items on the post-test than she was on the pre-test. I also believe this had to do with Ann's tendency to compare herself with others in the group who she perceived as coping better than she. Items which showed particular deterioration were "I feel that others get along much better than I do" and "I feel that if I could be more like other people I would have it made".

There were items that did indicate particular improvement on the ISE and these were "I feel that I am a very competent person" and "I think I have a good sense of humor".

Written Evaluation

Ann's impression of the group experience as indicated on the final evaluation was that "it was a new experience and I learned how to communicate". She wrote that the personal benefits derived from the group were that she "learned how to open up and how to not let others manipulate me". She reported that the group was "helpful and non-judgemental". She said it "felt like a family", something she had rarely experienced in her life. I think that this was a very meaningful statement particularly because she shared with the group how difficult it was for her to be able to trust people.

Ann recognized changes in the quality of her relationship with her husband from pre-test to post-test. She wrote "I now can get him to communicate more easily [as I am] learning to express my feelings and not keep them inside".

Case Discussion

Ann attended ten of the eleven sessions. Ann stated at the first session that her mother "pushes every button you can imagine". She wanted "to know how to deal with it without biting her head off". Ann could not identify any changes in the quality of her relationship with her mother after the group terminated, although I believe her anger which she expressed during the group did lessen to some extent and this resulted in her being more patient with her mother.

I believe that Ann was in a state of crisis during the period that the group was in process. Her father had recently died and her mother's physical health and coping abilities were deteriorating. This made it more difficult for Ann to process the information presented in the group and achieve her goals. One comment she had made at

the beginning of the group was that I had been her "life line" when I had called her about being a part of the group. She also said that she had been feeling very "desperate" at the time, and I observed an improvement with Ann in that she no longer felt desperate after the group had terminated. As stated previously, she also felt more supported than she had pre-group, and positive changes occurred in how she expressed her anger. Ann's suggestions for the group were that "it should continue all year round"

5.0.3 #4 Beth

Quantitative Data

Beth's scores from pre-test to post-test on the quantitative measures all improved with the exception of self-esteem. However, her low score on the ISE before the group commenced indicated that she already had a healthy level of self-esteem.

Table 5.4 - Results of Pre-test and Post-test Measures for Client #4

	Pre-test	Post-test
Caregiver Burden Inventory		
Factor 1 - Time Dependence	4	3
Factor 2 - Developmental Burden	7	2
Factor 3 - Physical Burden	1.25	0
Factor 4 - Social Burden	5	3
Factor 5 - Emotional Burden	10	6
CBI Total	27.25	14
Perceived Social Support for Caregiving Scale	27	39
Social Conflict Scale	11	8
Child's Attitude toward Mother/Father	65.3	53.3
Index of Self-Esteem	28	34

Beth's score on the CBI showed improvement from pre-test to post-test. She said that her mother had become more demanding of Beth since the group began but because she understood her mother better it did not create as much of a burden for her. Beth's developmental burden improved particularly on the items which read "I wish I could escape from this situation", and "I expected that things would be different at this point in my life". Her emotional burden also improved particularly on the items which read "I feel embarrassed over my care receiver's behavior" and "I resent my care receiver".

Beth's score on the PSSC also improved from pre-test to post-test. Items which showed greatest improvement included "Others I know have given me useful advice about how to plan for the future", "Others have helped me gain insight into my behavior and feelings as caregiver", and "I've learned from others I know by watching how they manage stress". Her SC score indicated that she had less social conflict in her life post-group than she did pre-group.

Beth's CAM score decreased from pre-group to post-group, however her post-group score still indicates that she has difficulties in relation to her attitude toward her mother. Hudson reports that scores above 30 indicate a clinically significant problem in the area of attitude toward parent. Beth's score on the item "My mother does not understand me" improved. She said that she thinks this is because she does not really care any more if her mother understands her or not.

Beth's score on the ISE was slightly worse post-group than it was pre-group. Her score before the group began indicated that Beth did not have a clinically significant problem with self-esteem because her score was less than 30 (Hudson, 1982). She

attributed her deteriorated self-esteem score as being due to a severe headache she was having at the time of the post-group interview.

Written Evaluation

Beth indicated on the final evaluation for the group that "for a first time group such as this I was pleased everyone was friendly and sympathetic to others - a very good experience". She wrote that the personal benefits derived from participation in the group included "knowledge that others have the same and sometimes more problems" and that she was "not alone". She found that the "freedom to speak freely and openly" in the group was the most helpful.

Beth identified that the quality of her relationship had changed with her mother in that she had "more understanding of their situation" because she thought more "about their upbringing and own childhood, (didn't even consider this before)". She did not identify any changes in other relationships in her life. Beth's only suggestion for the group was that members keep in touch with each other.

Case Discussion

Beth was the one group member who attended all eleven group sessions. Beth identified that she had come to the group to help her father cope with her mother and also lessen her own guilt. She recognized that her guilt had dissipated to some degree.

A very important change in caregiver burden occurred as measured by the CBI. Beth also said that little had changed in her life since the beginning of the group except that her mother was more demanding than she had been before.

Beth took her membership in the group seriously. She was one of the members of the group who took notes during sessions. She also took on a leadership role many times throughout the group intervention and benefitted from all of her efforts. She felt comfortable with how much she had learned and was prepared to move on from the group experience.

5.0.4 #5 Karen

Quantitative Data

Table 5.5 - Results of Pre-test and Post-test Measures for Client #5

	Pre-test	Post-test
Caregiver Burden Inventory		
Factor 1 - Time Dependence	0	0
Factor 2 - Developmental Burden	0	0
Factor 3 - Physical Burden	0	0
Factor 4 - Social Burden	0	0
Factor 5 - Emotional Burden	9	3
CBI Total	9	3
Perceived Social Support for Caregiving Scale	27	34
Social Conflict Scale	9	4
Child's Attitude toward Mother/Father	29.3	24
Index of Self-Esteem	22.6	33.3

Results of quantitative measures administered to Karen are presented in Table 5.5. Her quantitative scores from pre-test to post-test improved on the factor of emotional burden on the CBI. Improvements were also indicated from pre-test to post

test on the PSSC, SC, and the CAM. Her scores on the CAM and the ISE pre-test did not indicate that these areas were particular problems for her.

Karen's scores on the CBI suggest that Karen's emotional burden decreased from pre-test to post-test. She agreed with this finding, and felt that the group had helped her with easing the emotional burden as she understood her mother better. Her score on the item "I feel embarrassed over my care receiver's behaviour" improved from "very descriptive" to "moderately descriptive". Her score also improved on the item "I feel angry about my interactions with my care receiver" changing from "moderately descriptive" to "not at all".

Karen's scores on perceived social support showed an increase. A particular increase in scoring was observed with the item "Others I know have given me useful advice about how to plan for the future". There was also a decrease in Karen's score on the SC which would indicate decreased conflict. She scored particularly lower on the question "people don't approve of some things I've done to care for my relative with a difficult personality". This could indicate that the way she had been doing things for her mother was reinforced by her attendance in the group. This may have also occurred because she developed a deeper understanding of the stress which occurs when a caregiver spends a great deal of time caring for their parent as she heard others talk about in the group.

Karen's score on the ISE was higher post-group indicating a decrease in self-esteem. She attributed this to a difficulty she was having adjusting to her husband's new working schedule which was causing stress in the relationship.

Karen's score on the CAM indicates a more positive attitude toward her mother from pre-test to post-test. Her pre-test score indicated that she had slightly less than clinically significant problems in her attitude towards her mother in the first place.

Written Evaluation

Karen's evaluation of the group experience was very positive. She found it to be a "relaxed setting" where "group members felt comfortable with each other". She indicated that the benefits of the group included "thinking before you speak" and realizing "you are not alone".

Karen also found it helpful to talk about her own and others experiences growing up. She said that she gained a new understanding of her sister Beth's experience growing up and as a result had a greater appreciation for her sister. Karen recognized that her relationship with her mother had changed in that she was more patient with her mother. She stated that she had a better understanding of her mother and was more receptive to her needs. She also said that she had experienced positive changes in her mother as well.

Karen recognized that the quality of her relationships with her husband and children changed in that she was less sarcastic with her husband and more patient with her children. She stated that she "realized the importance of relationships and I don't need to be stressed".

Case Discussion

Karen attended nine of the eleven sessions. Her initial reason for attending the group was in order to help her father cope better with her mother's behaviour. I think she was surprised by the degree to which she benefitted personally.

Karen was also able to incorporate much of the information she gained at group sessions and apply it to other situations in her life. For example, at session #4, she said that understanding roles in one's family also helped her to understand the roles which were played out by the employees who worked for her. She said that this understanding helped her to deal with them more effectively. Karen also indicated to me that "you have opened an understanding in me I never knew I had". Perhaps Karen was able to incorporate information from sessions more readily because of a healthy self-esteem and very low caregiver burden. She did not see herself as the primary caregiver to her parent and instead viewed Beth as having this role.

Karen said that although she felt that she did not "need" to continue to meet in the group, she would still like to meet with group members as she said she could talk to them about things that she did not talk to others about.

5.0.5 #6 Carol

Quantitative Data

Carol's scores improved on every quantitative measure that was administered pre-test and post-test.

Carol's score on the CBI dropped greatly from pre-test to post-test because, as she agreed, her father was no longer alive. She also said that although her father was dead she felt emotionally drained and felt that her health was still suffering. This made sense given that her father had been dead for only approximately two weeks. She said that she also felt burdened in the relationship with her partner with whom she had been involved for six years. She said that because of the group she recognized similarities between this

relationship and the one with her father and had been spending a great deal of time analyzing why she was in this relationship. She was also seriously considering ending this relationship on the day of the post-group interview.

