ATTACHMENT-BASED GROUP THERAPY FOR MOTHERS AND CHILDREN AFFECTED BY DOMESTIC VIOLENCE

BY

SHANNON LEIGH GREEN ROSS

A Practicum 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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DEDICATION AND ACKNOWLEDGEMENTS

This practicum is dedicated to the women and children who participated in the Mother-Child program. Without their enthusiasm and dedication this practicum would not have been possible. The participants willingly shared their stories of hardship and adversity in ways that demonstrated strength and resiliency. Thank you for your courage.

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ABSTRACT

Empirical research suggests that children affected by domestic violence experience internalizing and externalizing behaviours, while mothers display elevated levels of parenting stress. These interrelated factors may undermine the mother-child relationship. Research has begun to study the effects of domestic violence from a systemic perspective, focusing on family functioning, rather than on individual adjustment. Dyadic mother-child therapy is intended to ameliorate the harmful effects of domestic violence, enhance the resiliency of individual members and strengthen the mother-child relationship.

A time-limited, structured and closed group work approach which incorporated Theraplay and attachment theory was utilized. The Mother-Child group was comprised of a concurrent mothers' and children's group and a parent-child multi-family group component for mothers and children.

The twelve session group initially consisted of seven mother-child dyads, ranging in age from eight to ten years old. At termination, a total of four mother-child dyads remained. The outcomes were evaluated using the *Parenting Stress Index* (PSI), the *Child Behaviour Checklist* (CBCL) and the *Kansas Parental Satisfaction Questionnaire* (KPS). The evaluative results indicated that the group was moderately beneficial to group members.

TABLE OF CONTENTS

LIST OF TABLES

CHAPTER ONE: OVERVIEW OF PRACTICUM

The intention of this practicum was to acquire knowledge and proficiency in the implementation, facilitation and evaluation of a therapeutic group intervention designed to enhance the parent-child relationship for mothers and children affected by domestic violence. This overview chapter will outline the relevance and rationale for this practicum, the context for implementation, a statement of my learning objectives and the goals of the intervention.

Rationale and Relevance to Social Work Practice

Sanders (1999) suggested that the quality of family life is essential to the well-being of children. In general, family relationships and specifically the parent-child relationship have an overwhelming influence on the psychological, physical, social, and economic well-being of children. Numerous significant mental health, social, and economic problems have been associated with disturbances in family functioning and the breakdown of family relationships. Research has consistently linked the physical, social and psychological problems of children to domestic violence (Evans & Shaw, 1993).

Domestic violence is usually not an isolated problem in an otherwise well-functioning family. In 30 to 60 percent of families in which domestic violence occurs, child maltreatment is also present (Cox, Kotch, & Everson, 2003; Folsom, Christensen, Avery & Moore, 2003; Fritz, 2000; Salcido Carter, Weithorn, & Behrman, 1999). Recently, research has begun to shift attention towards the effects of domestic violence on family functioning rather than on individual adjustment (Levendosky, Lynch, & Graham-Bermann, 2000). As a result, it would be beneficial to view the social problem of domestic violence from a systemic perspective and treat both members of the mother-

child dyad in conjunction, in cases where domestic violence has occurred. In this instance, mother-child therapy is intended to ameliorate the adverse effects of domestic violence, enhance the resiliency of individual members and subsequently strengthen the relationships between remaining members of the family unit.

Society has long acknowledged domestic violence against women as a serious societal problem; however, children in these families have remained largely "silent" and "forgotten" victims (Boyd Webb, 1999; Graham-Bermann & Hughes, 2003; Koverola & Heger, 2003; Salcido Carter et al., 1999). Violence against women gained awareness during the women's movement in the early 1970s, while public awareness of children's exposure to domestic violence did not emerge until the late 1980s (Folsom, Christensen, Avery, & Moore, 2003; Graham-Bermann & Hughes, 2003). Interventions and treatment were developed for each population disjointedly. It has not been until recently that interventions have surfaced that have logically joined this interrelated dyad - mother and child.

Koverola and Heger (2003) suggested that the realities of children exposed to domestic violence could not be recognized until the gulf between the battered women's advocacy movement and the child abuse advocacy movement had been linked. Each advocacy movement was diverse in its mission, mandate and historical development. The child advocacy movement was mandated to focus on the safety of the child, while the women's advocacy movement responded to the needs of the women and provided safety for the adult victim. Although tension and intense distrust were evident and still persist significant progress has been made in bridging these two movements.

A mounting body of knowledge regarding the prevalence and effects of childhood exposure to domestic violence has augmented concern about children's exposure to this

(Anderson & Cramer-Benjamin, 2000; Cox, Kotch, & Everson, 2003; Cummings, Pepler, & Moore, 1999; English, Marshall, & Stewart, 2003; Feerick & Prinz, 2003; Fritz, 2000; Graham-Bermann & Hughes, 2003; Henning, Leitenberg, Coffey, Bennett & Jankowski, 1997; Koverola & Heger, 2003; Litrownik, Newton, Hunter, English & Everson, 2003; McFarlane, Groff, O'Brien & Watson, 2003; Salcido Carter et al., 1999; Stiles, 2002; Wolfe, Crooks, Lee, McIntyre-Smith, & Jaffe, 2003).

Research estimates that between 3.3 million (Carlson, 1984) and 10 million children in the United States are exposed to domestic violence each year (Fritz, 2000). Nearly two decades of empirical studies indicate that children exposed to domestic violence can sustain significant harmful effects to their behavioral, emotional, social and cognitive development (Feerick & Prinz, 2003; Graham-Bermann & Hughes, 2003; Kitzmann, Gaylord, Holt, & Kenny, 2003; Salcido Carter et al., 1999; Wolfe et al., 2003). Retrospective studies indicate that negative effects may carry on into adulthood, including depression, low self-esteem, violent practices and criminal behaviour (Karp & Butler, 1996; Salcido Carter et al., 1999).

Women's shelters of the 1980s were the primary setting for many interventions that were developed for children. The first programs were designed in a group-format to provide support, as well as to reduce problem behaviour and to enhance coping of children exposed to domestic violence. Graham-Bermann and Hughes (2003) provided evidence that attested to the effectiveness of early intervention. In their studies, comparisons of pre-to post-intervention functioning demonstrated that children exhibited fewer behavioural problems and enhanced their coping as a result of group interventions.

During the 1990s, researchers began to focus on clarifying the mechanisms by which the impact of exposure to domestic violence originates, and identified moderators

to the impact. Graham-Bermann and Hughes (2003) identified direct and indirect mechanisms that were moderators to the impact of violence and were theorized to have implications for treatment. Direct mechanisms included both the modeling of aggressive behavior and stress in the family. The modeling of aggressiveness was theorized to strongly influence the externalizing type behaviors (e.g., disobedience, aggressiveness) and the impact of stress was assumed to be reflected in internalizing type behaviors (e.g., anxiety, depression, trauma symptoms). Indirect mechanisms such as characteristics of the parent-child relationship, parenting stress, and disciplinary practices were believed to exert their influence on the child's adjustment (Anderson & Cramer-Benjamin, 2000).

Graham-Bermann and Hughes (2003) presented evidence that supports the notion that interventions are most successful when attention is directed towards ameliorating children's symptoms as well as parenting education and support. The authors described an intervention that was designed to foster resiliency and to enhance children's recovery from the potentially traumatic effects of exposure to domestic violence. The Kids Club was a 10 week program that provided support to children between the ages of 5-13 years old and their mothers. The intervention was designed to educate the children about violence, help children identify feelings associated with the violence, change social cognitions and to develop effective coping and social skills. The researchers evaluated the program from a sample of 221 families where children were randomly assigned to child-only interventions, child-plus-mother interventions, and no intervention (comparison group). Graham-Bermann and Hughes (2003) concluded that children in all three groups demonstrated improvement in internalizing problems over time; however, change was strongest for those in the child-plus-mother groups, followed by those in the

child-only intervention, and with the least improvement occurring in the comparison group.

Currently, numerous programs throughout the country have integrated both child protective services and domestic violence services (Koverola & Heger, 2003). Also, programs abroad have been established to enhance family protective factors and reduce risk factors associated with severe behavioral and emotional problems in preadolescent children through multilevel parenting and family support strategies (Sanderson, 1999).

Prinz and Feerick (2003) highlighted the need for further research that examines the "impact of domestic violence on parenting, family functioning, and the family system, with particular attention to both competent and compromised parenting and family functioning and the context in which the child is developing" (p.217). Future research should focus on how domestic violence affects parenting and child-caregiver interaction, and should examine the impact of exposure to domestic violence on the ability to form and maintain relationships. Additionally, an understanding of attachment theory could provide social work researchers and clinicians with an approach to plan programs and interventions directed towards ameliorating the detrimental effects of domestic violence on women, children and their relationship with one another (Page, 1999).

Lantz and Raiz (2003) proposed how play can facilitate child and family trauma therapy treatment through the dynamics of holding, telling, mastering and honoring. Play can facilitate work with traumatized children and their parents because the treatment methods of play communication match the language of childhood. Play becomes the vehicle through which the family can process and master their pain.

Researchers have advocated for a multidimensional approach when treating abused children (Boyd Webb, 1999; Gil, 1991). Gil (1991) suggests that treatment

consists of an array of services including individual, parent-child, group and family therapy.

In summary, the Mother-Child group is an innovative program designed to improve outcomes for mothers and children exposed to domestic violence and to enhance the mother-child relationship within a multi-family group format.

Implementation Context

This practicum was undertaken at the Elizabeth Hill Counselling Centre, 301-321 McDermot Avenue, Winnipeg, Manitoba. The agency provides services to parents and children who have been affected by domestic violence. The Mother-Child Group Program offers services to mothers and their children (age 7 to 10 years old) who are experiencing emotional or behavioral difficulties and aims to enhance their interactions and the parent-child relationship. The program was based upon the "Theraplay" model developed by Ann Jernberg (Jernberg & Booth, 2001) and was adapted by employees of the agency (RESOLVE, 2002). A healthy parent-child relationship, as defined by the Theraplay model, is based on four dimensions: structure (establishing boundaries to ensure the child is safe and that his/her needs are consistently being met), nurture (calming, reassuring and comforting the child), engagement (encouraging interaction that stimulates and engages the child), and challenge (encouraging the child to master new behaviors by providing opportunities for success) (Jernberg & Booth, 2001; RESOLVE, 2002).

The interventions in this practicum were developed based upon documented literature on interventions for mothers parenting children exposed to domestic violence

and incorporated various components that have been identified in helping women and children heal.

Intervention Goals

The Mother-Child Group was a 12 week program that involved an individual group for mothers, a concurrent group for children, and a multi-family parent-child group component. During the two-hour weekly group sessions, one hour was devoted to the mother's group and children's group, respectively, and one hour was allocated to the parent-child multi-family group (see Appendix A). Individual family work and advocacy occurred between group sessions as needed to address environmental factors and stressors. The content of the sessions covered topics relevant to the mothers' understanding of the impact of violence on the parent-child relationship; the children developed social skills and learned to express their feelings in more socially appropriate ways. Sessions included the use of play and age-appropriate activities aimed at strengthening the parent-child relationship and the related topic of the session.

In general, the goals of this intervention were to assist women and children to understand the ways in which they had been impacted by the domestic violence, to help mothers increase their effectiveness as parents, to help children deal with their feelings about violence and transformation in their families, and to strengthen the mother-child relationship. Following the conclusion of the group, an evaluation occurred to determine the effectiveness of the intervention on target variables.

Learning Objectives

The learning objectives for this practicum involved the development of knowledge and skills in the area of interventions designed to strengthen the parent-child relationship for women and their children who have been exposed to domestic violence.

Throughout the implementation of this group intervention it was my goal to achieve the following personal learning and intervention objectives:

Personal Learning Objectives.

1. To enhance my knowledge and understanding of the risk and protective factors associated with domestic violence for women, children and the mother-child relationship;
2. To enhance my group facilitation skills, my ability to work with a co-facilitator and to learn more about group dynamics and processes within this population;
3. To develop intervention skills in attachment-based therapy, multi-family group therapy and Theraplay techniques.

Intervention / Practice Objectives.

1. To implement a group intervention for mother-child dyads exposed to domestic violence;
2. To strengthen the mother-child relationship through attachment-based therapy;
3. To enhance maternal parenting whereby reducing emotional and behavioral difficulties experienced by children.

The following chapter will elaborate on the characteristics identified in the literature on the impact of family violence on women and children, the effect on the parent-child relationship, the relevant aspects of group interventions implemented with this population, and a review of the efficacy of these interventions. The third chapter will provide a detailed outline of the intervention as it was undertaken within this practicum and an account of how the evaluation was accomplished. The fourth chapter will provide discussion about the client's experiences, stages of group development and dialogue how the four dimensions of Theraplay were incorporated within the group intervention. The fifth chapter will discuss how the personal learning objectives and intervention/ practice evaluation occurred throughout the practicum experience. The last chapter will provide some commentary on the strengths and limitations of the intervention given the identified needs of this population.

CHAPTER TWO: LITERATURE REVIEW

Definitions

Despite the controversy and complexity of conceptualizing and operationalizing the term domestic violence, researchers continue to document a strong and consistent relationship between such violence and children's adjustment (Graham-Bermann & Edleson, 2001; Holden, 2003). For the purpose of this practicum, the Barnett, Miller-Perrin, and Perrin, (1997) definition of the term, "*domestic violence*" will be used: "a continuum of behaviors including physical aggression, sexual assault, neglect, financial exploitation, and many forms of psychological maltreatment such as verbal denigration, terrorizing rejection, and exposing other family members to the observation of violence" (p. 277).

The term "*partner*" includes those individuals who are legally married, common-law, cohabiting, involved in an intimate relationship, or are separated and living apart from their former partner. Typically, researchers have broadly defined "*children's exposure*" to domestic violence, as children's exposure to physical violence (Graham-Bermann, & Edleson, 2001; Grych & Fincham 2001). However, Holden's (2003) proposed taxonomy of children's exposure to domestic violence specifies ten discrete categories. Children may be exposed: prenatally; through their verbal or physical attempts to intervene; through verbal or physical victimization during an incident; through coercion to participate; through direct eyewitness observation; indirectly by overhearing; through the observation of the initial effects (bruises or injuries, police intervention, property damage and intense emotions); experiencing the aftermath (maternal depression, change in parenting, separation from father, relocation); told or

heard about violence (through mother, sibling, relative or counsellor), or may be seemingly unaware.

Impact of Domestic Violence on Children

Emotional and Behavioral Problems.