Table 5.6 - Results of Pre-test and Post-test Measures for Client #6

	Pre-test	Post-test
Caregiver Burden Inventory		
Factor 1 - Time Dependence	15	0
Factor 2 - Developmental Burden	14	7
Factor 3 - Physical Burden	8.75	7.5
Factor 4 - Social Burden	2	2
Factor 5 - Emotional Burden	6	0
CBI Total	45.75	16.5
Perceived Social Support for Caregiving Scale	26	40
Social Conflict Scale	9	8
Child's Attitude toward Mother/Father	39.3	24
Index of Self-Esteem	20.8	14

Carol's score on the PSSC improved from pre-test to post-test. Items on the PSSC that showed greatest improvement in support included "Others have helped me gain insight into my behavior and feelings as caregiver", "Others I know have given me information about difficult personalities", and "Others I know have helped me realize my problems are not unique". The SC score decreased indicating somewhat less conflict in one's life.

Carol's CAF score improved from pre-test to post-test. This change moved her from above the cut off of 30, indicating a significant problem in this area, to well below the cut off. Carol's score on the ISE also improved although her pre-test score indicated that she did not have a significant problem in the area of self-esteem.

Written Evaluation

Carol indicated on the final evaluation that she "really had a good impression" of the group experience. She wrote that the personal benefits and changes derived from participating in the group were that she was able "to tell my father that I loved him on his death bed, and was able to let all my inner feelings out". She indicated that what she found most helpful about the group was "we all had some problems of our own and we were able to share them". Carol also recognized that her relationship with her daughter had changed as a result of coming to the group sessions. She wrote that "I feel closer to my daughter", "I can hug her". It was very significant for Carol to be able to hug her daughter because affection was something she witnessed very rarely in her own family of origin.

Case Discussion

Carol attended nine of the eleven sessions. Her father was admitted to hospital just before group sessions began and he died the day before the group terminated.

Although her father had died, I believe, and she agreed, that the group had been very positive in helping her to resolve a number of issues from her past. Quantitative measures demonstrated her improved mental health. At the first session she said that she wanted to learn how "not to always feel guilty". At the second session she said that the

group session the week before had brought out how much guilt she actually felt. She said "I recognized the degree of my guilt". She also said that since she had been coming to the group she was able to express her feelings without becoming as angry as she had in the past. By the end of the group Carol had resolved a number of issues and was feeling very little guilt.

5.0.6 #7 Marie

Quantitative Data

As can be seen on Table 5.7, Marie's post-group scores on the CBI indicated improvement in the areas of time dependence and physical burden. Her CAM and ISE scores also showed some improvement from pre-test to post-test.

Table 5.7 - Results of Pre-test and Post-test Measures for Client #7

	Pre-test	Post-test
Caregiver Burden Inventory		
Factor 1 - Time Dependence	3	1
Factor 2 - Developmental Burden	3	6
Factor 3 - Physical Burden	3.75	0
Factor 4 - Social Burden	0	1
Factor 5 - Emotional Burden	4	8
CBI Total	13.75	16
Perceived Social Support for Caregiving Scale	37	34
Social Conflict Scale	3	6
Child's Attitude toward Mother/Father	34	31.3
Index of Self-Esteem	33.3	22.6

Items on the CAM which showed particular improvement were "I dislike my mother" and "I think my mother is terrific".

Marie showed improvement on the ISE and moved out of the clinically significant range.

Marie's perception of burden as measured by the CBI increased on developmental burden, social burden and emotional burden from pre-group testing to post-group testing. Marie's scores on the PSSC and the SC slightly decreased from pre-test to post-test. Although her score on the PSSC did not show improvement from pre-test to post-test, her scores on both occasions were higher than those of any other members at pre-group testing. This would indicate to me that she perceived herself to have quite a healthy social support system to begin with.

Written Evaluation

Marie said that she benefitted from the group by listening to other members' experiences and realizing how difficult it was to cope with a parent on an "intensive daily basis". On the written evaluation she said that what she found most helpful about the group was the humour and laughter and that it was "very relaxing", and "stress releasing". Marie did not identify that any changes had occurred in the quality of her relationships with other people.

Marie made a number of very good suggestions about the group. She complimented me indicating that I was a very good facilitator and suggested that more role plays would have been helpful. She also indicated that if I was not prepared to continue to meet with the group that perhaps members could still have the opportunity to

meet in a neutral setting such as Deer Lodge Centre. She suggested that if I was to facilitate another group, that this particular group could also meet at the same time using a different space at Deer Lodge Centre. Therefore, although I would not be facilitating the group I would be available after the group session ended.

Case Discussion

Marie attended six group sessions and was quite late for one other session. She had indicated at the tenth session that she was "just coasting" and agreed with me that this was a very honest statement on her part, about how she viewed her involvement in the group. A number of other group members indicated that they had not gotten to know Marie and I spoke to her about this. She said her situation with her mother had not been stressful during the time frame of the group, and had she attended the group last summer when she had been having more difficulty with her mother she would have spoken out much more. She also said that she felt her issues to be somewhat different and much more trivial than those of other group members and did not know if others would appreciate where she was coming from. Marie also recognized in herself that she is much more interactive one-on-one than in a group setting. This was also my experience in my interactions with Marie.

At the first session she stated that she was coming to the group to help her cope with her mother in that the content of group sessions put her own situation into perspective. She agreed with me that the group positively reinforced how she was coping with her parent and also helped her to put her own situation into perspective.

It is difficult to comment in great detail about Marie as she attended about half of the group sessions, and when she was in attendance she maintained an emotionally safe distance from other members of the group until the last formal group session when she started to share more about herself.

5.0.7 #8 Ruth

Quantitative Data

As can be seen on Table 5.8 Ruth's scores on the factors of the CBI from pre-group to post-group all showed improvement except for emotional burden. Her scores on the PSSC, SC, and CAM also showed improvement from pre-test to post-test.

Table 5.8 - Results of Pre-test and Post-test Measures for Client #8

	Pre-test	**Post-test**
Caregiver Burden Inventory		
Factor 1 - Time Dependence	10	6
Factor 2 - Developmental Burden	11	8
Factor 3 - Physical Burden	6.25	2.5
Factor 4 - Social Burden	5	3
Factor 5 - Emotional Burden	1	2
CBI Total	33.25	21.5
Perceived Social Support for Caregiving Scale	13	36
Social Conflict Scale	4	3
Child's Attitude toward Mother/Father	68	42.6
Index of Self-Esteem	61.3	78

Ruth's scores on the CBI decreased slightly in all five areas of burden. She said her attitude towards her mother had changed and what had helped was the change in her mother's attitude towards her, in that her mother gave her permission not to visit her every day in the personal care home.

Ruth's score on the PSSC indicated a great improvement from pre-test to post-test in her perception of social support for caregiving. Particular improvements were seen on the following items: "Others I know have given me useful advice about how to plan for the future", "Others have helped me gain insight into my behavior and feelings as caregiver", "I know someone who understands the difficulties I face as a caregiver", "I've learned from others I know by watching how they manage stress", "Overall, I feel satisfied with support I receive from others as I take care of my relative with a difficult personality".

Changes in Ruth's SC score were minimal. Her score on the CAM decreased indicating a much more positive attitude toward her mother. When Ruth filled out the ISE post-test she said she found it very interesting as it reinforced to her that her self-esteem continued to be a difficulty for her. On both occasions her scores suggest that self-esteem was a significant problem. Post-test scores indicate a decrease in her self-esteem as measured by the ISE. This may be similar to Ann's situation, in that she was more honest about her feelings of herself post-test. There were a number of times throughout the group when Ruth would indicate that she did not know how she "felt", however, as sessions progressed she became much more in touch and honest with herself and others about her feelings.

Written Evaluation

Ruth found that what was most helpful about the group was "the way people opened up and I found out that I wasn't alone in my feelings". She had expected that there would be more people in the group who had a similar background of the degree of abuse she had experienced. She said that she would have benefitted more had her past been discussed more extensively. Initially she had found the group "a little intimidating [but later]found out this was not the case at all". She found that through the group she met "great people" with whom she hoped to keep in touch. She also indicated that she would not hesitate to come to see me in the future for help.

Ruth indicated that her relationship changed with her mother in that she felt she did not have to see her every day. She also said that she did not dwell on her mother as much as she used to before the group. She identified that her mother's attitude had changed as well in that her mother gave her permission not to come every day. Ruth recognized positive changes in her attitude as well. Ruth did not recognize changes in other relationships in her life.

Case Discussion

Ruth attended nine of the eleven sessions. As mentioned previously, Ruth's self-esteem may have worsened because she became more in touch with how she felt about herself, and because she had more time to do so because her perception of burden changed in a way which gave her more time to focus on herself.

Ruth stated at the first session that she wanted to understand why she felt so compelled to visit her mother as much as she did. The fifth session she stated that she

was beginning to understand that she was going to see her mother so that she could say "that she was a good daughter" and that she was not going for her mother "at all". She felt guilty and selfish about this revelation but group members were supportive in helping her work this through. At the sixth session she said "one of my problems is I don't really know who I am". At the seventh session she said that "since I have been coming here, I've been really questioning myself. I'm starting to come into doing things, thinking different, but I've gotta become a person, a whole person on who I really am and if that means being vulnerable and showing people, then that's what I'm going to have to do". It was also at this session that she said she had always wanted to travel but could not have that dream fulfilled because she was married. Group members encouraged her still to consider going on a trip. She stated to me later that she felt I had given her permission to go, and at the post- group interview she said that she was planning a trip to China with her friend. I also learned that after being encouraged a number of times by Beth to go to the gym (because Beth knew she enjoyed it) Ruth bought herself a membership at a gym shortly after the group terminated.

Ruth stated that she would like the group to continue at a more advanced level. We discussed this at length and I suggested to her that perhaps other group members did not have the need to delve as deeply into their past. I also suggested that with the complexity of Ruth's situation she may benefit from individual counselling. Ruth did see a psychologist in the past for a period of about one year and was receptive to my suggestion. After the group terminated she approached me to inquire about marital therapists, as difficulties in her relationship were starting to arise. Although Ruth did not

recognize changes in the quality of other relationships in her life, she had made statements during group sessions which alluded to growing discomfort in her relationship with her husband as she began getting more in touch with who she was. I also learned that just after the termination of the group, she and her older child, who had not been speaking to one another for a number of years, reconciled some of their differences.

An interesting change in Ruth's situation was that she stopped taking her anti-depressants about six weeks before the post-group interview and six weeks into the group intervention. As she stated in the pre-group interview, she had felt that the anti-depressant only masked her problems and she said that she preferred to deal directly with her issues rather than medicate herself in order to cope. This may have made the quantitative score changes even more meaningful in that she was on an anti-depressant during the pre-test and not during the post-test. Her self-esteem was the only measure which did not improve, and in fact deteriorated, probably indicating a more honest picture of how she felt about herself. Ruth may have become more in touch with her own level of self-esteem, since her mother occupied less of her emotional time and energy, and yet was able to cope with this understanding without the use of an anti-depressant.

5.1 CAREGIVER BURDEN INVENTORY (CBI)

Novak and Guest (1989) established mean scores of the Caregiver Burden Inventory (CBI) by measuring the burden experienced by those who care for individuals suffering from some form of cognitive impairment. The group under study for this practicum report included only one person who was caring for a parent with cognitive

impairment and this parent was in a Personal Care Home. Seven of the eight members in the group were caring for a parent who was not suffering from a dementing process.

It is true that because of the small sample used in this intervention, major conclusions cannot be drawn. It is interesting, however, to note the mean scores of the factors in the pre-test scores of the CBI presented in Table 5.9. Mean scores in the first four factors and total scores of the CBI all fall within established mean score ranges (see Table 5.9) as identified by Novak and Guest (1989). Emotional Burden (Factor 5) however, is much more elevated with the population in this study as opposed to Novak and Guest's research. Table 5.9 indicates that the mean score of emotional burden measured with the present sample is much more severe than those caring for an individual with Alzheimer Disease according to Novak and Guest's research.. Novak and Guest's sample was also heterogeneous in that 44.9% were spouses, 48.8% were Adult children, and the remainder were essentially relatives of the impaired individual.

Table 5.9 - CBI Mean Scores of Group Members and Novak and Guest's Research

CBI Factors	Pre-test Mean	Post-test Mean	Novak & Guest's Means and Standard Deviation Scores
1	5.9	5.19	6.98 (s.d. 5.89)
2	8.75	8.6	7.08 (s.d. 5.89)
3	4.53	3.7	5.47 (s.d. 5.9)
4	2.5	2.0	2.54 (s.d. 3.54)
5	9.5	8.0	2.02 (s.d. 3.04)
Total	**31.16**	**27.5**	**22.14 (s.d. 16.30)**

5.2 PERCEIVED SOCIAL SUPPORT FOR CAREGIVING AND SOCIAL CONFLICT SCALE (PSSC/SC)

Goodman's (1991) Perceived Social Support for Caregiving and Social Conflict Scales (PSSC/SC) are relatively new measures which have been utilized very little in research studies. Goodman and Pynoos (1990) conducted a study with 66 individuals (spouses, Adult children) who cared for a person with Alzheimer disease. Thirty-one of the participants were placed in a peer telephone network of four to five caregivers who phoned each other regularly over a 12-week period. Thirty-five participants were provided with 12 telephone-accessed taped lectures about Alzheimer Disease which they listened to over a 12-week period. The PSSC was utilized to measure changes in perceived social support. The mean pre-test score for the first group of participants was 31.0 (s.d. 7.0) and the mean post-test score was 28.4 (s.d. 8.0). The mean pre-test score for the second group of participants was 35.2 (s.d. 6.6) and the mean post-test score was 31.6 (s.d. 6.1). I find the pre-test scores very interesting in that the individuals who attended the group under study (see Table 5.10) scored much lower in terms of perceived social support than did those participants in the Goodman and Pynoos (1990) study. This suggests to me that perhaps people who struggle with a parent who they perceive as having a "difficult personality" are much more isolated than those caregivers who care for an individual with Alzheimer Disease. Mean post-test scores (see Table 5.10) are also interesting in that the members who attended the group under study scored higher than those participants in the Goodman and Pynoos (1990) study.

As has been identified previously, one of the objectives of this intervention was to increase perceived social support. Results obtained utilizing the PSSC demonstrate that seven of the eight members met this objective (see individual members' tables). Marie's score did not improve from pre-test to post-test. However, her pre-test score and post-test score were both higher than any of the other members' pre-test scores, indicating that she already had a healthy social support network.

Table 5.10 - Mean Scores of Other Applied Pre-test and Post-test Measures

Measures	Pre-test Mean	Post-test Mean
PSSC	24	35.25
SC	7	6.62
CAM	55.7	45.67
ISE	38.4	41.28

The PSSC scale represents "understanding, information, advice, insight, emotional control, universality, expression, modeling, and support satisfaction" (Goodman, 1991, p. 167). Each item on the PSSC is rated on a scale from 1 to 5; 1 = Not at all, 2 = Slightly true, 3 = Moderately true, 4 = Very true, 5 = extremely true. All mean scores on the 9 items of the PSSC showed improvement from pre-test to post-test. The four items with the highest mean scored items post-test were:

5. "I know someone who understands the difficulties I face as a caregiver" (pre-test 4, post-test 4.62);

7. "Others I know have helped me realize my problems are not unique" (pre-test = 3.37, post-test = 4.62);

4. "Others have helped me gain insight into my behaviour and feelings as caregiver" (pre-test = 1.62, post-test = 4.25);

6. "Others I know have given me information about difficult personalities" (pre-test = 2.25, post-test = 4.25).

The four items on the PSSC where the greatest changes occurred from pre-test to post-test were:

4. "Others have helped me gain insight into my behaviour and feelings as caregiver" (pre-test = 1.62, post-test = 4.25);

6. "Others I know have given me information about difficult personalities" (pre-test = 2.25, post-test = 4.25);

8. "I've learned from others I know by watching how they manage stress" (pre-test = 1.5, post-test = 3.12);

3. "Others I know have given me useful advice about how to plan for the future" (pre-test = 1.88, post-test = 3.35).

The mean scores for items 4, 5, 6, and 7 on the PSSC indicate that group members as a whole found these statements very true. The mean for items 3 and 8 indicated that the group members as a whole found the statements to be moderately true. All group members acknowledged the value of getting together as a group and most of them commented that "sharing experiences with each other" was the most valuable.

The last three items on the PSSC/SC scale attempt to measure the degree of social conflict in one's life. There was little difference in pre-test and post-test scores. Qualitative data does support, however, that the quality of some relationships in the group members' lives had improved. All group members except Marie were able to

recognize positive changes in at least one of their relationships. Beth, Ruth, Pat, Alice and Karen all acknowledged that the quality of their relationship with their parent had changed. Ruth and Pat had also seen positive changes in their parents attitude as well, and Pat said that the two of them were getting much better at communicating and listening to each other. These statements reflect that relationships can change positively even when one suffers from dementia, and sometimes focusing on one's own behaviour can result in positive changes in another.

Beth attributed the positive change in the quality of her relationship with her mother to her own increased understanding of her mother. Karen attributed the positive change to her own increased patience with her mother. Alice indicated that because people in the group understood her better than her own friends, she was able to establish a "new" attitude towards her mother. She indicated that she was able to ignore comments from her mother that she normally would have reacted to in the past.

Carol, Ann, Pat, and Karen all identified positive changes in other relationships in their lives. Pat stated that in general she was more receptive to others. Karen recognized changes in her relationships with her husband and children as she was more patient, less sarcastic and valued the importance of these relationships. She also recognized that she was much more attentive to how she deals with her own children. Ann acknowledged that she was able to express herself more honestly and openly with her husband and Carol said that because of the group she took the risk of hugging her daughter more sincerely which made her feel closer to her daughter. She spontaneously acknowledged that this change was because of her experience in the group.

It is interesting that group members experienced positive changes in relationships with others even though positive changes did not necessarily occur with one's parent. This indicates to me that some relationships are easier to change than others, and that some people are more open to change than others.

5.3 CHILD'S ATTITUDE TOWARD MOTHER/FATHER (CAM/CAF)

The CAM/CAF which were developed by Walter Hudson are measures which were researched and revalidated in 1987. Saunders and Schuchts (1987) researched 2,419 adolescents. Those adolescents who acknowledged a difficult relationship with their mother obtained a mean score of 59.4 (s.d. = 19.6). Those who identified a negative relationship with their father averaged a score of 59.9 (s.d. = 12.4). The authors indicate that these scores support previous research on this scale completed by Giuli and Hudson. They also report that because of the large standard deviation scores, more than just the measure is required to complete an assessment on the attitude toward one's parent. It is also interesting to note that after my own research on the CAM/CAF, I was unable to find this measure administered to adults. Therefore, I could not locate means and standard deviation scores for adults. The effect of differences in gender between the child and the parent was not fully explored in the study conducted by Saunders and Schuchts (1987).

Table 5.10 present mean scores of the CAM/CAF pre-test and post-test. Every member of the group experienced positive changes in her attitude toward her parent as measured by the CAM/CAF. It is interesting to note that seven out of the eight scores pre-test were over 30 with a mean of 55.7. The mean of the CAM/CAF did improve to 45.67 post-test, however all but two scores were still above 30 at post-group testing.

Perhaps this indicates the long-standing issues which were not yet resolved and/or maybe it has to do with simply having to spend periods of time with a person you do not really like.