The effects of children's exposure to domestic violence can be quite varied depending on the type, intensity, severity, and frequency of domestic violence (Graham-Bermann & Hughes, 2003; Holden, 2003; Prinz & Feerick, 2003). Anderson and Cramer-Benjamin (2000) identified a number of factors that appear to affect children's level of distress and adjustment as a result of exposure to domestic violence. These include the severity and frequency of the violence, the content of the parent's disagreements, the child's relationship to the perpetrator and victim, the extent to which parents are able to resolve their conflicts, and children's level of involvement in parental conflicts.

Despite the common misconception that domestic violence typically occurs out of view of the children, interviews with children from violent homes suggest that between 40 and 80 percent of these children have witnessed their fathers assaulting their mothers. Various forms of violence such as domestic abuse and child abuse frequently occur concurrently (Anderson & Cramer-Benjamin, 2000). Researchers have indicated that the overlap between child abuse/maltreatment and domestic violence toward mothers is between 30% (Fritz, 2000; Salcido Carter et al., 1999) and 75% (Graham-Bermann & Hughes, 2003). Wolfe, et al. (2003) found that among 114 women interviewed by a telephone survey, almost 25% of their children were reported to have been physically involved in a violent incident, and over 50% verbally intervened while in the same room.

Negative effects can result from exposure to domestic violence, particularly increased internalizing and externalizing behavior problems and decreased social competence, school achievement and general health functioning (Boyd Webb, 1999; Fainsilber Katz, 2001; Gil, 1991; Graham-Bermann, & Edleson, 2001; Levendosky, & Graham-Bermann, 2001; Levendosky et al., 2000; Morrel, Dubowitz, Kerr & Black, 2003; Stiles, 2002; Wolfe et al., 2003). These effects may include problems such as anxiety, fear, guilt, denial, poor concentration, irritability, hypervigilence, aggression, phobias, insomnia, poor problem-solving, low self-esteem, low levels of empathy and depression (Anderson & Cramer-Benjamin, 2000). Chronic and extreme exposure may result in symptoms consistent with post-traumatic stress disorder (Fritz, 2000) and difficulties regulating emotional affect (Folsom et al. 2003).

Studies suggest that boys and girls respond differently to witnessing domestic violence. Generally, boys are more likely to exhibit externalizing symptoms such as anger, defiance and aggression and girls are more likely to display internalizing behaviors such as depression and withdrawal (Anderson &Cramer-Benjamin, 2000; Graham-Bermann & Hughes, 2003). Also, boys are generally more at risk for physical child abuse than girls in families with domestic violence. The findings of Cummings et al. (1999) indicated that violence has more harmful long-term consequences on the development of girls rather than boys. A larger percentage of girls than boys obtained clinical range scores indicating the need for clinical intervention in their study. The amount of violence witnessed and the degree of mother-child aggression were significantly better predictors of girls' rather than boys' behavior problems in relation to externalizing problems. They surmised that girls internalize responsibility and

consistently manifest greater interpersonal sensitivity, theorizing that this was due to gender socialization or innate behavioral dispositions.

Theorists believe that exposure at any age can create disruptions that can interfere with the accomplishment of developmental tasks, but the earlier the exposure, the more disruptions on subsequent developmental tasks. Researchers advocate for prevention and earlier intervention so that children and adults may be spared years of pain and developmental upheaval (Graham-Bermann & Edleson, 2001).

Henning et al. (1997) found that both male and female undergraduate students who witnessed interparental physical conflict reported higher levels of current psychological distress. Depression, low-self-esteem, violent and criminal behavior may persist into adulthood as indicated by retrospective studies (Salcido Carter et al., 1999).

Researchers using comparison groups noted that children exposed to domestic violence had higher rates (approximately 50%) of both internalizing and externalizing behavior problems, lower self-esteem, and more difficulties in school relative to children raised in nonviolent families (Graham-Bermann & Hughes, 2003). Studies have indicated that children exposed to both domestic violence and child maltreatment generally exhibit higher levels of distress than children exposed only to domestic violence (Salcido Carter et al., 1999; Graham-Bermann & Hughes, 2003). In contrast, the meta-analytic review by Kitzmann et al. (2003) suggested that children exposed to domestic violence as well as physical abuse did not show significantly worse outcomes than children exposed only to domestic violence, suggesting that violence anywhere in the family may be sufficient to disrupt child development.

Nonetheless, children exposed to multiple forms of violence have been identified as high risk for negative outcomes and frequently those most in need of intervention

services (Graham-Bermann & Hughes, 2003). In addition, the presence of other stressors such as family structure and processes, poverty, homelessness, substance abuse, and exposure to community violence are believed to intensify the negative effects of exposure to domestic violence (Graham-Bermann & Hughes, 2003; Prinz & Feerick, 2003; Salcido Carter et al., 1999).

Protective Factors.

The meta-analytic review by Kitzmann et al. (2003) indicated that 63% of child witnesses fared more poorly than the average child who had not been exposed to domestic violence. Notably, however, this result can be interpreted to mean that 37 % of the child witnesses showed outcomes that were similar to, or better than, those of children who had not witnessed domestic violence. Consequently, this lends optimism to the belief that children exposed to domestic violence may develop resiliency to the substantial negative effects.

Researchers have advocated for the use of study designs and methodologies that can more fully describe the natural variation that occurs among children and their experiences within a developmental framework (Prinz & Feerick, 2003; Wolfe et al., 2003). Kitzmann et al. (2003) articulated five suggestions for continued research on the topic of children who witness domestic violence. They suggested that increased attention be directed toward: distinguishing mild or moderate forms of physical aggression from more severe examples of violence; identifying the processes by which domestic violence affects child development; assessing children's specific cognitive, emotional, and behavioral responses to inter-adult conflict; identifying children's sub clinical distress as well as resiliency; and utilizing more complex methodologies, appropriate for testing

more complex models of associations between interparental aggression and child outcomes.

A large-scale longitudinal and intergenerational study was conducted for children exposed to violence to delineate the consequences of exposure to violence at different developmental stages and to identify both risk and protective mechanisms that operate over time and across generations. Researchers concluded several factors strengthen the child's ability to cope or increase their risk for harm. The child's individual personality characteristics, family situation and community environment all interact to exacerbate or ameliorate the effects (Prinz & Feerick, 2003).

The most critical protective factor for children is the existence of a strong, positive relationship between the child and a competent and caring adult. The child needs to be able to speak freely and openly with a sympathetic adult, preferably with someone who can intervene to improve the situation (Salcido Carter et al., 1999). Children often rely on one or both parents to provide a nurturing and supportive environment in the face of crises and emotional adversity.

Mothers enmeshed in relationships characterized by chronic domestic violence may be less emotionally available to their children due to preoccupations with safety and feelings of depression which can thwart their parenting efforts (Salcido Carter et al., 1999). Graham-Bermann and Hughes (2003) associated parenting stress and the presence of multiple forms of violence as linked to more negative outcomes for children exposed to the abuse of their mothers. As with children's individual characteristics in resiliency, mothers' emotional availability may be critical to children's ability to cope with the exposure (Salcido Carter et al., 1999).

Graham-Bermann and Hughes (2003) summarized that it is imperative to look beyond individual psychopathological outcomes to create a better understanding of children's problems, including an ecological approach focusing on both risk and protective factors of a child's life.

Impact of Domestic Violence on Women

Emotional and Behavioral Problems.

Researchers estimate that 21 % to 34% of women will be assaulted by an intimate partner during their lifetime (Levendosky et al., 2000). This figure represents a significant portion of women in society who may experience the detrimental impact of domestic violence. Women's mental health can suffer long-term negative consequences from victimization (Morrel et al., 2003). Women who are abused experience increased levels of depression, anxiety, lower self-esteem, and higher levels of psychological distress than non-abused women (Levendosky et al., 2000). Levels of depression can be a predictor into the severity of physical abuse. The prevalence of post-traumatic stress disorder (PTSD) in abused women is notably high, ranging from 45% to 84% (Levendosky & Graham-Bermann, 2001).

Morrel et al. (2003) have suggested that women with a history of victimization are at increased risk for mental health problems, particularly depression, which may undermine their parenting. Mothers with sexual victimization histories report less knowledge of parenting skills, less satisfaction with themselves as parents and greater use of physical conflict tactics with their children. Studies indicate that women with victimization histories display more behavioral, emotional, and parenting difficulties than women who have not been victimized. Current research supports the negative impact of

maternal victimization on children. Mothers who have been victimized demonstrate depressive symptomatology, and engage in harsh parenting, resulting in more problem behaviour in their children.

Impact of Domestic Violence on Mothering and the Mother-Child Relationship

The impact of domestic violence and other relationship processes like marital conflict appears to have both direct and indirect impacts on children (Anderson & Cramer-Benjamin, 2000). Direct effects have been defined as the actual signs and symptoms that emerge in children as a result of being exposed to domestic violence, whereas indirect effects generally involve effects on children resulting from the disruption in parenting practices.

The effect of domestic violence on mothering can begin during pregnancy and childbirth (Allanson & Astbury, 2001; Graham-Bermann & Edleson, 2001). It has been documented that the risk of moderate and severe domestic violence are greater for women during pregnancy and women who are abused in pregnancy seem to be at greater risk of homicide. Miscarriage and low-birth weight babies are also more widespread among this population (Graham-Bermann & Edleson, 2001). Simpson, Rholes, Campbell and Wilson (2003) noted changes in attachment orientation of mothers across the transition to parenthood. The findings of their study indicated that women became more ambivalent across the transition if they entered parenthood perceiving less partner support and more partner anger, and those whose partners were higher in avoidance became more avoidant across the transition.

There are limited studies on the effects of domestic violence on parenting and the effects of maternal parenting on children's adjustment. Overall, however, researchers

suggest that domestic violence creates stress in parenting that can negatively affect parenting behaviours (Anderson & Cramer-Benjamin, 2000; Graham-Bermann, & Edleson, 2001; Graham-Bermann, & Hughes, 2003; Levendosky & Graham-Bermann, 2001; Morrel et al., 2003; Salcido Carter et al., 1999).

Anderson and Cramer-Benjamin (2000) suggested that children are affected by violence within the family, indirectly, through the quality of the parent-child relationship. Recent evidence suggests that many of the effects of children witnessing domestic violence are mediated through the parenting relationship. Violence within the home is likely to affect children by making each parent less emotionally and physically available to the child and less effective as a caretaker. Men who behave abusively have been described by their partners as more "irritable, less involved in child rearing, less physically affectionate, less likely to use reasoning in response to children's misbehavior, and more likely to use physical punishment and power-assertive responses," (Anderson & Cramer-Benjamin, 2000, p.6). Subsequently, children may become more emotionally needy, and their behavior may become more difficult to manage.

Tension and conflict in the couple subsystem may "spill over" into other subsystems, including the parental and sibling subsystems (Anderson & Cramer-Benjamin, 2000; Cox, Paley & Harter, 2001; Holden & Ritchie, 1991). Conflict is a risk factor for children because power struggles that occur in the parental system are accompanied by "intensification of either intimacy, rejection or both in the parent-child relationship which is also accompanied by symptomatic behaviors in the child" (Margolin, Oliver, & Medina, 2001, p.12). Anderson and Cramer-Benjamin (2000) stated that "emotional negativity in the form of overt hostility towards the child or withdrawal from, or neglect of, the child is associated with children having internalizing

and externalizing problems," (p.6). When children are exposed to aggression or conflict they exhibit physiological, emotional and behavioral arousal that can last well beyond the incident.

Parents involved in aggressive, highly conflictual relationships have been found to display two styles of parenting: inconsistent, lax discipline or a coercive, power-assertive, authoritarian style (Anderson & Cramer-Benjamin, 2000). In fact, 34 % of the women in this study reported frequently changing their child-rearing behavior in their partner's presence (presumably to avoid invoking their partner's anger). Margolin et al. (2001) highlighted empirical evidence indicating that parents involved in relationship discord use more "power assertive punishment, less positive reinforcement, and more inconsistent discipline" (p.26). Relationship discord can disrupt the parenting process, which in turn, could potentially result in adverse consequences for children.

Social learning theorists suggest that children learn aggressive behavior from the observation of aggressive models. When children are exposed to conflict and models of angry and hostile behavior, they are not being provided with models of warmth, caring, and productive problem-solving (Margolin et al. 2001). A connection has also been made between marital conflict and less sensitive, responsive parenting and children's insecure attachment to their parents. The "emotional security hypothesis," conceptualizes how parental conflict may threaten the emotional aspects of parent-child relationship, and the emotional integrity of the family system (Cox et al., 2001).

The child's level of emotional attachment to the perpetrator and victim will determine the degree of trauma experienced by the child. Children display the strongest negative reactions if the violence involves a parent or caregiver with whom they are close (Anderson & Cramer-Benjamin, 2000). Levendosky and Graham-Bermann (2001)

focused their study on the interrelated effects of domestic violence on women and children with regard to parenting. The theoretical model integrated the ecological perspective and trauma theory to propose hypotheses about the mediating factors for the effects of domestic violence on women and children. They theorized that the parenting context (violence) impacts parenting behaviours (warmth, control, and effectiveness) through its traumatic effects on the women's psychological functioning. The research reported that poor parenting was related to lower psychological functioning. They postulated that if women had been abused and suffered depression for a substantial period of time, the child might be unable to form a secure attachment with the mother, thus indicating a need for treatment in this area.

Morrel et al. (2003) support the notion that women who are victimized suffer from emotional and behavioral consequences that can hinder effective and nurturing parenting, which can negatively impact their children's development and behaviour. They advocated for treatment of victimized mothers that reduces their depressive symptoms and promotes adaptive parenting practice which may lead to fewer behaviour problems in their children.

In the aftermath of domestic violence mothers may experience difficulties with parenting; children simultaneously may exhibit difficult behaviour as they process the violence they have witnessed or experienced. Parenting practices have been significantly correlated with children's adjustment in families affected by domestic violence which suggests intervention in this area (Anderson & Cramer-Benjamin, 2000; Graham-Bermann & Edleson, 2001; Graham-Bermann & Hughes, 2003; Levendosky & Graham-Bermann, 2001; Morrel et al., 2003; Salcido Carter et al., 1999).

Graham-Bermann and Edleson (2001) contend that research that focuses on mothering mostly documents the harm and negative impact of abuse on women's behaviour or capacity to parent and protect children. These studies perpetuate negative stereotypes about abused women and deficient mothering. An important fact to consider is that mothers may be inconsistent with their parenting because of the abusive, controlling, and isolating behaviour of their partner related to the dynamic of that particular relationship. Research needs to shift its focus from mother-blaming to look for more constructive ways of developing empowering and effective social supports for mothers and children surviving abuse.