The greatest change in attitude toward one's parent occurred with Ruth. Ruth's score went from 68 to 42.6. Ruth acknowledged not only a change in her attitude but a change in her mother's attitude as well. Perhaps this supports the importance of a parent validating his/her own child's experience which is very relieving for the Adult child (Hargrave and Anderson, 1992)

Research on the CAM/CAF, as indicated previously, has focused on individuals under 18 years of age. More specific information is also not available in terms of differences in gender between the gender of the child in relation to the gender of the parent on the CAM/CAF. Carol was the only member of the group who had a father in contrast to a mother whom she described as having a "difficult personality" . I found it interesting that although she had incredible caregiver burden and her father was very emotionally abusive to Carol, her score on the CAF was quite low. I realize that there could be many reasons why her score on the CAF was as low as it was. Therefore, two questions which I think deserve further exploration are, whether one's attitude toward one's parent is less intense if the parent is of the opposite gender and, if this were the case, would this indicate that higher differentiation between parent and child is easier with a parent of the opposite gender and therefore one's attitude less intense when an Adult child cares for a parent who is of the opposite gender?

Both Beth and Karen's scores on the CAM dropped from pre-test to post-test.

It is interesting to note their scores because although they both had the same mother their scores were dramatically different. Beth's pre-test score was 65.3 (post-test 53.3) and Karen's was 39.3 (post-test 24). There were many differences in their situations as well. Beth is the second oldest in the family and Karen is the "baby" of the family. At the time of the group Beth was 55 years old and Karen was 40 years old. Beth was raised by her maternal grandmother whom she described as a very strong individual and a person whom she had greatly admired. Both Karen and Beth admired her. Beth came back to live with her parents as a young teenager and both Karen and Beth agreed that Beth acted as a "mother" to Karen and their younger brother. Beth stated that when she was married she was amazed with all the time on her hands and what little work was required compared to when she lived with her parents. Beth acknowledged that not only her mother but also her father had high expectations of Beth to care for the family. Both Beth and Karen agreed that more was expected of Beth than Karen. Beth said that this was especially true when Beth retired. I also think that the fact that Beth was raised by her grandmother affected her bond with her mother, and may have helped her in establishing a more objective view of her family. This also may have increased her ability to differentiate herself from her mother. I do, however, believe she still had issues left to resolve. Although she comes across as very calm and self-assured, she stated that she lives with a constant feeling of anxiety, which may be a result of feeling abandoned by her parent as a child.

It is interesting that although both Alice's and Ann's scores on the CBI indicated increased caregiver burden, their attitude toward their parent as measured by the CAM improved. Alice was also able to identify a change in her attitude toward her mother.

5.4 INDEX OF SELF-ESTEEM (ISE)

I found it interesting that the three group members who spontaneously identified a positive parental role model in their lives were also the members who had the healthiest scores on the Index of Self Esteem (ISE). Scores pre-test indicated that 5 of the 8 members in the group had clinically significant issues in the area of self-esteem. This was one measure where the mean scores actually deteriorated from pre-test to post-test. Only Alice, Carol and Marie showed an improvement in their self-esteem. These results are not particularly surprising as self-esteem is "a concept, an attitude, a feeling, an image" (Satir, p. 20) which has been learned and developed over a life time. Consequently, positive changes in self-esteem may only be seen over a longer period of time because it is often deeply ingrained in a person.

Reasons why self-esteem actually deteriorated for some members may have been because some members had come from particularly abusive homes and were becoming more in touch with how they actually felt about themselves. Ruth and Pat acknowledged that they needed to continue to work on their self-esteem. Ann's score on the ISE deteriorated from pre-test to post-test, as well. At the post-group interview she was being very hard on herself about how she was coping with her mother's behaviour. Both she and Alice gave a great deal of credit to Carol and Beth in terms of their way of coping with their parent, and they both compared themselves to them. This was not particularly

helpful for Ann in that she became more critical of herself in comparison. Both Alice and Ann, however, viewed Beth and Carol as positive role models, looked to them for advice and direction, and respected their opinions.

The use of the ISE was less helpful in measuring improvements in self-esteem and more helpful as an intervention in assisting members to explore feelings about themselves and reinforcing whether there was an indicated need for particular group members to address this issue more closely.

5.5 OVERALL SUMMARY

Quantitative and qualitative data gathered throughout this group process suggest that all group members benefitted from their participation in this intervention. All members appreciated the group experience and all but one member perceived their social support for caregiving to have improved as measured by the PSSC. As well, all members acknowledged positive changes in their attitudes towards their parents and view of their present situations.

CHAPTER 6 - DISCUSSION

The purpose of this practicum was to develop, implement, and evaluate an intervention which would assist the Adult child to improve her ability to cope with a parent whom she perceived as having a "difficult personality". In particular, the aim of my intervention was to facilitate improved ways of coping for members through the improvement of social support networks, and/or the reduction of feelings of burden, and/or the improvement of one's attitude toward the parent, and/or the improvement of self-esteem. This group intervention was informed by intergenerational and feminist theory. A review of quantitative and qualitative results demonstrates that this intervention made a positive impact on group members and their ways of coping.

As has been indicated previously, this intervention focused on the needs and challenges of the Adult child. In keeping with feminist theory the interaction between the parent and the Adult child was also focused upon to affirm the Adult child's perceptions and then acknowledge that the Adult child had the personal power and control over her behaviour to learn to react, cope and perceive her situation differently.

This chapter focuses upon common factors or themes which emerged upon reflection about this intervention. Topics discussed in this chapter include: Benefits of a Group Format; Gender; Emotional Burden; Model of Intervention; and Achievement of Learning Objectives.

6.0 BENEFITS OF A GROUP FORMAT

A number of reasons for choosing a group format were outlined in the literature review section of this practicum report. Quantitative and qualitative data confirm that

members involved in the group under study benefitted from the experience of a group format. Quantitative data gathered from the PSSC indicate that mean scores showed improvement in members' perception of support as a result of the group experience. Such items as gaining insight, planning for the future, understanding difficulties faced as a caregiver, learning to manage stress, and feeling that one's problems were not unique all showed particular improvement as a result of the group experience. Results of the qualitative data also support the value of utilizing a group format with this population. Some members' reports about what was most helpful about the group were: "finding out that we share many common experiences", "the way people opened up and I found out that I wasn't alone in my feelings", "talking about own and others experiences growing up", "humour - laughter" was "stress releasing" and "very relaxing", "we all had some problems of our own and we were able to share them", "just listening and being a part of the group helped". Other comments included "the group was helpful and non-judgemental. I felt like a family". These comments indicate to me that many of the benefits of the group experience would have been lost had sessions been in the context of individual or family therapy.

Goodman (1991) writes that "social support from peers in a support or self-help group has unique benefits and characteristics, some of which differ from the benefits of friendship". She refers to Borkman who theorized that friends and family may actually be unable to support people through certain types of crises as they may become overinvolved, stigmatize the person, or make demands that the individual cannot meet. They also may lack the knowledge or experience which enhances understanding. Karen

alluded to this and Alice actually identified this concept and wrote that the change in her relationship with her mother was "maybe just the idea that people here understand me better than my friends". Pat also said at one group session that it was easier to talk in the group session because "I know everyone and I feel protected here". This was very significant because Pat had made statements in the past that she had always been looking for a place to belong.

Group members did have different experiences, and different ways of coping, as well. Marie and Ruth thought that they could have benefitted more if they had experienced more common issues with other group members. Differences in general, however, seemed to help rather than hinder the group process. A number of common issues were addressed within the group setting. These were:

- coping with feelings of pity, guilt, frustration and anger, towards one's parent;
- fear of being like one's parent;
- expectations of women by family and society in general;
- coping with feelings of anxiety;
- struggles in setting limits with a parent and others in one's life;
- interest in learning and receiving feedback about how to manage one's relationship with one's parent more effectively; and
- the need for information about "difficult personalities".

Goodman (1991) writes that groups develop cohesiveness, enhance self-esteem, and produce better coping. Cohesiveness as well as improved coping definitely developed through the group process. Quantitative measures did not demonstrate an

overall improvement in self-esteem. I believe that cohesiveness developed more quickly because the group was closed. I do not think that members would have shared as intimately as they did if the group had been open. Members shared some very personal and traumatic events in their lives and were able to do so because of the trust which developed among those particular members.

I think it is also important to limit the number of members in a group. The group under study in this practicum consisted of eight people. I do not think membership should exceed this number because I believe that the Adult child whose parent has a "difficult personality" has a great need to "tell his/her story", to hear and be heard, to listen and be listened to. Some of these children have felt like caregivers all of their lives and have not given themselves permission to express their needs and wants and to realize their identity as human beings. As Ruth said at one of the beginning sessions, "I don't know who I am". There were times during the group when I felt that perhaps group members would have benefitted more if membership had been limited to six individuals. Ann commented after one of the group sessions which only five people attended that she felt she had gotten more out of that session because individual issues were explored at a deeper level.

I believe that cohesion was developed and enhanced because of the homogeneity of the caregivers in that they were all Adult children, all women, and could relate quickly and easily to each others' feelings and experiences as they all had a parent whom they perceived as having a "difficult personality". Members also became very aware that they were not alone, and acknowledged that women do a large majority of the caregiving.

Intervention with group members involved pre-group and post-group interviews, ten formal sessions, and an eleventh session which involved a written evaluation and a social event. I found that the number of sessions was appropriate for this particular group. A time-limited group was also useful because it was my impression that although some members claimed that they were invested in continuing the group in a formal way, there were others in the group who were ready for termination. This gave those individuals the permission to leave the group and have closure with other group members. Perhaps more sessions could have given members more time to address more issues and process information. Pre- and post-test measures may have also shown greater changes if the time between testing had been greater. I think, however, that it may have been difficult to facilitate an ongoing group because of the particular mix of members and their varied needs. I gave members the option of contacting me if they required my input, but I think that there were enough members in the group who would initiate contact with others that future meetings might occur without the need for a professional facilitator.