Protective Factors.

Factors that serve a protective function are parental competence, mother's mental health and the availability and strength of social support and resources (Graham-Bermann & Edleson, 2001). Grych and Fincham (2001) claimed that the main effect of healthy childhood development can be attributed to parenting effectiveness. There is consensus that parental behavioral patterns such as responsiveness, sensitive control, warmth and parental effectiveness in discipline, supervision and monitoring can promote optimal child development and provide a protective factor against adverse stressors.

Levendosky et al. (2000) conducted a study that used women's narratives to describe how their parenting was affected by domestic violence. The majority of the women reported that their parenting was affected by their partner's violence. Women reported not only negative influences of the violence on their parenting but also some positive effects such as mobilizing their resources to respond to the violence on behalf of their children. Furthermore, the authors described women's responses to the violence:

"as providing increased empathy and caring or explicit guidance about the importance of not repeating the violence, (which) suggests methods of actively working to prevent or buffer the impact of the violence on their children," (p. 267).

In addition, participants in their study identified concerns about financially providing for their children, the impact of their emotional and physical well-being on their parenting, and worries about their children's emotional and physical needs. Specifically, many women emphasized the difficulty of meeting children's needs as single and distressed parents (Levendosky et al., 2000).

Graham-Bermann and Edleson (2001) contend that when the mother and children are no longer in the abusive situation, outcomes for both tend to improve. Many women who have left abusive situations report an increased sense of enjoyment regarding parenting and are very emotionally supportive toward their children. Distinctions need to be drawn between the difficulties of parenting while living with an abuser and the possible difficulties after separation. Parenting after separation may be stressful both because the mother is unable to cope with a myriad of factors and because the children may be exhibiting signs of distress or difficult behaviour as a result of the violence. Separation becomes the crucial period of time to begin to rebuild the damaged mother-child bond and to ameliorate the harmful consequences that the violence has had.

Attachment Theory

Given the diversity of needs identified for this population it would be beneficial to work from a theoretical orientation that is inclusive of the factors. Attachment theory addresses a constellation of factors including a "biological or behavioral component, an emotional or psychodynamic component, and a social or systemic component that

addresses issues of communication and interpersonal interaction," (Pickover, 2002, p. 358).

Bowlby (1969; 1973; 1980; 1988), the founder of attachment theory, theorized that children had a biological predisposition to form attachment relationships and that these begin in mother-infant interactions. Bowlby theorized that the nature and quality of this attachment relationship is profoundly determined by the caregiver's emotional availability and responsiveness to the child's need for a secure base (Finzi, Ram, Har-Even, Shnit, & Weizman, 2001; Vadas, 2002). He believed that the pattern of attachment a child develops during the early years of life will affect the individual's development and the extent to which he or she becomes resilient to stressful life events.

Maccoby (1980) defined attachment as a relatively lasting emotional tie to a specific other person. Liddle and Schwartz (2002) broadly defined attachment as a reflection of one's level of confidence that significant others will provide support and protection and will remain within emotional proximity. Vadas (2002) defined attachment as an affective bond implying strong emotions and the full spectrum of emotion and feelings from the child to the parent/caregiver. Attachment can be demonstrated in infancy and early childhood by the child seeking to be near the other person, showing distress upon separation from that person, showing happiness or contentment upon reunion, and being oriented toward that person even when not in close proximity i.e.) listening for the person's voice, watching the person's movements, and directing actions toward that person. The child's choice of attachment object does not have to be the biological mother. However, first and strongest attachment is almost always the biological mother or primary caregiver (Maccoby, 1980).

Attachment promotes the development of life skills that are necessary for successful interaction with the environment and is the main influence in the development of internal relationship models. Internal working models guide an individual's behavior toward others, enable the individual to interpret and anticipate the behavior of others, and serve as a template for current and future relationships (Byng-Hall, 2002). Page (1999) proposed that a child will internalize in their memory characteristic patterns which have accumulated over time, of a parent/caregiver's response to the children's expression of attachment behavior. These internalized memories are reflected back to the child and form his/her appraisal of worthiness to receive care and comfort. However, Bolen (2000) cautioned that internal working models are not determined solely by past relationships but that they work reciprocally in current relationships, that working models can be revised throughout one's lifetime.

Attachment Styles

Attachment theorists divide attachment style into four categories based on scientific observation (Ainsworth, 1992). Central to all attachment formulations is the basic distinction between individuals who have developed a secure attachment versus those whose attachment is of an insecure nature (Bowlby, 1988). All attachment styles are considered adaptive in nature. It has been theorized that an infant develops the form of attachment that best matches the availability of the caregiver (Johnson, Ketring, Abshire, 2003; Vadas, 2002).

Ainsworth (1992) studied infant-caregiver attachment in what was called the strange situation, involving numerous separations and reunions of the infant and caregiver. A classification scheme was developed to describe the qualities of these types

of infant-caregiver attachment (Bowlby, 1988; Maccoby, 1980). Based on studies of countless mother-infant interactions she described four attachment styles. The first, the secure attachment style, was characterized by infant behavior in which the infant explored freely in the presence of the caregiver, checking on her periodically (Ainsworth, 1992). Byng-Hall (2002) stated that a secure attachment supports autonomy because the child is confident that the parent will be available to protect them when needed. When the infant became separated from the mother/caregiver he/she became distressed to varying degrees, but was content when she returned. Allanson and Astbury (2001) described secure attachment when "children experience their primary caregiver as available and appropriately accessible and responsive to their needs, they gradually develop a secure representational schemata or internal working model of relationships that confirms others as trustworthy and as sources of comfort," (p.146). Secure attachment is "crucial to the development of a strong sense of self, feelings of self-worth and self-confidence, a sense of trust and security, and the capacity to form healthy, mutually satisfying relationships" (Perry & Gerretsen, 2002, p.58).

In contrast, the development of three types of insecure attachment was related to an internal working model that accurately reflected disrupted or unpredictable care giving practices (Allanson & Astbury, 2001). The first insecure attachment style was the insecure/ avoidant style, where the infant explored without interest in the mother/caregiver's presence, was minimally distressed when they were separated, and seemed to ignore her upon her return (Ainsworth, 1992). The infant developed an avoidant style to adapt to the relationship with a parent/caregiver who had been either rejecting or unusually unresponsive (Bowlby, 1988; Maccoby, 1980). Finzi et al. (2001) suggested that avoidant behavior becomes a defense mechanism in response to prolonged

unresponsiveness, rejection, hostility, and serves to lessen the child's anxiety and anger, but can result in a lack of empathy, and antisocial and aggressive behavior. Allanson and Astbury (2001) commented that the insecure avoidant type involved distancing from others and as a consequence an inability to form deep relationships.

The second insecure attachment style was the insecure/ambivalent/anxious or resistant style. The infant exhibited restricted play, was intensely distressed when separated from the mother/caregiver and focused intensely upon the mother/caregiver upon her return and had difficulty returning to play (Ainsworth, 1992). According to Byng-Hall (2002) the child has learned that the parent is only intermittently emotionally available; often the caregiver is pre-occupied with unresolved emotional issues from the past. The child begins to exhibit demanding behavior in an attempt to get attention and the child's behavior may not correspond with his/her chronological age. Allanson and Astbury (2001) described insecure anxious attachment as typified by ambivalence and a "tendency to make excessive demands on others and to be anxious and angry when those needs are not met," (p.146).

The third insecure attachment style, the insecure/disorganized/disoriented style, develops later on in infancy and is characterized by the infant who appears confused or frightened by the mother/caregiver (Ainsworth, 1992). Often, this infant had been abused, or his/her parent had been abused and the infant was reacting to the effects of the parent's trauma and lack of capacity to attach. The infant exhibits unusual behaviors like being unable to approach the mother/caregiver when significantly distressed (Bowlby, 1988; Maccoby, 1980). Bolen (2000) suggested that disorganized children have inconsistent coping strategies and display diverse and sometimes contradictory behaviors upon the attachment figure's return. The author suggested that these children's

attachment figures are "simultaneously the source of and the solution to children's anxiety, (p.131).

Several researchers have suggested the value of using attachment theory as a conceptual model for understanding the role of the parent-child relationship and its consequences for the child's budding self-concept and view of the social world (Byng-Hall, 2002; Finzi et al., 2001; Johnson et al., 2003; Liddle & Schwartz, 2002). Johnson, et al. (2003) indicated that attachment theory could provide an extensive theoretical knowledge base for assessing family functioning. Byng-Hall (2002) explained that attachment theory is the most suitable developmental theory for therapists because it describes the reciprocal processes between a parent and a child. Attachment evolves over time within the context of daily interactions between children and caregivers. An individual's attachment style is rooted in childhood development and provides the context for later emotional, behavioral, and cognitive transactions with the world (Finzi et al., 2001; Johnson et al., 2003; Vadas, 2002). The theory explains the impact of the child-parent emotional bond on the child's personality and behavior.

For the last two decades, attachment theory has been used as a model for conceptualizing and understanding the effects of various forms of violence. It provides perspective into certain family dynamics that appear with some frequency in families affected by domestic violence (Bacon & Richardson, 2001; Bolen, 2000). Liddle and Schwartz (2002) suggested that the quality of the family attachment system is fundamentally defined as a function of the attachment relationships among family members. Families that tend to be characterized by secure attachment among their members have a propensity to be organized, flexible, and cohesive. Families that are

more distant, conflicted and chaotic, however, tend to be characterized by avoidant and insecure attachment.

Intergenerational Transmission Theory

Johnson et al. (2003) suggested that there appears to be an association between the intergenerational transmission of certain aspects of the attachment relationship that can be attributed, in part, to the early mental and emotional models developed by children in relation to adult caregivers. Domestic violence can contribute to long-term negative effects on individual's internal working models (Bacon & Richardson, 2001)

Researchers provided evidence for the concept of intergenerational transmission of attachment and violence. They suggested that a caregiver's response to a distressed child will depend on their ability to accurately empathize with the child, which is strongly influenced by his/her own history in attachment relationships. In addition, physical abuse promotes avoidance attachment styles and increases the likelihood of violent behavior in subsequent relationships (Byng-Hall, 2002; Cassano, 1989; Finzi et al., 2001; Page, 1999).

Attachment literature has focused studies on the effects of abuse on children and found that approximately two thirds of maltreated infants are diagnosed as insecurely attached. Further studies indicated that maltreated infants who were insecurely attached maintained their insecure attachments over time and that maltreated infants who were securely attached developed insecure attachment styles over time. Maltreatment affects infants' future relationships even in the absence of the original mother/caregiver. Children internalize their "working model," of their relationships with these primary attachment figures. These beliefs are enduring and affect children's relationships over

time (Bowlby, 1988;Vadas, 2002). Consequently, insecure attachment styles are pervasive among maltreated infants and affect both present and future development. (Vadas, 2002).

Attachment styles can have far reaching implications. Secure attachment has been linked to healthier personality variables such as lower anxiety, less hostility, greater resiliency and improved ability to regulate affect (Vadas, 2002). Allanson and Astbury (2001) studied pregnant women presenting for an abortion and indicated that women with anxious attachment reported "the most adverse life circumstances and physiologically and psychologically demanding experiences," (p.149). These experiences included the highest incidence of violence, pregnancy, abortion, emotional problems, and poorer education. In contrast, women with secure attachment demonstrated the least association with such experiences. They reported that the higher a woman's attachment rating, the fewer previous pregnancies or abortions she had had, and the higher her education. The secure women demonstrated the lowest incidence of violence and emotional problems. In the study, women with avoidant attachments generally fell somewhere in between these two categories.

Notably, these early templates which children form in relationship with their parents are malleable (Vadas, 2002). Evidence suggests that attachment can vary throughout the lifespan and individuals have reported experiencing different attachment styles within various adult relationships (Johnson, et al., 2003). Relationships other than the parent/caregiver relationship can have considerable impact on the child's development of bonding (Vadas, 2002). A caring nurturing adult can be a buffering figure promoting secure attachment.

Treatment of Attachment Issues

Attachment styles are developed in infancy and are reciprocal in nature. The infant develops either a secure or insecure attachment in response to the attachment style of their primary caregiver. Attachment styles are changeable, and insecure attachments without intervention, will affect both the child's current and future functioning (Byng-Hall, 2002; Vadas 2002). Attachment theory and research indicate that "expectations and patterns of attachment behaviors in children with histories of problematic attachment relationships may gradually change if subsequent relationships develop along different lines," (Haight, Doner Kagle & Black, 2003, p.197). Therefore, it becomes imperative to target both the mother and child dyad to enhance their relationship to prevent adverse long-term consequences. Bacon and Richardson (2001) highlighted numerous studies that demonstrated that support from the non-abusive parent or caregiver is a good mediator to the effects of domestic abuse.

The goal of therapy is to provide ongoing support and guidance for individuals and the family unit, to work through unresolved traumas which have contributed to mistrust and insecure attachment and to establish a protective environment in which these new relationships can be maintained. The aim of therapy is to develop a secure family base, which provides a network of sufficiently reliable attachment relationships so that all members of the family are able to feel secure (Byng-Hall, 2002).

Therapy provides individuals with insecure attachment styles an opportunity to modify these emotional and relational patterns. It is an effective intervention in the treatment of attachment difficulties and can entail a combination of individual child therapy, individual adult therapy, and dyadic or family therapy modalities (Boyd Webb, 1999; Gil, 1991;Vadas, 2002). Byng-Hall (2002) suggested that in order to understand

the complexities of attachment in families, it would be necessary to explore with individuals and dyads initially. Child and family therapy can be combined to create an effective intervention that will achieve the necessary therapeutic goals.

Attachment and Theraplay

In the 1960's, Ann Jernberg developed the Theraplay approach that is strongly rooted in attachment theory. Theraplay focuses on enhancing the interactions and relationship between the child and parent through play and is useful for families who have experienced trauma.

Since attachment formation occurs at a young age, Theraplay activities should be adapted from activities parents would typically do with their infants at those early ages. It is theorized that the child must regress to an earlier stage of development and experience attachment behavior at that earlier stage (Myrow, 1999; Perry & Gerretsen, 2002). The goal of Theraplay is to replicate a style of parenting that enhances a secure attachment for the child. The activities of Theraplay teach the mother how to respond affectionately and empathically to the child's needs (nurture), be actively engaging with the child and create structure. Positive interactions that encourage the elements of a healthy parent-child relationship are addressed through specific activities (Mullen, 1999; Myrow 1999; Perry & Gerretsen, 2002).

Play therapy is considered the treatment of choice for children with insecure attachment patterns. Play provides a natural context for children to process their unconscious anxieties and work through them in a comfortable, safe environment (Boyd Webb, 1999; Vadas, 2002). Including both mother and child in family therapy also provides a preventative intervention aimed at interrupting intergenerational transmission

(Byng-Hall, 2002). Watts and Broaddus (2002) suggest that parents are trained to be therapeutic agents with their own children through a format of didactic instruction, play sessions and supervision. Parents learn basic child-centered play therapy skills including active listening, recognizing children's emotional needs, limit setting, building children's self-esteem in a structured weekly play session. The focus is on the relationship between the parent and the child, not the child and therapist (Schicke Athanasiou & Gunning, 1999).

In addition, group work has been demonstrated to be an effective intervention for this population as well (Boyd Webb, 1999; Gil, 1991; Sweeney & Homeyer, 1999). The group setting provides participants the opportunity to process their experiences with their peers in a supportive environment, which facilitates interpersonal skills and breaks the silence and shame associated with domestic violence. Watts and Broaddus (2002) studied the effectiveness of individual play therapy with child witnesses of domestic violence and compared it to a study using group play therapy with child witnesses of domestic violence. They found both of those approaches to be significantly effective and, in fact, found no difference in effectiveness.

Interventions for Children Exposed to Family Violence

Parent-Focused Interventions.

Interventions with the mothers/caregivers attempt to create a secure base within the family. Liddle and Schwartz (2002) defined a "*secure base*," as a "relational atmosphere that provides family members with access to safety and validation when needed. A secure base facilitates both connectedness to the family and exploration outside the family," (p.457). It is imperative to establish open communication, genuine

responsiveness, validation and engagement between the mother and the child as a way of healing the damaged relationship. Through specific interventions, children and mothers are helped to believe that it is safe to trust one another, despite past disappointments (Liddle & Schwartz, 2002).

Vadas (2002) has demonstrated the effectiveness of therapy for adults with insecure attachment styles in breaking the intergenerational cycle of abuse, based on the reciprocal nature of infant and mother/caregiver attachment patterns. In order for parents/caregivers to establish a secure attachment with their own children, they need to be more receptive to the attachment needs of their children and have resolved their own attachment issues. Parents are encouraged to develop empathy toward their children, to learn to communicate feelings, and develop the ability to engage their children in a way that enhances the child's sense of security (Byng-Hall, 2002; Page, 1999).

The four dimensions of "Theraplay" are based on normal playful interactions in a healthy parent-child relationship and are as follows: structure, challenge, engagement and nurture (Perry & Gerretsen, 2002). The "structure" dimension involves the parent setting boundaries to ensure the child's safety. It is important that the child learns that his or her needs will be met in a consistent manner and internalizes the notion that the world is safe and predictable. The "challenge" dimension has the parent encourage the child to take age-appropriate risks and master new behaviors in an environment that is safe and will lead to success. As children experience success, feelings of competence and confidence will increase. The "engagement" dimension encourages interactions between parents and their children by way of playful activities that lead to an enhanced parent-child relationship. The "nurture" dimension provides nurturing activities that allow the parent to sooth, calm, reassure and comfort the child.

Each dimension is incorporated into interventions with the mother's group. Discussion occurs around how each of these dimensions of their relationships with their children has been affected by the violence. The parents are provided with information and a repertoire of play activities that can enhance each of these areas, and are given an opportunity to practice the activities (RESOLVE, 2002). Theraplay is an intervention that focuses on enhancing the parent-child bond through attachment-based play. It is an intervention that is engaging and interactive and includes parents in the therapeutic process. Initially, parents are silent observers and then become active participants (Campbell & Palm, 2004). Parents develop skills and empathy and become more attuned and understanding to the needs of their children. As the mother-child bond becomes enhanced, children become more resilient and better able to cope with stress which can reduce risk factors and prevent future emotional and behavioral problems.

Studies have demonstrated that parent training administered in a group format can be successful (Campbell & Palm, 2004; Sanderson, 1999). Parents who completed the multi-level intervention reported significant reductions on instruments that measured children's disruptive behaviors than parents in the non-intervention comparison group. In addition, participation in a group program has resulted in significant reductions in dysfunctional parenting practices, parental stress and depression (Sanderson, 1999).

Child-Focused Interventions.

Play therapy helps the child work through recurring traumatic themes through play which represents previous experiences. The purpose of play therapy is to assist the child in expanding his/her fantasies and feelings in response to the recurring themes using the metaphor of the play (Boyd Webb, 1999; Gil, 1991; Lantz & Raiz, 2003;Vadas,

2002). Boyd Webb (1999) suggested that group work and structured activities can provide children a nurturing environment and an opportunity to have a corrective emotional experience. Anderson and Cramer-Benjamin (2000) stated that children's groups can assist in labeling feelings, dealing with anger, developing safety plans, obtaining social support, developing social competence, recognizing their lack of responsibility for the violence between their parents, and understanding family violence. A variety of techniques are used to address these themes such as arts and crafts, the use of videotapes, role-playing, puppet shows, group discussion, and processing of group dynamics. Watts and Broaddus (2002) suggested that family therapy offers both intervention and prevention of future problems. By enhancing the parent-child relationship, children will learn these new skills from their parents and learn to be better parents themselves.

Multi-Family Interventions.

Cassano (1989) describes the multi-family approach as a combination of professional and peer help within and across families to attain the goal of altered interaction patterns within families and increased sensitivity between family members. Multi-family groups are beneficial in providing an alternate framework for parents to listen to their children, promoting intense focus between family members, and providing an opportunity to practice new behaviors and skills as a family unit (Cassano, 1989; RESOLVE, 2002; Watts & Broaddus, 2002).

Boyd Webb (1999) suggested that many of the same techniques and materials appropriate to individual play therapy can be used effectively with the child and his or her family in the context of play therapy groups. Also, continuing concern about social

service costs has led to the search for more cost-efficient ways of delivering family interventions to populations at risk (Sanderson, 1999).

CHAPTER THREE: IMPLEMENTATION PLAN AND EVALUATION CONTEXT

Setting

This practicum was undertaken at Elizabeth Hill Counselling Centre. The agency works with families exposed to family violence and provides individual therapy for children, parent counseling, parent-child therapy and group therapy. Clients are self-referred, or referred from other professionals and agencies that deal specifically with domestic violence cases. Therefore, the agency has abundant knowledge and experience in the issues and problems experienced by these families. This setting provided access to the target population and a trained staff member who was available to perform both a supervisory capacity and a resource function.

Initiating a Treatment Group

At the onset, there were numerous factors to consider before the commencement of a treatment group for this population. Facilitators had to determine a suitable time, secure room space and ensure that participants had adequate transportation and daycare arrangements for additional children.

The facilitators made decisions regarding member selection, group size, whether the group would have open or closed membership, as well as decisions about length, duration and frequency of the group and about the leadership of the group (Toseland & Rivas, 2001).

Homogeneous and Heterogeneous Groups.

Homogeneity refers to the selection of group members based upon similarities either in relation to the purpose of the group or among personal characteristics of group members. Homogeneity facilitates cohesion among group members. Conversely, heterogeneity refers to the selection of group members based upon differences and diversity among their experiences. Heterogeneity allows for support, validation, mutual aid and learning among members (Toseland & Rivas, 2001). With the Mother-Child group, members were selected based upon homogeneous and heterogeneous factors as a means of contributing to both group cohesion and diversity within the group.

It was expected that the group would be homogeneous in the sense that the mothers and children had all been impacted by domestic violence to varying degrees; however, members would be heterogeneous in relation to age, gender of children, ethnicity, class, the variations of their experiences with domestic violence and coping abilities (Jernberg, 1979).

Sweeney and Homeyer (1999) stated that the success of a play therapy group is based upon the selection of the group members and the size of the group. The authors suggested that not all children respond well to group play therapy and that these children should be seen on an individual basis. Participant selection criteria were established before the onset of the group, for inclusion and exclusion criteria to assist during the selection of group members (Gerretsen, 2003; Gougeon, 2002).

The Theraplay activities within this group-format were designed for children between 7 to 10 years of age. It was believed that younger children may not have yet mastered the developmental tasks necessary to participate effectively or benefit from the

group work modality (Sweeney & Homeyer, 1999). There was no age restriction for mothers. The mothers ranged in age from 25 to 42 years of age.

The gender of the participants was also another consideration. The program was implicitly gender-based (i.e. "Mother-Child" group) denoting that this group is strictly for female caregivers. There was limited consideration of including fathers/male caregivers who may have been impacted by domestic violence and whether they should be permitted to attend. At the time of intake, however no fathers/male caregivers had requested service so this was not a consideration. Authors have suggested that the group should be a balance of both genders and that the dispositions of children should also be mixed, for example, introverted and extroverted children (Toseland & Rivas, 2001). Initially, the children's group was comprised of five girls and two boys. At the termination of the group, two girls and two boys remained.

Sweeney and Homeyer (1999) provided discussion about multicultural considerations in group play therapy. In cases where the group members are culturally diverse they suggested that the facilitator develop awareness and sensitivity to the "reactions, needs, and differences each child brings to the group," (p.279). They suggested that facilitators must be willing to view these differences as strengths and on occasion provide education to other group members. Facilitators must be willing to explore the common values, parenting practices and therapeutic concerns of minority groups in a way that engages these families and provides a culturally sensitive environment. Four participants self-identified as Aboriginal and three participants as Caucasian. The facilitators attempted to incorporate Aboriginal teachings and culture into both the group content and process. At the onset of each session members sat in a circular fashion and participated voluntarily in a "sharing circle." A "special object," a

decorated rock, was used to denote the speaker and that person was given undivided attention as they spoke, while other members attentively listened. In early sessions, the "Wellness Wheel" was used which was adapted from the medicine wheel with its four quadrants connoting the spiritual, emotional, physical and mental aspects of life. The "Wellness Wheel" enabled participants to articulate spheres in which women and children had (spiritual, emotional, physical and mental needs) and provided a forum to discuss how these needs had been affected by the domestic abuse.

Group Size.

The size of the group was determined by both the purpose of the group and the needs of the group members. In this circumstance, the needs of the children dictated the size of the group. Typically, the younger the age of the children, the smaller the group size. Toseland and Rivas (2001) outlined guidelines for group size suggesting that the group should be small enough to accomplish the group purpose and large enough so that the members have a fulfilling experience. Based upon the age range of the children a suggested group size for the Mother-Child program is six to eight mother-child dyads (Evans & Shaw, 1993; Gerretsen, 2003; Gougeon, 2002; Jernberg, 1979).

Open or Closed Membership.

The purpose of the group will affect the facilitator's decision to select either open or closed group membership (Toseland & Rivas, 2001). A group with open membership maintains a constant size, as members are replaced as they leave the group, whereas groups with closed memberships commence and terminate with the same participants. Groups that have closed membership may be more amenable to treatment as there is a

greater sense of cohesion and mutual aid among members, established roles and group norms, and higher group morale. Due to the therapeutic nature of the Mother-Child group, facilitators elected for a closed group from the onset (Evans & Shaw, 1993).

Length, Frequency and Duration of Sessions.

The length of each group session, the duration of the group, and the frequency of group sessions are all important considerations in the development of a treatment group. Generally, the age of the child members will direct the length of the sessions. The younger the children, the shorter the sessions should be. The group facilitator(s) must assess the children's attention span, with a consideration of both the child's psychological age and chronological age (Sweeney & Homeyer, 1999). The twelve weekly group sessions of the Mother-Child group were two hours in duration. The first hour was be devoted to the concurrent mothers' group and children's group, and the second hour was allocated to the parent-child multi-family group.

The duration of the group may vary depending on the depth of therapy and the composition of the group members. However, researchers have suggested that for group work to be effective with children, a minimum of ten sessions is required (Sweeney & Homeyer, 1999). For this reason, the Mother-Child group was structured with twelve sessions.

The frequency with which the group meets is another issue for consideration. The purpose of the group and the severity of the presenting problem should be the guide. Therefore, the sessions of the Mother-Child Group were facilitated on a weekly basis.

Group Leadership.

Group leadership refers to the process of guiding the development of the group and its members to achieve goals that are consistent with social work values (Toseland & Rivas, 2001). The interactional model of group leadership acknowledges that leadership is shared between the facilitator(s) and the group members. In this model, leadership surfaces from a variety of interacting variables based upon the purpose of the group, the process of group development, the presenting problem, the social environment, and the group as a whole and as individual group members.

Co-leadership can be advantageous both for the facilitator(s) and the group members (Toseland & Rivas, 2001). The co-facilitators share the responsibility of the work, give and receive emotional support, and are able to debrief with another professional. Benefits to the group members include modeling a relationship based upon equality, respect and caring, and demonstration that individuals can work together and overcome the difficulties.

Jernberg and Booth (2001) indicated that the Theraplay technique used in individual therapy, relies upon two leaders both because it often requires an interpreting therapist and it emphasizes a high degree of energetic physical activity. Since the Mother-Child program was designed in a group therapy format it was facilitated by four therapists. Two therapists co-facilitated the children's group and two therapists co-facilitated the mothers' group (Jernberg, 1979). All therapists participated in the joint parent-child multi-family group.

Participant Selection

Recruitment and Referral.

An informational poster was circulated to various social service agencies within the City of Winnipeg outlining the purpose and format of the group and selection criteria of participants. The mother-child dyads were recruited from two main sources. The first referral source was from parents who were already involved in the agency's existing programs (i.e., individual or group therapy, couple's project or family program). The second referral source was through a pool of families who were referred to the agency or were already on the waiting list. Child welfare agencies have commonly referred children who have been exposed to violence to Elizabeth Hill Counselling Centre to address attachment difficulties (Perry & Gerretsen, 2002).

Pre-Screening Interview.

An initial telephone call was made to each parent by the facilitator to provide more detailed information about the group and answer any questions. The facilitator invited parents who expressed interest in the program to attend a two-part screening interview and scheduled an appointment with the parent.

In December 2003, prospective participants attended scheduled pre-screening interviews to enable facilitators to gather relevant information from parents and their children. The initial pre-screening interview enabled facilitators to conduct an assessment. Perry and Gerretsen (2002) outlined questions to ask the mother during the assessment: queries about the child and his or her relationship with the parent, the mother's perception of the problem, a developmental history of the child, a description of the child's functioning, the parent's attitude and expectations of the child, the parent's

experience with his or her own family, the relationship between the parents, and a family history with particular focus on the violence.