Marie suggested having continued group sessions without a facilitator. Marie thought it would work quite well if, when I facilitate another group with new members, members from the previous group could also meet at Deer Lodge Centre but in a different room. In that way there would be a neutral meeting place and should my input be required group members could speak with me at the end of the group session. Group members did, indeed, agree to continue meeting, and based on their need would come as

often as once per week or as little as once per month. These meetings began on February 18, 1997, as agreed by the members of the group.

6.1 GENDER

The participants involved in this group intervention were all women, seven of whom were the primary caregivers. This fact supports the literature which indicates that it is largely women who are expected to be caregivers (Scheyett, 1990). This project also supports the literature which suggests that most caregivers are either daughters or daughters-in-law and span the ages of forty and sixty years (Brody, 1985, Cantor, 1983). All participants in this project were daughters and all within the mean age of 52. Six of the seven parents of the Adult children in the group were women and this supports Aronson's (1986) finding that the majority of care recipients are women (Aronson, 1986).

Five of the eight women who attended the group had at least one brother who was either not involved or minimally involved with the parent. Conversation in the group focused on patriarchal values about the family, societal expectations and the tendency for women to take on the role of caregiver. The literature indicates that a child who is parentified begins to meet the needs of other family members while sacrificing her own needs (Gelinas, 1983), and she often become the "super-responsible child" (Black, 1981). This was the experience for most of the women who attended the group. Women in the group also agreed that women achieve autonomy in society by being able to do for others while men achieve autonomy by being able to do for themselves (Subby, 1990). As a result differentiation is more of a challenge for a woman than it is for a man in society.

Differentiation was also a major theme which arose in this group intervention. Members spoke often about their fear of being like their parent and not until this was addressed openly at the sixth session did this fear subside somewhat. Interestingly, these fears were discussed just as the group itself was moving into the stage of group development of differentiation/group identity. After this session, instead of being afraid of being like one's parent, fears started to arise about being too happy. This shifted the focus from the parent to the Adult child, and helped members to explore the personal power they had to change parts of themselves if that was what they wanted. It was also after the sixth session that Boszormenyi-Nagy's Relational Ethics were focused upon. His theory, as stated previously, looks specifically at learning to discriminate another's needs as valid and distinct from one's own needs (Boszormenyi-Nagy & Spark, 1973).

6.2 EMOTIONAL BURDEN

As mentioned previously, subscale mean scores of emotional burden on the CBI were significantly higher with the members who attended this group in contrast to Novak and Guest's research with caregivers of those with Alzheimer Disease. Perhaps this relates partly to the Adult child being challenged by differentiating herself from her parent as mother-child bonds are one of the most intense, according to Goldenberg and Goldenberg (1991).

Emotional Burden was identified by McClelland (1993) as well. She utilized the CBI with caregivers of the elderly who were physically demanding and not suffering from a dementing process. The caregivers in McClelland's study found questions related to emotional burden less relevant than other areas of burden. McClelland (1993)

suggested that caregivers of cognitively well elderly may not find these questions relevant to their situation, because the inappropriate behaviours associated with cognitive impairment were not an issue.

In contrast to McClelland's finding, emotional burden was found to be very relevant to the members who attended the group described in this practicum report, despite the fact that six out of the seven care recipients did not suffer from a dementing process. Information identified in this report reinforces the notion that a parent does not have to be cognitively impaired to exhibit inappropriate behaviours. Perhaps inappropriate behaviour as a result of cognitive impairment may be easier to cope with because the caregiver can understand the behaviour in terms of a "disease". It can be much more difficult to accept the inappropriate behaviours of an individual who is cognitively intact and well aware of his/her behaviour. This observation was introduced in the first chapter of this practicum report. Ruth, whose mother suffered from dementia, agreed with this statement, and in fact, Ruth agreed that the inappropriate behaviour exhibited by her mother due to dementia was much easier to cope with than the inappropriate behaviour her mother had exhibited when she was cognitively well. The Adult child of a parent with a "difficult personality" may experience even more intense feelings of resentment, embarrassment, shame, discomfort and anger than those Adult children who care for a parent suffering from a "disease".

The findings in this project continue to reinforce the high degree of emotional burden that the family and society in general place on women. Brody (1985) states, and I emphasize, that the most pervasive and most severe consequences of caregiving occur in

the area of emotional strain, the area which is most often left up to women. It is also the emotional aspects of caring which many caregivers report as being the most difficult to handle (Bowers, 1987). Interestingly Brody (1985) has also found that it is emotional support that most individuals want in their old age (Brody, 1985).

6.3 MODEL OF GROUP INTERVENTION

The model created for this group intervention utilized a blending of Boszormenyi-Nagy's (1986), Toseland and Rivas' (1984), Garland et al.'s (1965), Maier's (1961-62), and Schultz and Schultz's (1990) theories. These theories integrated together beautifully in helping to frame the intervention and identify issues to be addressed. This framework allowed for flexibility to also incorporate emotional abuse issues and feminist theory as well. As indicated in the Literature Review, the impact of emotional abuse and that of caregiver stress have many similarities. As also stated in the Literature Review, intergenerational therapy models at times complement feminist theory, and those areas which conflict can be reworked to support feminist values. Although Boszormenyi-Nagy's contextual family therapy model was developed for use with families of course, this model was very useful for helping individuals in a group setting to understand themselves and their families.

This model of group intervention is one which can be used for various caregiver groups including parent groups. It reinforces the need to care for oneself and supports the belief that an individual can improve her quality of life if she is open to examining the nature and quality of her family relationships (Roberto, 1992) and shows insight into its significance in her daily life (Bowen, 1978). I believe that this intervention can also

provide a useful framework for social workers who engage individuals, couples, and of course families in therapy.

6.4 ACHIEVEMENT OF LEARNING OBJECTIVES

The knowledge and experience gained through the completion of this practicum was very rewarding both professionally and personally. My counselling and group work skills, as well as my ability to research and integrate a number of theories into practice, have shown marked improvement.

Four learning objectives were outlined in the first chapter of this practicum report. My first learning objective was accomplished: i.e. to develop and implement a support group targeted towards the Adult child whose parent was perceived as having a difficult personality. The support group was developed based upon the model of intervention which I was able to create utilizing a number of theoretical and practical perspectives researched through the process of completing the literature review. The group was successfully implemented from September 1996 - November 1996. Eight individuals agreed to be members of the group and participate in having this process evaluated. No one withdrew throughout the eleven sessions.

My second learning objective was to improve my skills and techniques in short-term group counselling. I have facilitated groups in the past, and found that this practicum experience not only developed and enhanced previous skills, but also provided an opportunity to learn new skills. Some facilitation skills which I was able to enhance included: enabling, brokering, mediating, advocating, and educating. Other skills which I was able to develop included eliciting, moratorium, rejunction, therapeutic

crediting, siding, loyalty framing, and exoneration. These are interventions developed by Boszormenyi-Nagy and identified in the literature review section of this practicum report (pp. 59 and 60). These skills and techniques were implemented within the framework of feminist theory and values. Members of the group came together and became cohesive very quickly. I believe that I enhanced this cohesion by structuring the room to increase members' comfort level, having the group over the dinner hour, and asking questions which helped group members recognize their commonalities. Through the group process and the content of sessions, members were able to identify their individual needs and empower themselves to take steps towards having those needs met. For some members, meeting their needs meant taking more courses, for other members, it was seeking help from outside resources. Others acknowledged the need to maintain contact with one another. Group members advised me that contact between them was continuing to occur two months after the group had terminated.

More specifically, I believe that I was able to promote insight development by providing alternative ways of viewing one's situation. Members also offered various perspectives and through this process members were able to provide and receive psychosocial support.

My professional skills were also enhanced by the help of my advisor Shirley Grosser who reviewed audio-taped sessions with me on a regular basis. Her assistance increased my confidence by positively reinforcing effective techniques that I had utilized and providing further feedback which could increase my effectiveness as a facilitator. She also spent a great deal of time teaching me new techniques such as guided

imagery/anchoring and other experiential exercises. I implemented these techniques during group sessions on a number of occasions. I am pleased with the degree to which I improved my skills and techniques in short term group counselling.

My third learning objective was to further enhance my knowledge of the difficulties associated with caring for an elderly parent who is perceived as having a difficult personality, and the effect it has on the Adult child. There is no doubt that I advanced my practical knowledge and experience through my contacts with each and every group member. Through the members' willingness to express their feelings, experiences and issues, not only did members learn from each other but I also learned valuable information about those Adult children who care for their parent with a "difficult personality". Through Geri McGrath's willingness to be available on site I was able to consult her regularly and this greatly enhanced my learning. Through my research and experience as a facilitator I believe I was able to meet my third learning objective.

My final learning objective was to develop knowledge administering instruments and gathering and analyzing data. Diane Hiebert-Murphy was instrumental in assisting me with the choice of measures which were administered in this intervention and interpreting the findings obtained. Quantitative measures administered pre-group indicated high levels of burden and low levels of social support. Elevated scores on the CAM and ISE also indicated that many of the Adult children in the group under study were dealing with a high degree of issues and stress. These quantitative measures were useful in learning that many of these Adult children were under a great deal of stress and that the degree of stress was not less with the Adult child whose parent was already in a

personal care home. The degree of stress and number of issues were less, however, with the one member of the group who was not a primary caregiver to her parent, which might indicate that with the stresses of caregiving, issues from the past also resurface. The number of issues members had were also quite diverse, with scores indicating a range from little or no issues to a number of difficulties in the areas of caregiver burden, social support, child's attitude toward parent, and self-esteem.

I also learned that the group was a very positive experience for group members in terms of increasing their social support. Post-group scores were much higher than pre-group scores on the PSSC indicating a valuable increase in social support.

I learned from post-group measures that although quantitative scores did not always indicate great improvement from pre-group to post-group, qualitative measures did indicate a number of positive changes within group members. As one member pointed out, she was more honest on the post-group measures than she had been on the pre-group measures. Through the group process members can become more in touch with, and honest about, their issues. Although this is a move in a positive direction, quantitative measures indicate the opposite. I also believe that individuals in the group did benefit more than both quantitative and qualitative measures would suggest. I believe this first, because this population of Adult children tend to be very critical of themselves. Second, the high degree of stress for some members in the group made it more difficult to integrate healthier ways of coping, suggesting that although the knowledge existed, integration could take more than two or three months, especially if one has relied on unhealthy ways of coping throughout her life.

I also learned that members of a group can achieve benefits even if the group is quite heterogeneous as this one was. From my experience of facilitating groups in the past I recognize that every group is different, and depending on the needs of the group, each group may take on different forms. I believe that this flexibility is helpful and if it is feasible, a group could be extended if this is agreed upon by group members.

CHAPTER 7 - CONCLUSION

This practicum report concludes with a review of the major findings gathered from this project. These findings are viewed in relation to implications for future social work practice.

As identified at the beginning of this practicum report, although there has been research about group interventions with caregivers, attention has seldom focused on the unique characteristics of a population of caregivers, in terms of their gender and their relationship to the care receiver. In addition, little attention has been given to family of origin issues and intergenerational conflict (Goldstein, 1990). The intervention discussed in this report was very specifically designed for the Adult children of a parent perceived as having a "difficult personality". The gender present in the group, although not deliberately, consisted only of women. A great deal of attention was given to intergenerational conflict and family of origin issues throughout the group process.

The purpose of this practicum was to develop, implement, and evaluate an intervention which would assist the Adult child to improve her ability to cope with a parent who she perceived as having a "difficult personality". In particular, the aim of my intervention was to facilitate improved ways of coping for members through the reduction of feelings of burden, and/or the development of social support networks, and/or the improvement in attitude toward the parent, and/or the improvement of self-esteem. Quantitative and qualitative data have supported that the group intervention was effective in meeting some of the needs of this population. The data suggest that all of the members of the group demonstrated some improvement in at least one of the following

areas: caregiver burden, perceived social support, attitude toward parent, and self-esteem. All of the members experienced an improved attitude toward their parent as measured by the CAM/CAF. Many members also identified positive changes in other relationships in their lives as a result of the group.

The personal learning objectives which were outlined at the beginning of this report were met to my satisfaction. I have developed more knowledge and awareness of the Adult child who has a parent with a "difficult personality" . I have enhanced and developed new techniques which can be utilized in a group setting. My knowledge and theory base have become more solid, particularly in terms of my ability to integrate a number of theoretical perspectives, including intergenerational theory, feminist theory and small group theory. I learned to develop the framework for intervention and utilize it effectively.

7.0 IMPLICATIONS FOR SOCIAL WORK PRACTICE

Social workers utilize group interventions with many different populations. The need for group interventions with the Adult children described in this practicum is no exception. As indicated in the literature review chapter of this report, caregivers may perceive that interpersonal conflicts between themselves and the care receiver are due to historical causes other than caregiving. As a result of this perception caregivers may not perceive caregiver support groups as an appropriate setting in which to resolve long-standing parent-child conflicts (Brody, 1985; Tobin, 1987). Perhaps up until this point support groups have not been appropriate settings for the resolution of these conflicts, because as Goldstein (1990) points out, many caregiver groups do not address

intergenerational conflict or family of origin issues. This research confirms and reinforces the need for groups for the Adult child who wishes to resolve interpersonal conflicts and family of origin issues. Since this group was developed I have received a number of telephone calls from individuals whom I have never met, expressing an interest in coming to a group such as this.

Another important component which professionals in health care must keep in mind is that caregiver burden does not necessarily decrease when one's parent or the care receiver is admitted to a personal care home. Burden can be decreased if professionals identify that the Adult child continues to experience intergenerational conflict and unresolved family of origin issues, and offer services to address these needs. In that same vein, perhaps burden is also transferred to personal care home staff. As mentioned previously, just as it is important for social workers to recognize the presence of a "difficult personality", it is also important for others in the health care system to recognize the time, energy, and frustrations which may occur when caring for an individual with a "difficult personality". In my experience dealing with these individuals requires specialized knowledge and skill which is not often readily available or priorized for health care staff.

I also find it interesting that five of the six mothers who were perceived as having a "difficult personality" were also individuals who had been prescribed valium in the past. After being taken off valium, four of these women were prescribed an anti-depressant which had a positive effect. Perhaps individuals (particularly women) seen as having a "difficult personality" have not been treated well in the past and have in fact

been dismissed by health care professionals. Had professionals recognized their difficulties and accurately treated the problem, much less damage could have been done to all members of the family. Additionally, if the identified patient could not be helped perhaps other members of the family would have been open to some kind of intervention. This example supports the need for health care professionals to assess the individual in the context of her environment and the dynamics inherent in that environment.

This group intervention may also have helped group members to consider their own issues of aging and, through this vehicle, assist them to prepare for the losses and stresses which come with old age. If this is the case, their "golden years" may actually be more "golden" because of their improved ways of coping learned through the group intervention. Perhaps this group intervention may have also decreased the potential risk for members to abuse others (particularly their parent) in the future.

Recruiting Adult sons and daughters for this group which explored interpersonal conflict and family of origin issues was done by identifying the parent as having a "difficult personality". Because of the burden already being experienced by group members I chose initially to address the parents as being individuals with "difficult personalities". Many Adult children seen in my professional work are much too quick to blame themselves for the difficulties in their relationship with their parent. Other family members, caregivers, friends, and society in general, are also quick to blame the Adult child. Although the term "difficult personality" appears as a label I would continue to use this term to recruit members for future sessions. Adult children have a right to their feelings and a right to be heard, and many have learned that when they have talked about

their parent in the past either people do not believe them or they are judgemental and place further pressure on the Adult child. If an Adult child has any sense that this could occur again, they may refuse to come to a group. The Adult child has reasons to feel angry, hurt, and victimized in her relationship with her parent based upon the inappropriate and often abusive behaviour exhibited by the parent. Putting the focus on the parent to begin with may be enough for them to feel less threatened about coming to a group, which in the process, acknowledges the Adult child's responsibility in the relationship and how she can change to improve the situation. I must add that although I used the term "difficult personality" when I initially spoke with group members, nowhere in the body of the letter of invitation sent to members did I use this term (see Appendix A). The letter states clearly that the group is for Adult children who "would like to change their relationship with their parent".

This group ran for a total of eleven sessions. It is my opinion that this number of sessions was appropriate for this particular group. This was a heterogeneous group in that although members had similarities, each had individual issues which were not the same as those of other members. As a result, issues which were identified by most of the members were the issues which were addressed. Other issues were identified but not addressed in depth because of the diversity of needs within the group. For example one group member had experienced severe emotional, physical, and sexual abuse. She acknowledged her need to discuss this abuse in more detail, however, other group members' experiences were less abusive and they had less need to explore their past to the same degree. As a result this group member could not fully explore her abuse issues,

however still benefitted from the group. The process of the group intervention helped her to clarify the areas where she had more work to do. It is true that other group members also became more clear about their own individual issues, and gained a clearer understanding of their strengths as well. Particular group members took the initiative to continue to work on their own issues, whether it meant taking a course or engaging in more intensive therapy.

The heterogeneity of the group was positive in that members were able to put their situation into perspective. Some members learned that their situation was not as "bad" as they had believed, while other members realized that their feelings of distress were well warranted given the difficulties they were having in coping with their parent. It was also helpful in that group members learned a variety of ways of coping from each other. Had the group been more homogeneous, however, perhaps some issues could have been explored at a much deeper level. This could be a consideration for future group interventions.

Although I felt that the number of sessions was appropriate for this particular group I was also sorry that time did not allow me to address issues of anger and anger management with the group, or engage members in mourning the loss of the fantasy of having the parent one had hoped for. I had some apprehension about going into depth about issues of anger, because I felt that one group member had an incredible amount of anger, which if tapped into could not be properly dealt with in group sessions. Again, however, my sense was that all members had a varied need to address these issues, and although these issues were not addressed they were identified during group sessions. As

mentioned previously, some members considered whether these were issues for them and took the initiative to explore them further.

The quantitative measures utilized for this practicum report were useful. They provided a profile of the struggles which many group members were experiencing. The elevated scores on the CAM/CAF verified that there were indeed problems between the Adult children and their parents. All but one of the scores on the CAM/CAF pre-test indicated that members had problems in relation to their attitude toward their parent (Hudson, 1982). Caregiver burden scores were within the means and standard deviations determined by Novak and Guest (1989) for caregivers of those suffering from a dementing process. What was particularly interesting for the members involved in this intervention was the elevated scores of emotional burden on the CBI. Mean scores on the CBI pre-test indicated that emotional burden was the factor where caregivers experienced the most burden. This score was even higher than mean scores and standard deviation scores found in Novak and Guest's (1989) research.

Two quantitative measures indicated consistent improvements in group members' lives. All members' scores on the CAM/CAF improved and all but one group member experienced improved social support for caregiving as measured by the PSSC. These scales were good indicators of some of the benefits derived from being a part of the group.

Comparison of the mean pre-test score of the PSSC obtained from the Goodman and Pynoos (1990) study and the pre-test score obtained from this group intervention may

suggest that those Adult children who care for a parent with a "difficult personality" are more socially isolated than those who care for a parent with Alzheimer Disease.