Vadas (2002) has suggested that due to the specialized nature of therapy for attachment issues, it is crucial that a thorough assessment of attachment patterns occur so that effective treatment plans can be articulated. Key factors to consider during the assessment for attachment issues include the parent's history, and infant/caregiver and family observations.

The second part of the screening interview included the mother and the child, and two facilitators. This provided an opportunity for parents and their children to meet with the facilitators before the commencement of group, to become familiarized with the setting and to learn about the purpose and content of the group. With the mother's support the facilitators sensitively spoke to the child about the fighting he/she had witnessed in the family. The theme of "breaking the secret" was conveyed to the child, as the parent explicitly gave the child permission to discuss the fighting in their families within the context of the agency setting. The facilitators helped the children to understand and articulate how the violence affected them and explained that the group may help them. The facilitators explained that there were other children who had experienced similar difficulties and that together they could all help each other (Evans & Shaw, 1993).

Further information about the objectives of the group was provided. Mothers and children were encouraged to ask further questions. Subsequent to the screening interview, the mothers were asked to complete pre-test clinical measures and a tour of Elizabeth Hill Counselling Centre was provided. At the end of recruitment, seven mother-child dyads had been accepted into the program.

Based upon the information collected, adaptations were made to the content and activities of the group sessions to ensure that the materials presented would be applicable and relevant to the needs of the participants. For example, the content of the puppet show would address issues that the children and mothers were facing.

Selection Criteria.

To be eligible for the group, mothers had to request services for both themselves and their children. The children who participated in this intervention had been identified by their parents as exhibiting emotional or behavioral difficulties. Mothers and children were included in the intervention if: (a) they had been exposed to violence, (b) children were between 7 to 10 years of age and were experiencing emotional and/or behavioral difficulties, (c) the child was in a safe, stable living situation and receiving ongoing support from caregiver(s), (d) the caregiver was supportive of child's participation in the program and was willing to be involved in the child's treatment, and (e) written parental consent had been provided by the legal guardian and children had provided their own written consent to participate in the group. Children were excluded from the intervention if there were: (a) ongoing abuse investigations, (b) children were dealing with issues specifically relating to sexual abuse, (c) children were experiencing overwhelming emotional or behavioral symptomatology relating to trauma (i.e., suicidal ideation, extreme aggression or withdrawal, or fire-setting), (d) children who were demonstrating high risk behaviors (i.e., self-mutilation, punishing acts, eating disorders).

Facilitators.

The Mother-Child group program was facilitated by four therapists. Linda Perry, M.A., M.S.W., Program Manager and therapist at Elizabeth Hill and Darah Sinclair, a BSW student co-facilitated the children's group. Monique Gougeon, M.S.W., School Social Worker and the writer, an M.S.W. student co-facilitated the mothers' group. All therapists participated in the joint parent-child multi-family group.

Intervention

Target Population.

The interventions presented in this practicum are designed for mothers and children affected by domestic violence. The literature has highlighted various issues that characterize this population.

Overview of Intervention.

The Mother-Child group was a closed, structured and time-limited group that was facilitated for 12 weekly sessions from January 29, 2004 to April 22, 2004. Each group session was two hours in duration. Authors have suggested between 10 to 12 sessions for filial and/or multi-family groups and that sessions last between one and a half and two hours (Cassano 1989; Sweeney & Homeyer, 1999; Watts & Broaddus, 2002). Watts and Broaddus (2002) indicated that filial therapy typically takes place in a group format, and suggested that the number of parents range between a maximum of six to eight participants.

The interventions combined a psycho-educational support group component for mothers and a multi-family group for mothers and children. Generally, during the first

half of the session the mother's and children's groups, respectively, met to discuss the weekly theme and then during the second half of the session the mothers and children were joined for the parent-child multi-family group. Both the mother and child group components addressed family violence themes and integrated Theraplay activities. At times, it was necessary for the facilitator to provide individual family work and advocacy for the family between group sessions to address environmental factors and stressors.

The weekly themes of the Mothers' Group were as follows (see Appendix A for a more detailed description):

Week 1	Opening – Purpose of group and importance of play
Week 2	Effects of family violence on women
Week 3	Effects of family violence on parenting
Week 4	Effects of family violence on children
Week 5	Enhancing the Relationship with our Children
Week 6	Healthy parent-child interaction – Nurture
Week 7	Healthy parent- child interaction – Engagement
Week 8	Healthy parent-child interaction – Structure
Week 9	Emotional Intelligence – Problem-solving children's behaviors – Part One
Week 10	Emotional Intelligence – Problem-solving children's behaviors – Part Two
Week 11	Healthy Relationships
Week 12	Closing – Termination Issues: Past, present and future

Each Mother's group followed a structured format that included a check-in, discussion of housekeeping issues, an introduction to the weekly theme, a warm up game, discussion on the weekly theme and a check-out.

In summary, the purpose of the mothers' group was to provide women an opportunity to share their experiences and increase their knowledge of the effects of the violence on them, both as women and mothers, as well as their children and the parent-child relationship.

Gougeon (2002) described the weekly themes of the Parent-child multi-family group as follows:

Week 1 - 3	Acknowledge family violence issues Facilitating play between mothers and children that focus on Theraplay activities of nurturance, engagement, structure and challenge.
Week 4- 11	Speak to issues related to family violence (feelings, breaking the secret, stopping the violence, and living without violence). Facilitating play between mothers and children that focus on Theraplay activities of nurturance, engagement, structure and challenge.
Week 12	Closing – Termination issues

Each Parent-child multi-family group followed a structured format that included: a hello song, a check-in and sharing between mother and child groups, puppet play (week 4-11), Theraplay activities, and a closing song.

In summary, the purpose of the parent-child multi-family group was to provide mothers and their children with an opportunity to share their experiences of how family

violence affected them and their relationship, and to offer solutions to problems they were experiencing. The content of the children's group was integrated into the multi-family group through the introduction of the puppet play. Positive parent-child interactions were demonstrated through Theraplay activities (nurturance, engagement, structure, and challenge) and were taught in the parent-child multi-family group. Mothers learned the Theraplay theory and practical application and recognized the importance of play in strengthening their parent-child relationships.

Record Keeping.

The procedural and recording requirements of the agency were adhered to with regard to the storage and release of information about clients at the agency. A file was kept for each mother and each child. This file contained the intake form, the signed consent forms, pre-group interviews and assessments, process notes, and contact summaries. Each group session was documented for mother's participation and reaction to weekly activities. Each group session was videotaped. A learning log was maintained for personal reflection and the documentation of learning objectives. This information was also used post-group for assessment and evaluation purposes.

Supervision Methods.

The committee members for this practicum included Dr. Brenda Bacon, Professor in the Faculty of Social Work at the University of Manitoba, Ms Linda Perry, Program Manager and therapist at Elizabeth Hill Counselling Centre and a member of the Faculty of Social Work at the University of Manitoba and Ms Susan Kerr, Provincial Program Coordinator of the Family Violence Prevention Branch.

Supervision duties were shared between both on-site and faculty supervisors. Ms Linda Perry provided assistance in all phases of intervention and in weekly supervision meetings. Dr. Brenda Bacon provided insight and clinical skills that facilitated the learning process. There were various methods employed to supervise the practicum. Individual consultation occurred periodically throughout the practicum with Ms Linda Perry. The frequency of these meetings varied from the program planning phase throughout the implementation phase. A list of concrete goals and tasks to be completed throughout these phases was made at the beginning of the practicum (see Appendix B). These were reviewed at the meetings to ensure that goals and tasks were being met in a timely manner. Upon implementation of the group, individual consultation took place with the Faculty Advisor, Dr. Brenda Bacon, to supervise the evaluation aspect of the practicum.

Group consultation occurred weekly between the four facilitators to debrief about both the content and process of each phase of the group and each session. The co-facilitator monitored and evaluated my group facilitation skills throughout the duration of the group sessions.

Sessions were videotaped and were reviewed weekly. This method was utilized to facilitate my learning as well as for observing the group's progress over the course of the intervention. At times, the videotapes were reviewed at individual consultations. The use of this method occurred with the written consent of each of the families.

Termination Issues.

Since the intervention is a time-limited group, an assessment was formulated for each parent and child with regard to their relationship and level of functioning at the

conclusion of the group. A follow-up meeting was scheduled with the parent individually to discuss any concerns the parent still had with regard to their child's functioning and/or the parent-child relationship. Through this discussion, the parent was given the option to contract for time-limited sessions to continue parent counseling, individual therapy and/or parent-child therapy.

Evaluation of the Intervention

The literature review indicated that women who have experienced domestic violence may experience elevated levels of parenting stress and that their children may experience both increased internalizing and externalizing behaviors. Since the intervention is aimed at targeting the parent-child relationship as a means to decrease parenting stress and child behavioral problems, measurement addressed three variables: a reduction in parenting stress, a decrease in the children's internalizing and/ or externalizing behaviours and an enhancement of the parent-child relationship.

For the purpose of this practicum the *Parenting Stress Index* (Abidin, 1995), *Child Behavior Checklist* (CBCL) (Achenbach, 1991), and the *Kansas Parental Satisfaction Scale* (KPS) (Schumm & Hall, 1985) were used to assess pre- and post-intervention functioning. The measures were based on the evaluation methodology used in the literature on group interventions for women and children exposed to violence and the parent-child relationships (English et al., 2003; Gerretsen, 2003; Gougeon, 2002; Litrownik et al. 2003; McFarlane et al., 2003; McKay & Pickens, 1996; Schicke Athanasiou & Gunning, 1999).

During the pre-screening interview, the information collected from parents formed the baseline and was used as a point of comparison between pre-intervention and

post-intervention. Upon the conclusion of the program the same measurement scales were repeated with the parents, in addition to the *Client Satisfaction Questionnaires* (Adapted from Gougeon, 2002) (see Appendix C). During the follow-up interview, qualitative information was obtained from the parents about improvements or changes in their level of parenting stress, their children's behaviour and the mother-child relationship. Post-intervention and follow-up data was compared to the initial data collected during the pre-intervention phase.

A comparison of qualitative and quantitative information gathered during the pre-screening interview and termination session was compared and analyzed for improvements in the level of maternal stress, children's behaviour and the parent-child relationship.

Parenting Stress Index

The *Parenting Stress Index (PSI)* (Abidin, 1995) is a standardized measure completed by parents in a self-report format that assesses parenting stress. The *PSI* consists of 120 items which uses a five-point scale which the parents answer "strongly agree," "agree," "not sure," "disagree," and "strongly disagree" in response to the statements. This measure assesses aspects of the parenting stress which include parent and child characteristics. The *PSI* includes four broadband scales: the Child Domain Stress, Parent Domain Stress, Total Stress, and Life Stress. The Child Domain Stress scale includes the characteristics of the child identified as stressors in parenting which includes the child's temperament, the degree to which the child satisfies parental expectations, and the extent to which the child rewards the parent. The Parent Domain Stress scale includes the characteristics of the parent and the parent's environment

identified as stressors. The Total Stress Scale is the combined Child Domain Stress and the Parent Domain Stress score, and can be useful in identifying parent-child systems in need of professional intervention. The Life Stress scale provides an indication of the amount of external stress acting upon the parent-child relationship (Abidin, 1995).

The *PSI* is a well-known and established measure. Reliability of this scale is quite high ranging from .90 to .93 (Abidin, 1995). In addition, the measure can readily be completed by a parent within half an hour.

Evaluation of the *PSI* is based on scores calculated for the Child Domain, Parent Domain, Total Stress and Life Stress sections. Child Domain and Parent Domain scores between the 15th and 80th percentile are within the normative range. Child Domain and Parent Domain scores above the 85th percentile are within the clinical significant range. Total Stress scores that are at or above 260 are above the 85th percentile, and should be considered to be high and would indicate intervention for the mother-child dyad (Abidin, 1995).

Child Behaviour Checklist

The *Child Behaviour Checklist (CBCL)* (Achenbach, 1991) is a standardized measure completed by parents in a self-report format that assesses children's behaviour. The *CBCL* consists of 113 items which use a three-point scale, "not true," "somewhat or sometimes true," or "very true or often true," in response to the question about the child's behaviour. The *CBCL* identifies the types of behavioural difficulties the child is experiencing along two broadband scales, including Internalizing Behaviours and Externalizing Behaviours. These two broadband scales are divided further into syndrome scales. Under the heading of Internalizing Behaviour are the sub-categories of anxious/

depressed, withdrawn/ depressed and somatic complaints. Under the heading of Externalizing Behaviour are the sub-categories of rule-breaking behaviour and aggressive behaviour (Achenbach, 1991).

The *CBCL* is a well-known and established measure that has been shown to have high inter-interviewer reliability and test-retest reliabilities. Reliability of this scale is high ranging from .81 to .87. This measure is excellent for a small sample size as client scores can easily be compared with the established norms both by age and gender (Achenbach, 1991). In addition, the measure can readily be completed by a parent within half an hour and requires a Grade 5 reading level.

Evaluation of the *CBCL* is based upon T scores for Internalizing Behaviours, Externalizing Behaviours, and Total Problem scales. T scores less than 60, which is below the 95th percentile, are considered to be within the normative range. T scores between 60 and 63, which is between the 95th and 98th percentile, are considered to be borderline clinically significant. T scores over 64, which are beyond the 98th percentile, are considered to be clinically significant (Achenbach, 1991).

Kansas Parental Satisfaction Scale

The *Kansas Parental Satisfaction Scale (KPS)* (Schumm & Hall, 1985) is a non-standardized measure completed by parents in a self-report format that measures the parent's satisfaction with the behaviour of one's child, oneself as a parent, and one's relationship with one's child (Schumm & Hall, 1985). The *Kansas Parental Satisfaction Scale* is a 3-item instrument which uses a seven-point scale: "Extremely dissatisfied," "Very dissatisfied," "Somewhat dissatisfied," "Mixed," "Somewhat satisfied," "Very satisfied," and "Extremely satisfied." This scale has very good internal reliability with

alphas that range from .78 to .85. It has good concurrent validity, correlating significantly with marriage satisfaction and the Rosenberg Self-Esteem Scale. This measure can be administered within two minutes, and is one of the few scales available to directly measure satisfaction with parenting (Schumm & Hall, 1985).