Mean scores on the ISE actually deteriorated from pre-test to post-test. Not all members had issues with self-esteem. Those who had issues with self-esteem seemed to experience a deterioration in their scores from pre-test to post-test. Some members identified that they were more honest in answering the items on the post-test. Others became more in touch with how they actually felt about themselves because their perception of burden decreased, giving them more emotional time and energy to think about themselves. The ISE was useful in reinforcing to members their need to address this particular area.

The SC scale (Goodman, 1991) consisted of only three items. I did not find this scale useful, and found qualitative data much more helpful in determining improvements in the quality of relationships in the group members' lives.

I think that a very important aspect of this group was to reinforce to members to use their discretion in terms of who they talked to about the difficulties they experienced with their parent. They began to realize who they could talk to and that the members of the group provided a safe and secure milieu in which individuals could discuss these issues at length. Members also recognized their need for ongoing support and took the initiative to coordinate future get-togethers with each other. Some met in dyads in addition to get-togethers where all members were invited.

The population of caregivers who care for an individual with a "difficult personality" share some issues and characteristics similar to those who care for an

individual who suffers from alcoholism. This intervention is much broader than many of the ACOA treatment groups and although there is overlap, I believe that the experience of having a parent who abuses alcohol provides some kind of explanation for a parent's behaviour whereas a "difficult personality" is much more ambiguous.

It is true that this group sample was small, and in some ways heterogeneous. It is also true that the absence of a control group makes it difficult to make generalizations about how valuable or effective this particular group intervention was. Nonetheless, both quantitative and quantitative data presented in this report indicate that group members benefitted from this group intervention. Further support of the effectiveness of the intervention lies in the fact that the member who attended the least number of sessions experienced the least improvements. The member who attended all eleven sessions experienced some of the greatest changes as measured by quantitative measures. All group members could identify positive changes in their lives as a result of being part of this group intervention.

In conclusion, this practicum describes the effectiveness of an intervention for a small group of Adult daughters. Interventions of this nature must continue in order for professionals to gain a greater understanding of the Adult child who cares for a parent who is perceived as having a "difficult personality". More research is required into the study of those who care for an individual with a "difficult personality". Further study regarding the needs and issues of, for example, spouses, Adult sons, other relatives and those who care for males in contrast to females with "difficult personalities" is also in order. I have planned to facilitate a group in the coming months with caregivers who are

siblings, nephews/nieces, and in-laws to the elderly person with a "difficult personality". It has been my experience that formal, professional caregivers also face difficulties in caring for an elderly person with a "difficult personality", and they may be an appropriate target for a similar intervention in the future.

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APPENDICES

APPENDIX A

LETTERS TO PROSPECTIVE GROUP MEMBERS

MEMBERS' CONSENT FORM

Deer Lodge Centre

2109 Portage Avenue • Winnipeg • Manitoba • R3J 0L3 • Telephone (204) 837-1301

Dear

I have met a number of Adult children who would like to change their relationship with their parent. Some of these children feel helpless or demeaned by their parent; others feel that nothing they do for their parent is ever good enough. Some Adult children recognize that their parent acts differently with different people, causing miscommunication and misunderstanding.

As discussed with you on the telephone, you and your siblings are invited to a group for Adult children. This group will give you the opportunity to share your own experiences with others in a similar situation. We plan to look at the following issues:

- understanding your parent/understanding yourself
- developing healthier coping strategies
- setting limits
- self-esteem and self-image
- caring for oneself

This group will be held 10 Wednesdays from 6:00 - 8:00 p.m. on the following dates:

September 18, 25
October 2, 9, 16, 23, 30
November 6, 13, 20

The meetings will be held at Deer Lodge Centre, 2109 Portage Avenue, Winnipeg, Manitoba, on the 3rd floor of the North Pavilion. The entrance is off Duffield Street, close to Lodge, and you can park on the street. Coffee, tea, and snacks will be served.

If you would like to do some reading in the meantime, I would suggest you take a look at the book entitled "Toxic Parents" by Susan Forward.

To confirm your attendance, or if you have any questions please call me at 831-2180 by September 3, 1996. If you can not reach me in person, please leave a message. I look forward to hearing from you.

Sincerely,

Suzanne Rutledge, B.S.W., R.S.W.
Social Worker
Deer Lodge Centre

2109 Portage Avenue • Winnipeg • Manitoba • R3J 0L3

Dear

This is just a follow-up letter inviting you to the Support Group beginning on September 18/96 from 6:00 - 8:00 p.m. The Group will run for 10 Wednesdays.

Because I am utilizing the group as the basis for completing my Master of Social Work degree it is necessary for me to meet with each group member individually the week of September 9th.

If you are still interested in attending the group, please contact me in order to set up an appointment. As interest is high I would ask that you contact me as soon as possible. Membership may have to be cutoff and those who have made an appointment with me will be considered on a first come first serve basis.

Enclosed is a form which I'd like to ask you to fill out before we meet together the week of September 9. If you have any questions at all about the form or anything else about the group I can answer these questions thoroughly when we meet.

I look forward to hearing from you and eventually meeting and getting to know you.

Sincerely,

Suzanne Rutledge, B.S.W., R.S.W.
Social Worker
Deer Lodge Centre
831-2180

For the purposes of my practicum it would be helpful to have some specific information about yourself. This information will be kept confidential and will in no way effect your participation in the group.

Age and birthday of your parent? _____

Is your parent a widow? _____
If yes, when did his/her most recent spouse die? _____

# of brothers alive_____ # of sisters alive _____
# of deceased siblings_____
How many miscarriages did your mother have? _____
Were any of your siblings adopted?_____ If yes, how many?_____

How long have you cared for your parent?_____

What is your marital status?_____

How many sons (include ages) do you have? _____

How many daughters (include ages) do you have? _____

When is your Birthday? _____ Where were you born? _____
day/month/year
Level of education: _____

Place of employment and position _____

Who do you live with? _____

Ethnic background _____

Religious Background _____

Present church affiliation, if any _____

Do you have any health problems? _____ If yes, please list:

_____ _____

_____ _____

Thank-you

INFORMED CONSENT FOR PARTICIPATION IN SUPPORT GROUP

FACILITATOR: Suzanne Rutledge, B.S.W., R.S.W.
Master of Social Work Student
University of Manitoba, Winnipeg, Manitoba
Telephone: 831-2180 (office) or 772-7979 (home)

SUPERVISOR: Professor Shirley Grosser, M.S.W.
University of Manitoba, Winnipeg, Manitoba
Telephone: 474-8273

The purpose for this support group has been explained to me. I understand the group process and have been advised that I may benefit from the group.

I consent to participate in ten group sessions, and approximately three individual interviews which will be audio-taped, for the purposes of this study. I understand that all written and taped information is confidential. I understand that my identity will not be disclosed in any material which results from these sessions/interviews. Records may be accessed only by the facilitator's practicum committee, who are University of Manitoba professors. Records will be kept in a locked file. Records will be destroyed upon successful completion of the practicum. I understand that I may have access to a completed report.

I understand that this project will contribute to a better understanding by professionals of the needs of those caring for a parent with a difficult personality.

I have had the opportunity to ask questions related to this project and they have been answered by the facilitator. I understand that I am free to discontinue with this process at any time. I understand that my participation is voluntary.

THIS IS TO CERTIFY THAT I, _____
(print name)
HAVE READ AND UNDERSTOOD THIS CONSENT AND HEREBY AGREE TO PARTICIPATE AS A VOLUNTEER IN THE ABOVE NAMED PROJECT.

_____ _____
(participant signature) (date)

_____
(witness)

Please print your name and address if you would like a summary of the study results.

_____

_____

_____

APPENDIX B

QUALITATIVE EVALUATION TOOL

WRITTEN EVALUATION

Thank-you very much for your participation in this group experience. In order to help me evaluate and plan for future group sessions I would appreciate if you would take a few moments to answer the following questions. Please use the back side of the sheet if you require more writing space.

1. What personal benefits and changes were derived from your participation in the group?

_____

_____

_____

2. What was it about the group that you found most helpful?

_____

_____

_____

3. What was it about the group that you found least helpful?

_____

_____

_____

4. What was your impression of the group experience?

_____

_____

5. Has the quality of your relationship with your parent changed since the group began? _____

If so, in what ways?

_____

_____

_____

To what do you attribute the change?

_____

_____

_____

6. Has the quality of other relationships in your life changed since the beginning of the group? _____

If so, which ones, and in what ways?

_____

_____

_____

To what do you attribute the changes in those relationships?

_____

_____

_____

7. Do you have further suggestions for the group?

_____

_____

_____

Thank-you very much!!

APPENDIX C

CIRCLE OF COMPETENCE SCRIPT

Guided Imagery Exercise/Circle of Competence and Confidence

Think of a time in your life when you had a feeling of confidence and competence. It could be when you were a child having learned how to walk, it could be as a teenager when you received your driver's license, or as an adult after a successful interview or having made a meal which everyone loved. If you cannot think of a time, try and imagine a "hero" figure who would be capable of feeling confident and competent. When you have thought of a time, close your eyes and begin to think about that time. Where were you? Was anyone there with you? What time of year was it? What was the weather like? What else do you see as you imagine this time? What were you wearing? What did you hear from others? What were you saying? Were you sitting or standing? Take a deep breath and remember the details of that time in your life. How did you accomplish what you had done?

(Pause for 15 seconds)

When you have a clear picture of that time, stand up in a way which would represent your feelings of confidence and competence. Take another deep breath and allow yourself to explore the feelings associated with your competence and confidence.

(Pause for 20 seconds)

Now, look down to the floor and imagine a circle on the floor. In the circle put all those positive feelings, sensations, and affirmations in the circle. Can you make the circle? What colour is the circle? What can you do to the circle to make it stronger, richer, more meaningful? Does the circle need to be bigger, deeper, brighter? When you have the circle the way you want it, step into the circle allowing your body to absorb all of the circle's energy. You may take two or three breaths to help in absorbing and breathing in the energy, or notice that you are bathed in light, perhaps feeling tingling sensations of positive energy. When you are ready, step out of the circle bringing with you all that you gained from the circle. Bring your thoughts, words, sounds, and feelings with you and remember that these can be with you wherever you go.