Limitations of the Standardized Measures

The *Parenting Stress Index (PSI), Child Behaviour Checklist (CBCL)* and *Kansas Parental Satisfaction Scale (KPS)* are all measures that rely upon maternal reports, and maternal self-reports which have inherent limitations. The *Parenting Stress Index (PSI)* may be impacted by the mother's defensive or dishonest responses as it relates to the issue of bias and social desirability (Abidin, 1995). The *Child Behaviour Checklist (CBCL)* has limitations because it may be difficult for mothers to accurately assess their children's behaviour based upon a three-point scale. Maternal reports may not be an accurate reflection of their children's behaviours and could be falsely influenced by the mother's attitudes and beliefs about her child. The *Kansas Parental Satisfaction Scale (KPS)* is a combination of a maternal report and a maternal self-report and may possess the same above-mentioned limitations.

Client Satisfaction Questionnaires and Post-Group Interviews

Client Satisfaction Questionnaires and post-group interviews were selected as a qualitative measure to evaluate the intervention. Upon completion of the group, the mothers were asked to complete the questionnaires and participate in a post-group interview. Facilitators met with the mothers individually to hear feedback regarding their group experience and to discuss the results of their pre- and post- test measures.

Accordingly, an intervention plan was developed if the need for further intervention existed.

Evaluation of Learning Objectives

The evaluation of the learning objectives occurred in a variety of different ways. Initially, my knowledge and understanding of the risk and protective factors associated with domestic violence for women and children was enhanced through the literature review and analysis related to the practicum report.

In addition, weekly supervision meetings with Ms Linda Perry facilitated clinical skills and an understanding of the implementation of an attachment-based therapy with Theraplay techniques. In addition, meetings with Dr. Brenda Bacon provided clinical insight that facilitated the learning process in the evaluation of this multi-family group intervention aimed at enhancing the mother-child relationship for women and children affected by domestic violence.

Feedback was provided throughout the duration of the group by co-facilitators, and clients offered feedback through way of the *Client Satisfaction Questionnaires* upon termination of the group. Self-evaluation occurred through personal reflections and the analysis of weekly videotaped sessions. As well, a personal learning log was used throughout the duration of the intervention as a way of recording my thoughts and feelings about the therapeutic process.

CHAPTER FOUR: GROUP EXPERIENCE AND ANALYSIS

The Mother-Child Group

The Mother-Child group was facilitated over twelve sessions from January 29, 2004 to April, 22 2004. At the outset, the group began with seven mother-child dyads and by the end of the sessions four mother-child dyads remained.

The following sections will provide a brief description of the mother-child dyads and will discuss the development of the group process. Later, in the chapter the four dimensions of Theraplay will be discussed as it related to the intervention.

Group Member Profiles

Wendy and Benjamin

"Wendy" was thirty-three years old, Caucasian and a single parent to two children. Wendy had been separated from her husband for a year and a half. Initially, Wendy was referred to the Mother-Child group by both EVOLVE and Child & Family Services. Wendy expressed interest in the group out of concern for her eight year old son's (Benjamin's) exposure to family violence and the verbal and physical abuse he experienced at the hands of his biological father. An incident occurred a year and a half ago in which the police were called to intervene and Child & Family became involved. Wendy identified her concerns about Benjamin's temper tantrums, aggression and defiant behavior at home.

Wendy described a ten year relationship that included a history of domestic violence perpetrated by her husband toward herself and her son, Benjamin. Wendy described that Benjamin witnessed excessive drinking, incidents of hair pulling, choking, pushing and overheard name calling. On numerous occasions, Benjamin's father was

verbally abusive towards him and physically assaulted him during one incident. Wendy stated that she was concerned that the abuse would escalate and contacted the police to intervene. Later, Child & Family Services intervened and the family violence court sentenced Benjamin's father to probation. Subsequently, Wendy and her husband separated. Following the separation, her husband attended counselling for his alcohol abuse and continued to have regular unsupervised visitation with his children.

Throughout the group, Wendy attended vocational training and received significant emotional and practical support from her mother and sister. After Wendy terminated her relationship with her husband, her sister also left an abusive relationship.

Wendy and Benjamin attended the previous offering of the Mother-Child group, but due to a significant waiting list for family Theraplay, they were offered the Mother-Child group again and readily accepted. Wendy presented as very motivated to attend the group and arrived at least half an hour early for each session. Wendy's mother was supportive of her attending group and provided transportation for her and the children. Wendy received childcare services for her second child from the agency's volunteer throughout the duration of the group. Wendy and Benjamin attended all twelve of the sessions.

Cynthia and Chelsea

"Cynthia" was forty-two years old, Caucasian and a single parent to five children. Cynthia had been separated from her common-law partner for two years. Initially, Cynthia and her eight-year old daughter, Chelsea were referred to the Mother-Child group by Child & Family Services. Chelsea's school contacted the child welfare agency and expressed concern about her behavior, particularly running away from the classroom,

hiding and being aggressive toward her peers. Cynthia identified that both she and her daughter had been affected by domestic violence. Cynthia expressed a desire to attend the mother-child group as a means to assist both herself and her daughter resolve their abuse experiences.

Cynthia described a history of domestic violence between herself and her common-law partner. Cynthia reported that Chelsea witnessed excessive drinking, incidents of physical assault resulting in bruises, and emotional abuse which included put downs, swearing, and name calling. The police were contacted on numerous occasions. Several years ago, the violence escalated when Cynthia attempted to end the relationship with her common-law partner. Cynthia described an incident in which her partner, depressed and drinking heavily, threatened her life by placing his shot gun in her face. Chelsea witnessed this exchange and was obviously terrified. Subsequently, Cynthia's ex-partner was incarcerated and attended alcohol treatment and continued to have frequent visitation with the children in their home.

Over the past two years, Cynthia had maintained full-time employment and receives some practical support from her mother. Her relationship with her mother had been somewhat strained since her mother permitted Cynthia's ex-partner to take residence with her during his unemployment.

Cynthia and Chelsea had attended the previous offering of the Mother-Child group in September 2003, but Child & Family Services felt that continued service would be beneficial since Chelsea's school continued to have serious concerns about her disruptive and aggressive behavior. While participating in the group, Cynthia and her daughter continued to receive a variety of support services from Child and Family

Services. Cynthia presented as very determined to attend the group. Cynthia and Chelsea attended ten out of the twelve sessions.

Nicole and Ryan

"Nicole" was twenty-five years old, Caucasian and a single parent to two children. Nicole was self-referred and discovered the group through her Outreach Counsellor at the women's shelter and through the counselling agency that she attended for individual therapy. Nicole expressed concern regarding changes in her eight year old son's (Ryan's) behavior and demeanor. Nicole identified both herself and her children, particularly Ryan, as being affected by domestic violence. Nicole's primary concerns regarded Ryan's aggression, inattention and problems with enuresis and encopresis at home and in school. Nicole indicated a desire to attend the Mother-Child group as a way to help her and her son resolve their abuse experiences and strengthen their relationship.

Nicole described a two year relationship with her last partner and stated that they had separated months before. Nicole explained that her children have two different fathers. She described a history of violence perpetrated by the last common-law partner towards her and the children, particularly Ryan. Over the course of the two year relationship, Nicole recalled excessive alcohol and drug use by her ex-partner and indicated that the emotional, physical, and sexual abuse began when she became pregnant. She described the emotional abuse as yelling, screaming, belittling, and jealous controlling behavior and the physical abuse as shoving, pushing, punching, pinching, hitting and kicking, much of which Ryan witnessed and overheard. Ryan indicated that his mother's ex-partner had hit him on the head on numerous occasions and often called him names. During one particularly violent incident the police were contacted by a

neighbor and her ex-partner was removed from the home. Nicole stated that she felt compelled on numerous occasions to engage in daily sexual intercourse with her ex-partner out of fear that he would follow through on his threats to cheat on her with other women. Nicole commented that despite changes in her behaviour he did in fact cheat on her with numerous other women.

The couple briefly reconciled and then later separated following another episode of violence in which Nicole was forced to contact the police. Afterwards, she and her children were forced to reside in a women's shelter. Since the separation, her ex-partner had not had any contact with his biological child. Nicole remained fearful of her ex-partner as he continued to engage in harassing and stalking behavior and on one occasion attempted to cause a gas leak in their home. Since the separation, Ryan remained fearful of his mother's ex-partner.

Throughout the group, Nicole attended academic upgrading and vocational training in an effort to pursue a career. Nicole received significant emotional and practical support from her mother and Ryan's biological father.

Nicole presented as very motivated to attend the group. She and her son attended all twelve of the sessions.

Deborah and Rebecca

"Deborah" was thirty two years old, Aboriginal and a single parent to five children. Deborah had two previous common-law relationships. Deborah had been separated from her common-law partner for four months. She was self-referred to the Mother-Child group and discovered the group through the second-stage shelter in which she and her children were residing. Deborah was interested in the Mother-Child group

due to her concern about her ten year old daughter's (Rebecca's) exposure to domestic violence. Deborah was distressed about Rebecca's angry outbursts, difficulty relating to her siblings, running away and defiant behaviours. Deborah indicated a desire to attend the Mother-Child group as a means to help she and her daughter resolve their abuse experiences.

Deborah described a seven-year relationship with her last partner. Deborah indicated that Rebecca has not had any contact with her biological father since she was three years old, and that Rebecca identified Deborah's former partner to be her father. Deborah reported that the common-law relationship became physically abusive and emotionally abusive within two years and there were sustained periods of excessive alcohol and drug use. Rebecca overheard and witnessed numerous episodes of violence and substance abuse. Also, Deborah indicated that Rebecca had disclosed to a previous therapist that her former partner had physically hit Rebecca on at least one occasion. Child and Family Services intervened and her partner was mandated to attend parenting courses and in-home supports were established. However, the violence escalated and Deborah and her children were forced to reside in a women's shelter on several occasions. Prior to attending the group, Deborah and Rebecca received counselling through women's shelters, individual and group therapy.

After the separation her partner attended counselling for his alcohol abuse and participated regularly in healing ceremonies and other cultural traditions. Deborah indicated that the children have regular unsupervised contact with him.

Deborah received formal vocational training and expressed a desire to return back to work after some time had passed, allowing her and her children time to heal. Since her

mother's recent passing, Deborah indicated that she received significant support from a maternal aunt.

Deborah was quite motivated to attend the group, she and her daughter attended eight of the twelve sessions. While participating in group, Deborah and her daughter continued to receive a variety of support services from the shelter.

Olivia and Molly

"Olivia" was twenty-nine years old, Aboriginal and a single parent to four children. Olivia had three previous common-law relationships. Olivia was referred to the Mother-Child group through the Child Guidance Clinic where her daughter was receiving individual therapy. Olivia expressed concerns about her nine year old daughter's (Molly's) aggression toward her siblings and peers, her inability to verbalize her feelings and lack of social skills.

Olivia reported that her biological mother had been physically abusive towards her growing up. Olivia described a brief relationship with Molly's biological father and indicated that he had not been involved in Molly's life after she was born. Olivia stated Molly identified her former partner, the biological father of her younger children, as her surrogate father. Olivia described a history of domestic violence perpetrated by her common-law partner towards her. Over the course of her primary common-law relationship, Olivia described that Molly overheard name calling, witnessed excessive alcohol and drug use, observed slapping, pinching, and biting. Olivia indicated that her partner had cheated on her with other women. Olivia attempted to separate from him on several occasions and once briefly attended a women's shelter. The couple separated

several months before the group began and her partner continued to have regular visitation with the children.

Prior to coming to the group, both Olivia and Molly had received individual counselling. Olivia was concerned because Molly remained very confused about why her surrogate father could no longer live with them.

Olivia has limited contact with members of her biological family and reports that she received support from friends.

At the outset, Olivia appeared motivated to attend the group with her daughter. However, after a few sessions Olivia began a relationship with a new partner and decided to terminate their participation in the group. Olivia and Molly attended the first two sessions, missed the next two, and then returned for the fifth and sixth session before ultimately withdrawing. In total Olivia and Molly attended four of the twelve sessions.

Teresa and Danielle

"Teresa" was thirty-six years old, Aboriginal and a single-parent to three children. Teresa was self-referred and learned of the Mother-Child group through her former employer. She indicated that her eleven year old daughter (Danielle) had been aggressive towards her siblings, was clingy towards her and could benefit from enhanced coping skills.

Teresa reported a history of domestic violence perpetrated by Theresa's mother and last common-law partner. Teresa described a thirteen year relationship with the children's father. Over the course of the relationship, there were episodes of physical and emotional abuse perpetrated by her partner towards her, including yelling, throwing, breaking objects and name calling. Teresa described that Danielle overheard and

witnessed the episodes and saw the police attend on numerous occasions. Teresa commented that her former partner had significant problems with gambling and had been charged with fraud. She initially attempted to separate from him five years earlier when he became involved with another woman, however later reconciled. After the reconciliation, the physical abuse ended; the verbal abuse of herself and Danielle continued, however. Subsequently, she separated from him five months before the group began. Since the separation, the children had infrequent contact with their father.

Due to the significant stress Teresa terminated her employment and attempted to secure adequate housing for her and the children. Teresa reported that she received significant support from friends, but indicated that her mother continued to be verbally abusive towards her and her daughter.

At the outset, Teresa appeared motivated to attend the group with her daughter. However, due to overwhelming stressors and inadequate housing arrangements Teresa and Danielle were forced to terminate their participation. Teresa and Danielle attended only one of the twelve sessions.

Barbara and Amber

"Barbara" was thirty-eight years old, Aboriginal and was parenting two of her four children. Barbara had three previous common-law relationships. Barbara had been encouraged to attend the Mother-Child group by a counselling group she had been attending at an Aboriginal agency. She expressed concerns about her eleven year old daughter's (Amber's) behavior which Barbara described as clinging, fearful, misguided towards men, and being negatively influenced by her peer group.

Barbara described a history of domestic violence perpetrated by her parents, her siblings and several common-law partners. Barbara articulated that Amber overhead yelling, screaming, name calling and witnessed excessive drinking, and physical assaults which resulted in numerous bruises, black eyes and a miscarriage. Barbara also indicated that Amber's biological father attempted to rape Amber several years ago, and since has that Amber had since been sexually abused by a third party. Amber has not had contact with her father since the attempted rape. Barbara indicated that her abusive relationships jeopardized her ability to care for the child and that Winnipeg Child & Family Services apprehended her children and placed them in foster care for two years after the last violent incident. Barbara expressed interest in attending the Mother-Child group with her daughter as a means to help them both resolve their abuse experiences.

Following the initial screening and assessment interview, Barbara and her daughter did not attend group. It should be noted that at the time of intake, Barbara had indicated that she and Amber would be moving and subsequently lost contact with the agency.

Summary

Upon review of the client profiles, a number of similarities and differences became apparent among the women and children's experiences. Six of the original seven women had been living common-law with partners who perpetrated violence against them; only one had been legally married. All of the women identified that their former partners had issues with drugs/alcohol and/or gambling addictions. Several of the women identified histories of intergenerational abuse and experiences with depression and anxiety. Four of the members had some involvement, past or present, with Child and

Family Services. Children had witnessed police intervention in all cases. Several of the women had accessed women's shelters and most women had attempted reconciliation at least once. In four cases, the perpetrator of violence was the children's biological father, and in five cases the violence was also directed towards the child, most often by a non-biological parent.

All of the women had expressed concern that their children had been impacted by the domestic violence. However, only a few reported that it had affected them as women, as mothers, or had affected the mother-child relationship. Only half of the women had sought individual therapy for their own experience of violence.

The apparent differences between mothers were the type, duration and severity of the domestic violence. The majority of women had experienced both emotional and physical abuse, while several women indicated that their partners were also sexually abusive and had been unfaithful in the relationship. Another disparity was the length of the women's relationships with their abusive partners which ranged from two years to thirteen years. Another difference was in the degree of contact the women and their children had with their former partners and the extent to which Child and Family Services was involved. Only one of the women had a child removed from her care due to the domestic violence. Variations also existed with regard to age, culture, ethnicity, marital and employment status and degree of social support.

Group Dynamics

Facilitators must have a thorough understanding of group dynamics when practicing effective group work. Toseland and Rivas (2001) define a group as a social system that is "made up of elements and their interactions," (p.69). Group dynamics refer

to the forces that result from the interactions of group members and can influence the behavior of individual group members as well as the group as a whole. Therefore, it is crucial that facilitators establish group dynamics that "promote the satisfaction of members' socio-emotional needs while facilitating the accomplishment of group tasks" (p.69). Toseland and Rivas (2001) identified four dimensions to group dynamics that are important for facilitators to understand in order to work effectively with treatment groups: communication and interaction patterns, group cohesion, social control dynamics and group culture.

Communication and Interaction Patterns.

The first dimension of group dynamics relates to communication and interaction patterns among members. Toseland and Rivas (2001) defined social interaction as "the dynamic interplay of forces in which contact between persons result in a modification of the behavior and attitude of the participants" (p.70). Verbal and non-verbal communications are elements of social interaction. As group members communicate with one another, a reciprocal pattern of interaction occurs and these developing interaction patterns can be beneficial or detrimental to the group.

The group facilitator is responsible for ensuring that the patterns of communications and interactions are helpful to ensure that the group meets the socio-emotional needs of the members and achieves the group goals. It is beneficial to have group members in a circular seating arrangement to promote social interaction and enable members to freely interact with each other (Toseland & Rivas, 2001).

Group Cohesion.

The second dimension of group dynamics relates to group cohesion. Toseland and Rivas (2001) defined group cohesion as "the result of all forces acting on members to remain in a group" (p.79). Participants are affected by four interacting variables that attract members to group work: the need for affiliation, recognition, and security; the resources and prestige available through group participation; expectations of the beneficial and detrimental consequences of the group; and the comparison of the group with other group experiences.

Social Control Dynamics.

The third dimension of group dynamics relates to social control. Social control describes "the processes by which the group as a whole gains sufficient compliance and conformity from its members to enable it to function in an orderly manner" (Toseland & Rivas, 2001, p.82). Social control results from the interaction between the norms that develop in the group and the roles and status of individual group members. Group norms are the shared expectations and beliefs about the overall pattern of behavior that is acceptable within the group and may be both overt and covert. Roles are the shared expectations about the functions of individual members in relation to a specific function group. Status refers to "an evaluation and ranking of each member's position in the group relative to all other members" (Toseland & Rivas, 2001, p.84).

Group Culture.

The last dimension of group dynamics relates to group culture. Group culture is defined as the "values, beliefs, customs, and traditions held in common by group

members," (Toseland & Rivas, 2001, p.84). In groups that are heterogeneous, group culture will emerge slowly. The diversity of members' values, beliefs and personal experiences will be contributed through group communications and interactions. Conversely, group culture will emerge more quickly for groups that are more homogeneous.

For the effective practice of group work it is important to have an understanding of group development. Facilitators must be knowledgeable about the stages of group development to anticipate and guide the members throughout the various phases.

Stages of Group Development

It is believed that groups progress through discernable stages in the process of growth and development. The stages of group development "may be affected by the needs of the group members, the type of the group, the goals of the group, the setting in which the group meets, and the orientation of the leader," (Toseland & Rivas, 2001, p.89). The decisions the facilitators make about interventions will be influenced by the immediate needs and interactions of the group members, the group dynamics, group structure, setting, group culture and the stage of development the group is in (Schiller, 1997).

Numerous models have been proposed to classify stages of group development. The most common model of group development is comprised of: the forming, norming, storming, performing and adjourning stages (Toseland & Rivas, 2001). Within the context of this particular group the Relational Model is used as a formulation to understand the stages of development for the women's group (Schiller, 1997). The

Relational Model is based upon feminist ideology and is derived from the practice of group work with women. Within the Relational Model, women in group work progress throughout the stages of development differently than groups of men or children. Women involved in group work focus primarily on their sense of connection and affiliation within the group and on their feelings of safety. As a result, women often have different reactions to power and conflict when compared to men or children.

Schiller (1997) theorized that women's groups are similar to normative development models in the first and last stages of group development, but differ during the middle stages. It has been suggested that women experience the conflict stage differently. The Relational Model is comprised of five stages of development: pre-affiliation, establishing a relational base, mutuality and interpersonal empathy, challenge and change, and termination.

Group Analysis

This section will provide an analysis of the group intervention. Schiller's (1997) five stage Relational Model of group development will be used as a framework for discussion. Themes of group development and group dynamics will be reviewed throughout the various stages.

Stage One- Pre-Affiliation.

In the beginning stage of group development, members focus on becoming acquainted with one another, the facilitators, the group setting and the group culture (Toseland & Rivas, 2001). Prior to the commencement of this group, members became acquainted with the facilitators, the group setting and the overall goals, structure, process

and content of the group during the pre-screening interviews. The first three sessions of group emphasized themes of pre-affiliation. During the first session the members appeared apprehensive yet interested in learning about each other and how the group would meet their needs. At the start of the initial session the facilitators developed a structured, non-threatening question for check-in. That was intended to reduce anxiety, build safety and to encourage members to become more familiar with one another. The facilitators participated in check-in to model the type and degree of self-disclosure that would be acceptable during the beginning phase of group. All of the members shared their reasons for participating in group. Women cited their motivations for attending group and the rationales they provided were: to break the cycle of violence, reestablish relationships with their children and to assist them in overcoming their behavioral difficulties. Members participated in a non-threatening warm-up activity which also encouraged the women to get to know one another.

Several activities were used to introduce members to the group culture and expectations, including: a structured session agenda, the development of a group agreement, the group purpose was reviewed and mothers practiced the Theraplay activities in preparation for the parent-child multi-family component. The facilitators took an active leadership role throughout the initial sessions and followed a structured format. The use of an agenda permitted the members to prepare for the session content both for themselves and for their children (Toseland & Rivas, 2001). Within the first session, a group agreement was established between members outlining guidelines for behaviors. The group agreement was completed to ensure a non-threatening treatment environment. In the group agreement members highlighted the importance of confidentiality as a way of building safety and trust among members (Toseland & Rivas,

2001). The facilitators reviewed the group's purpose and encouraged the members to establish individual goals for themselves and their children during their participation in the group. The facilitators requested that parents discuss their own experiences and feelings about play before they were introduced to the Theraplay activities. The mothers were then given an opportunity to practice the activities prior to the parent-child multi-group component, since Theraplay was so central to the therapeutic process (Jernberg & Booth, 2001). The rehearsal of these activities enabled parents to learn more about Theraplay and encouraged them to feel more at ease with play, touch and the various Theraplay dimensions. The facilitators modeled these activities which set the culture for the group by establishing a safe and comfortable working environment for the treatment process. During check-out, the facilitators introduced a ritual which encouraged the mothers to nurture themselves by lotioning their own hands before the parent-child multi-family group component. The facilitators felt it was important to have the mothers meet some of their own needs prior to being expected to be attentive and nurturing with their children.

Within the pre-affiliation stage, it is the facilitator's responsibility to establish a relational base among members by actively highlighting themes of affiliation, similarity and safety (Schiller, 1997). The weekly session topics created an opportunity for group members to discuss common themes which promoted dialogue between members and satisfied the psycho-educational component of group. Within the first few sessions commonalities were evident among group members. Members began to openly share with one another how the domestic violence had impacted them as women, and had affected their children and their parenting.

During the first stage of group development, the members needed to establish non-intimate relationships, while permitting more intimacy to develop as the group progressed. The issue of trust emerged regarding group membership. By the third session group membership had undergone significant changes due to drop-out and five of the seven members remained. After attending the pre-group screening interview, Barbara withdrew from the group and did not attend any of the group sessions. Due to severe winter weather conditions, Cynthia and Teresa were unable to attend the initial group session. Fortunately, they both returned and joined the group for the second session. However, the following week in session three, Teresa elected to terminate her participation from the group and did not to contact the facilitator. Prior to session three, Olivia contacted the facilitator to explain that she would be unable to attend due to a pressing family situation. Discussion occurred among participants regarding the absence of certain group members. According to Toseland and Rivas (2001) it is important for facilitators to discuss absences and withdrawals from the group to allow remaining members to process these changes. The remaining members appeared unsettled by the absences and withdrawals of two members, however were reassured by the facilitators that the group would begin to stabilize. The members appeared relieved and focused on beginning their own personal work. After session three, group membership began to solidify and the level of trust appeared to increase as members began to gradually share more of their personal stories.

With respect to group dynamics, communication and interactional patterns began to emerge as sessions continued. It was customary for members and facilitators to sit in a circular fashion and participate in a "sharing circle" at the start of the session which promoted open communication and interaction. During the initial sessions

communication was facilitator-directed; however the small group size provided increased opportunity for communication between all members. Group members began to positively engage with one another, by actively listening to each other and providing feedback and support.

The facilitator observed that group cohesion began to develop by the third session. Several members routinely arrived early for group and frequently engaged in conversation outside of the group context. The small group size and stabilization of group membership appeared to contribute to the development of group cohesion. Toseland and Rivas (2001) have suggested that a reduction in group size can contribute to the cohesion among members because the opportunity for communication increases as less motivated members drop out. Increased personal sharing promotes the awareness of commonalities among members which leads to enhanced group cohesion. Schiller (1997) stated that the development of cohesion is crucial to the development of an individual member's sense of safety and comfort, so that each may increasingly share more personal information later in the group process.

Within the Mothers' group, members' needs for affiliation and recognition were met through the validation and normalization of their common experiences. Group members actively listened to one another's personal stories, experiences and alternative coping strategies. The content of each session and written materials provided by the facilitators offered additional educational resources to the members. While participating within the group context women developed an enhanced social support network which permitted women to process their experiences collectively.

Group norms appeared to be somewhat established by the third session. Absent members made a concentrated effort to contact the facilitator prior to the start of group

when they were unable to attend. However, several members routinely arrived late which was disruptive for the opening activities of the group. Punctuality was difficult for the facilitator to enforce, despite the group agreement. Within the group context, members learned to actively take turns when they contributed to discussion and regularly volunteered to be the parent spokesperson during the multi-family group component. Members were courteous and waited to be asked by members to provide feedback or advice and did so in a manner that was supportive and non-judgmental. For the most part, the development of a group agreement during the initial session was helpful in establishing these expectations for behaviors.

The facilitators were responsible for establishing the group structure and process. Overall, the group sessions were pre-determined before the group began, but as the group progressed a portion of the content was modified to meet the members' needs. With respect to the members' roles, Nicole emerged as the internal leader within the group. Despite being the youngest member of the group, she was quite extroverted, projected a sense of confidence and visibly displayed a strong connection with her son. For these reasons, Nicole attained an elevated status within the group. In contrast, Olivia portrayed the quiet member role; her contributions were much less than other members making it difficult for others to get to know her (Kirst-Ashman & Hull, 1993).

The parent-child multi-family group was also characterized by the pre-affiliation stage. During the initial session, some of the children's anxiety, fear and ambivalence about the group experience became obvious (Evans & Shaw, 1993; Jernberg, 1979). An example of this was when Molly, age nine, attended the group with her protective blanket and wore it throughout the duration of the first session. The goals of the initial sessions were to establish a safe and comfortable environment for the members to identify the

commonalities among their families. At the first session, the purpose of the group was discussed within the parent-child multi-family group to enable members to visibly identify with the reality that they were not alone in their experiences and that other mothers and children had similarly been affected by domestic violence (Cassano, 1989). The atmosphere of commonality broke the silence, shame and isolation associated with domestic violence, and permitted the members to begin to share their experiences.

Some of the children exhibited disruptive behavior which affected their ability to purposefully interact with their peer group. Children appeared to distance themselves from one particularly deviant member. Evans and Shaw (1993) stated that it is not uncommon for children to misbehave during this stage of group as a way of testing the safety of the group and the genuineness of the relationships.

Stage Two- Establishing a Relational Base.

As the group progressed members sought to establish a relational base with one another by building upon the commonalities identified within the pre-affiliation stage. Throughout the context of the sessions women made comparisons with each other and their experiences which enhanced group cohesion (Schiller, 1997).

Normative development models suggest that conflict is likely to occur within this phase of development. However, in the proposed model women continue to build bonds of affiliation and connection as a means of establishing their safety within the group. It has been theorized that before the group can experience conflict, female group members need to establish safety. The Relational Model suggests that if conflict were to occur it would typically happen later in women's groups (Schiller, 1997). Consistent with the

model, the women within this group were so entrenched in the affiliation process that overt conflict was not observed during this stage of the group experience.

During the second phase of group the members continued to seek similarities between their experiences. The structured content of the third, fourth and fifth session provided a continuation for the linkages made between the group members in the pre-affiliation stage. As the women discussed how the domestic violence had affected them, and their parenting, and had impacted their children, commonalities became apparent. Members frequently identified similar struggles with their children, expressed difficulties with being a single-parent and discussed the systemic barriers that they faced in the aftermath of domestic violence (Levendosky, & Graham-Bermann, 2001; Levendosky et al., 2000). Women regularly expressed concerns about financially providing for their children.

Within Schiller's (1997) model the facilitators' role during this stage is to demonstrate a non-hierarchical style of facilitation where they view themselves as members of the collective. The facilitators continued to take an active role in guiding the direction of the session and contributed to the discussions by connecting similarities between women's stories.