(Pause for 20 seconds)

Now think of a time when you experienced a guilt provoking situation with your parent. If you were to live this scenario over again, how would you prepare for it? How would you act and what would you say? How would you feel knowing you are responding from a position of confidence and competence, knowing you had everything that the circle of competence had, within you?

Think about this, and when you have thought about this long enough, stretch if you like get a cup of coffee, or continue to sit quietly.

APPENDIX D

LETTERS OF PERMISSION

Deer Lodge Centre

2109 Portage Avenue • Winnipeg • Manitoba • R3J 0L3 • Telephone (204) 837-1301

November 28, 1996

1008 Dominion Street
Winnipeg, Manitoba, CANADA
R3G 2P1

La Trobe University
Department of Behavioural Health Sciences
Bundoora, Victoria, AUSTRALIA
3083
ATTENTION: CYNTHIA L. SCHULTZ

Dear Ms. Schultz:

I am writing you to express my interest and enthusiasm related to the model for caregiving developed by yourself and your colleague. I have incorporated this symbol of growth into a group intervention for caregivers. The caregivers were all women who cared for a parent with a "difficult personality"; or in other words a parent whose learned ways of coping impacts negatively on the caregiver.

I have been working on my Master of Social Work degree, and the above mentioned group has been the subject of my practicum report. Enclosed is a diagram of the concepts/theories which I utilized in my intervention. As you can see I have incorporated your Symbol of Growth into the diagram, and hope to include this in my report, with your permission. I would also appreciate your comments and/or feedback on this diagram.

I am also interested in obtaining a copy of your book, The key to caring (1990), Melbourne, Longman Cheshire. I would be very thankful if you could direct me as to how I could obtain a copy.

I have found your model to be very valuable. It is useful and appropriate in the work that I have done with the group for caregivers. Thank-you for considering my request to utilize your model in my practicum report and your anticipated response to my letter. I look forward to hearing from you.

Sincerely,

Suzanne Rutledge

Suzanne Rutledge, B.S.W., R.S.W.
Psychogeriatric Services, (204) 831-2180

JOURNAL OF FAMILY STUDIES
Editor: Cynthia L. Schultz PhD MAPsS

LA TROBE UNIVERSITY

School of Behavioural Health Sciences
FACULTY OF HEALTH SCIENCES

Ms Suzanne Rutledge
1008 Dominion Street
Winnipeg
Manitoba
Canada R3G2PI

Dear Suzanne
Thankyou for your letter of 28 November 1996, in which you informed me of your interest in the "Model for Caregiving". My co-author and husband, the Rev. Dr. Noel Schultz and I, were delighted to hear how helpful you are finding our work. We are happy for you to use the same, with due acknowledgement.
Your development of concepts and theories underlying your intervention, and the way in which you have incorporated the Model is most impressive. I particularly like your use of the term "Symbol of Growth" and the way in which you have matched group processes to the levels of the Model.
Enclosed please find a copy of *The Key to Caring* with an invoice for (Aus)$13.00. Also herewith is a brochure for the Journal of which I am Editor. Your organisation/University's library may be interested in subscribing. I believe the Special Issue on "Empowerment of Families" due out in April 1997 would be of interest to you, as the Model receives further development there. Please keep the Journal in mind if you intend to submit your work for publication some time.
Another point that may be worth noting is that we are publishing two books this year in which the Model is applied to parents of children with special needs.

Best wishes in your undertakings,

Sincerely,
4/1/97
Cynthia L. Schultz PhD MAPS

Encl : *The Key to Caring*
JFS Brochure
List of Schultz Caregiver Publications

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March 27, 1995

Dr. Mark Novak
Continuing Education Division
The University of Manitoba
Winnipeg, Manitoba
R3T 2N2

Dear Dr. Novak:

I am writing to express my interest in your Caregiver Burden Inventory and to request your permission to utilize this scale in my practicum for the completion of my Master's Degree in Social Work.

I have chosen to study adult children as caregivers to the elderly in my practicum, and will be facilitating a support group as my intervention. One of the variables I hope to measure is whether the group intervention affects subjective feelings of burden on the part of the caregivers. I have reviewed a number of burden inventories, and find yours particularly useful as it distinguishes between the various types of burden and therefore, provides more detailed information.

Should you have any suggestions for references on the use of the CBI, it would be greatly appreciated. I plan to begin my practicum by April or September '95, depending on when I will have recruited a sufficient number of group members. Your reply to the above address as soon as possible would be appreciated.

Thank you for your anticipated assistance.

Sincerely,

Suzanne Rutledge

Suzanne Rutledge, B.S.W., R.S.W.

THE UNIVERSITY OF MANITOBA

CONTINUING EDUCATION DIVISION

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April 20, 1995

Suzanne Rutledge, B.S.W., R.S.W.
Deer Lodge Centre
2109 Portage Avenue
Winnipeg, MB R3J 0L3

Dear Ms. Rutledge:

You have my permission to use the Caregiver Burden Inventory in your work.

Best wishes for successful project.

Sincerely,

Mark Novak, Ph.D.
Associate Dean (Academic)

Deer Lodge Centre

2109 Portage Avenue • Winnipeg • Manitoba • R3J 0L3 • Telephone (204) 837-1301

July 3, 1996

Professor Catherine Chase Goodman
Department of Social Work
California State University, Long Beach
1250 Bellflower Blvd.
Long Beach, CA
90840

Dear Professor Goodman:

I am writing to express my interest in your Perceived Social Support for Caregiving Scale and your Social Conflict Scale. I am requesting your permission to utilize these scales in my practicum for the completion of my Master's Degree in Social Work.

I have chosen to study adult children as caregivers to the elderly in my practicum, and will be facilitating a support group as my intervention. One of the variables I hope to measure is whether the group intervention improves subjective feelings of emotional and social support on the part of the caregivers. I have reviewed a number of scales, and find these two scales very specific to one of my purposes of intervention.

Just the article.

Should you have any suggestions for further references other than your article entitled "Perceived Social Support for Caregiving: Measuring the Benefit of Self-Help/Support Group Participation", it would be greatly appreciated. I plan to begin my practicum by September '96, depending on when I will have recruited a sufficient number of group members. Your reply to the above address as soon as possible would be appreciated.

Thank you for your anticipated assistance.

Sincerely,

Suzanne Rutledge

I would be delighted to have you use the scales. Let me know if I can be of assistance. Cathy

Suzanne Rutledge, B.S.W., R.S.W.
Psychogeriatric Services
(204) 831-2180
fax: (204) 895-2076

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2109 Portage Avenue • Winnipeg • Manitoba • R3J 0L3 • Telephone (204) 837-1301

March 27, 1995

WALMYR Publishing Co.,
P.O. Box 24779
Tempe, AZ
85285-4779

To Whom It May Concern:

I am writing to express my interest in utilizing the Index of Clinical Stress (ICS) developed by Neil Abell and the Child's Attitude Toward Mother Scale developed by Walter W. Hudson. I would like to utilize these scales in my practicum for the completion of my Master's Degree in Social Work.

Could you please advise me as to where I must direct a letter to obtain the permission to utilize these scales. Your reply, as soon as possible, would be greatly appreciated as I will be needing these scales in late Spring.

Thank-you very much for your time and attention to this matter.

Sincerely,

Suzanne Rutledge

Suzanne Rutledge, B.S.W., R.S.W.
Psychogeriatric Services
(204) 831-2180

WALMYR Publishing Company

April 10, 1995

Ms. Suzanne Rutledge
Psychogeriatric Services
Deer Lodge Centre
2109 Portage Ave.
Winnipeg, MB R3J 0L3

Dear Ms. Rutledge:

We are pleased that you have decided to use our scales in your practicum. Our scales are copyrighted and cannot be copied, reproduced or altered in any manner. Upon purchase of the instrument you do not need permission to use the instruments in your practicum.

Instruction on the use and the scoring of the instruments can be found in the *Walmyr Assessment Scales Scoring Manual.* Enclosed is information concerning the purchase of the instruments and manual.

If we can be of further assistance, please do not hesitate to contact us. Good luck with your project.

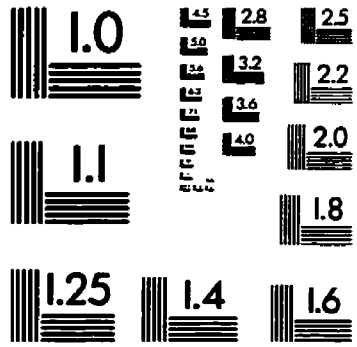
Sincerely,

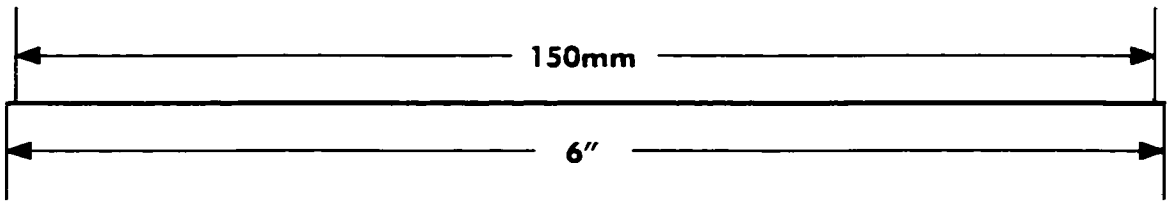
Myrna Hudson
Executive Director

Enclosures

P.O. Box 24779 • Tempe, AZ 85285-4779 • (602) 897-1040 • FAX (602) 897-8168

TEST TARGET (QA-3)





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