Although the check-in questions remained structured and non-threatening, members began to increasingly disclose more of their personal stories. In session three, Deborah informed the group that she had recently begun an alcohol treatment program. The reactions she received were non-judgmental and supportive. Deborah's disclosure set the norm for group members to be more forthcoming in their disclosures and with discussing the personal impact of their experiences. Later, during the discussion Cynthia described an incident in which her ex-partner had put a shotgun to her head, and that had

been witnessed by the children. She reported that as a result of this incident, her daughter Chelsea had been diagnosed with Post-Traumatic Stress Disorder. Children exposed to extreme violence may display symptoms consistent with Post-Traumatic Stress Disorder (Fritz, 2000). During the discussion, Nicole expressed remorse that the domestic violence had impaired her relationship with her son Ryan. She commented that the violence began when she was pregnant with her youngest child and she would often have to side with her ex-partner, rather than stand up for Ryan. She indicated that she did this out of fear that her ex-partner's behavior would escalate and direct his violence towards both of them (Anderson & Cramer-Benjamin, 2000; Cox, Paley & Harter, 2001; Margolin, et al., 2001).

In the fourth session, Wendy spoke about the attachment difficulties with her two children and expressed how hard it was for her to effectively soothe her children. Nicole spoke about her attachment to Ryan and alluded to her own unhappy childhood. She indicated that she had repressed a lot of memories. She shared with the group that the happiest moment of her childhood was as a teenager, when she discovered that she was pregnant with Ryan. She spoke fondly of her relationship with Ryan prior to her abusive relationship.

In the fifth session, Deborah informed the facilitator that she would be unable to attend and Olivia returned after missing two sessions and offered her apologies to the other group members. The women appeared unaffected by Olivia's absences and openly welcomed her back. During this session, discussion focused on attachment and the mothers shared stories about their experiences with their children. Wendy and Olivia both commented that when they were younger they had not intended on having children and were surprised to have two and four children, respectively. Nicole took another risk

and commented that personal trauma can affect a mother's ability to parent, both in the ability to appropriately establish and maintain boundaries with children (Morrel et al., 2003). The mothers began to develop an understanding of how their families-of-origin experiences had impacted their attachment with their children (Byng-Hall, 2002; Finzi et al., 2001; Johnson et al., 2003; Page, 1999).

The intergenerational theme of attachment continued throughout the sixth session. This session was the most intense in terms of the depth and content of women's disclosures. For example, Wendy and Olivia both described families-of-origin relationships that were quite stressed and tumultuous. Both expressed difficulty in relating to their children and acting demonstratively towards them (Liddle & Schwartz, 2002). Olivia indicated that in her opinion Molly was a difficult child to nurture; that she did not readily accept affection. This contrasted with the facilitator's observations and interpretation that Molly's diminished sense of boundaries with strangers was a reflection of the extent to which her emotional needs were unmet within the mother-child relationship. Wendy disclosed to the group that she had been in foster care for the first year and a half of her life. She had not disclosed this information in previous pre-group or group sessions. Simultaneous with these disclosures, the emergence of a personal crisis for Nicole prompted her to approach the group for assistance. Nicole expressed intense feelings of helplessness and frustration with Ryan's behaviors and requested guidance from the group on possible strategies to address the issue. Wendy and Deborah both offered support and advice.

These detailed disclosures of several members and the supportive responses from Deborah and Wendy, suggested the group had established itself to be a place of safety, which is an important issue for women's groups (Schiller, 1997). Furthermore, the level

of intimacy which developed, especially by session six, supports the Relational Model's perspective that intimacy emerges earlier in women's groups (Schiller, 1997). Overall, the increase in trust and disclosure resulted in the development of intimacy which reinforced and strengthened the group's relational base.

The second stage of group development was marked by the continued evolution of group dynamics. With regard to communication and interactional patterns, the members were observed to initiate communication with one another more readily, introduce issues for group discussion, and provide positive feedback to each other. The facilitators provided less direction and guidance to the group than in the previous pre-affiliation stage.

Group cohesion within the group was quite strong. Members frequently commented that they looked forward to attending group. For the most part attendance and punctuality were consistent among the four core members. During this phase of group development, members engaged in an increased degree of risk taking and disclosures that were the result of a high level of group cohesion.

With respect to roles within the group, Olivia remained quiet and was notably more of an observer than a participant in the group. At times, it appeared to the facilitator that Olivia had a difficult time relating to the content and looked uncomfortable within the group setting. Despite Nicole's confession about her personal crisis with her son, she was able to regain control of the situation after an individual session. The members appeared to admire her for these abilities. Both Deborah and Wendy had acted as caretakers for Nicole, as observed by their nurturing and support of her throughout the sessions.

The role of facilitator to balance an individual's needs with the needs of the group was particularly difficult during session six. At the start of session, the facilitator observed that Nicole was pre-occupied; however, when she did not elect to comment during check-in, the facilitator felt compelled to continue on with the structured agenda. The facilitator observed that Nicole remained uncharacteristically despondent throughout the session, even after Deborah attempted to engage with her. It was during check-out that Nicole finally began to share her personal situation with the group. Although the group had given permission for Nicole to problem solve her personal struggles, the amount of time this required was problematic. Nicole's disclosure during check-out resulted in the Mothers' session running overtime which reduced the parent-child multi-family portion and inconvenienced the co-facilitators of the children's group. In response to this episode, the facilitators modified the structure of the following week's check-in, and encouraged the members to use this time for personal sharing if they chose. Also, facilitators suggested that members request individual sessions with the facilitators between group sessions to address individual needs.

Despite the differences between members in relation to age, ethnicity, culture and racial background, a noticeable group culture began to emerge. The developing group culture reflected the acceptance of similarities and tolerance for differences. Members expressed acceptance for sharing, fairness, and diversity of opinion.

Within the parent-child multi-family group component, members continued to become more comfortable with one another and with the group rules. Since familiarity between members was increasing, Theraplay activities were selected that required more trust and group cooperation (Jernberg & Booth, 2001). The Theraplay activities continued to focus on dyadic interaction between the mothers and their children, but

increasingly included more inter-familial activities (Cassano, 1989). As a result there was more physical contact between all members of the group. Facilitators observed an increased sense of support and encouragement between the families during difficult activities. The mothers became more aware of each other's parenting style and strategies.

During the pre-affiliation phase, the parent-child multi-family group component emphasized safety and security. The focus of these initial sessions was on playful and interactive activities between mothers and children, which set the stage for the next more intense phase. During session four, the issue of domestic violence began to be directly addressed. The facilitators scripted a weekly puppet show with a character named "Max," a young boy who had experienced domestic violence within his home. The content of each puppet show was intended to replicate the commonalities among all of the families and create a forum to discuss the issue of domestic violence. The first puppet show focused on the issue of fighting in the family. For the most part, the children's reactions to the puppet show were notably cautious. Two of the children had previously attended the Mother-Child group and excitedly squealed when "Max" was introduced to the group, which served to lessen the other children's anxieties. Over the next two sessions, "Max" broke the secret of violence in his family and he and his mother went to live in a women's shelter. The puppet shows encouraged dialogue between families and led to a discussion about how to problem-solve Max's dilemma. Cassano (1989) suggested that support, cooperation and sharing are reinforced in the multi-family group. Also, problem-solving occurs within families and in the group as a whole.

Stage Three- Establishing Mutuality and Interpersonal Empathy.

Within the third stage of the Relational Model, women will move beyond similarities and begin to recognize differences. The stage of mutuality allows women to experience elements of both intimacy and differentiation. The recognition of similarities enhances members' levels of trust, and disclosure and differentiation permit members to respect each other's differences. Mutuality and interpersonal empathy is characterized by building upon the intimacy and commonalities established in the previous two stages (Schiller, 1997).

As discussed, the commonality of the members' experiences and level of intimacy had become well established during the previous two stages. The structured content of sessions provided an opportunity for discussion, and although consensus existed regarding numerous issues, some noticeable differences emerged regarding parenting strategies and how the mothers were emotionally affected by the abuse.

The level of intimacy achieved within the group permitted the discussion and acceptance of differences between members' experiences and opinions. The development of trust and respect prior to this stage of development permitted the members to explore their differences in parenting practices and emotional expressions.

Integral to the Relational Model and the third stage of development is the recognition of mutuality in the therapeutic relationship between members and the facilitators, as well as mutual aid among members (Schiller, 1997). Mutuality in the therapeutic relationship between the members and the facilitators was established at the outset of the group. From the commencement of the first session, the co-facilitators participated in the weekly ritual of check-in and shared some personal stories during group discussions. The members began to identify with the co-facilitators because of

their self-disclosures. The women identified with my co-facilitator especially, because she, like them, was also a mother. Schiller (1997) stated that "relational authenticity and presence by the worker help to create a relational context for empowerment of the members and a greater willingness to risk sharing from a deeper self," (p.13).

However, not all of the participants felt at ease with the heightened level of self-disclosure. By the seventh session, Olivia elected to terminate her participation from the group and informed the facilitator that she ultimately did not feel comfortable in the group sessions. The facilitator informed the group of Olivia's decision to withdraw; this was met with little affect by the group. Olivia's non-participatory role within the group may have accounted for the group members' muted reactions. The members appeared to graciously respect her decision to terminate from the group.

During this stage, the remaining four women increasingly shared their personal stories of struggle and adversity. Cynthia indicated that Chelsea's behavior at school had been improving up until recently, when she was suspended. Cynthia expressed feelings of frustration about how the violence continued to affect Chelsea. She had become increasingly concerned about Chelsea's inability to regulate emotional affect, but felt relieved when Nicole described similar concerns (Folsom et al., 2003). Nicole stated that she needed to work at becoming more empathetic to Ryan's feelings and experiences. She described a recent incident in which Ryan had three episodes of enuresis at school. Nicole indicated she believed that Ryan should be punished for his misbehavior, and disagreed with the facilitator when she suggested that rather then punish him she could try to be empathetic to his feelings. Feedback that acknowledged Nicole's inability to cope was given and the facilitators attempted to reframe the situation for Nicole to help her see that Ryan might be reacting somatically to his current living arrangement and the

situational stressors. By session eight, Nicole had temporarily sent Ryan to live with her mother. Deborah shared her parenting strategies for her children's misbehaviors with the group. She described a situation in which she did not punish her child for misbehavior, but nurtured the child instead. Deborah commented that Rebecca's angry exterior rapidly changed when she embraced her as Rebecca began to sob uncontrollably.

In session eight, during the discussion on structure further differences between the mothers became apparent. Nicole reported that she struggled to implement structure with her two sons, because of the lack of structure within her own family-of-origin. She indicated that being a teenage parent had been difficult. Cynthia attempted to reassure Nicole that it was possible to implement structure and related her experience after leaving her abusive relationship. Cynthia spoke about how her family-of-origin had influenced her need for structure and disclosed that she was a child of an alcoholic. Cynthia attempted to normalize Nicole's experience by demonstrating that it was possible to establish structure despite adversity. Wendy contributed to the discussion and indicated that she had profound difficulty implementing structure with her children and that they had trouble accepting structure from her and others. The facilitators observed this on numerous occasions.

In session nine, differences began to emerge with regard to how the women were emotionally affected by the violence. Cynthia commented that as a result of years of abuse she no longer experienced feelings with intensity. In fact, she stated that she felt like she was in "an emotional dead zone," and indicated that she had not be able to cry for years. In contrast, Nicole described how the abuse had left her emotionally vulnerable and she cried all of the time. Cynthia commended Nicole on still being able to experience feelings.

Mutual aid had clearly evolved within the group, as was evidenced by the sharing of advice and support between the members and facilitators. Within the third stage of group development the communication continued to be open and interactive, directed more between members and less by the facilitators. The group cohesion and culture remained strong enabling members to discuss similarities, differences and subtly challenge one another's opinions. In regard to the group roles, Nicole appeared to appreciate that she had dominated the group over the last several sessions. Her requests for assistance allowed the other group members to become more participatory during discussions.

The facilitator's role during the third stage of group was to promote mutuality and empathy. Several disclosures by the women prompted the facilitator to encourage the mothers to be more tolerant and empathetic towards their children. Another task for the facilitator was to focus the members on the remainder of the work that needed to be accomplished prior to termination. Sessions nine and ten were intended to help members focus on understanding and alleviate their children's misbehaviors through the techniques of "emotion-coaching" (Gottman & Declaire, 1997). The facilitators began to discuss the final sessions in order to provide members with the opportunity to recognize closure issues well in advance of the termination stage.

Within the parent-child multi-family group component, the level of intimacy between individual members appeared to have evolved and carried over to the multi-family group. As a result, the Theraplay activities selected focused on increased intensity and the relational issues of the members. The activities chosen required more trust, self-control and group cooperation. During the middle phase, group activities were geared towards increased eye contact and touch, increased trust, turn taking, cooperation, respect

and appreciating individual differences, managing excitement, and facing adversity (Jernberg & Booth, 2001). Mothers appeared to take a greater leadership role in terms of leading games and required less prompting in dyadic play with their children. For example, Wendy appeared to have internalized some of the discussion on nurture and appeared more relaxed with Benjamin's minor transgressions. In turn, Benjamin appeared to be more receptive to Wendy's nurturing demonstrations. Also, the children frequently volunteered their families for activities. However, intra-family difficulties remained; as some of the mothers struggled to exercise authority over their children and while others had difficulty actively engaging with their children.

The puppet show continued to be a medium through which the children were able to relate to the common theme of domestic violence. Max's character became a powerful vehicle that encouraged the families, particularly the children, to confront, provide support and problem-solve Max's predicament, and indirectly each other's predicaments. Anxiety appeared to resurface sporadically for the children as they related to the intensity of Max's experiences. As the story line progressed the children all became more vocal and engaged in dialogue with "Max." The familiarity of Max's situation contributed to the mutuality and empathy of the experiences within the parent-child multi-family group.

Stage Four- Challenge and Change.

As previously stated, the Relational Model of group development suggests that conflict typically occurs much later in women's groups. The fourth stage of development, the challenge and change phase is characterized by addressing issues of power, authority, and managing conflict. This is the stage of development where the

depth of women's growth will be challenged, as women attempt to negotiate conflict without sacrificing the bonds of connection and empathy (Schiller, 1997).

Contrary to the model that suggested that conflict would occur within this stage, no overt conflicts between members occurred. However, inner conflict was displayed by Olivia through her departure from the group experience. In this respect, the group's development did not fit with the Relational Model that suggested that conflict would occur in the later stages. Consistent with Gougeon (2002) findings, this particular group did not have to negotiate conflict in terms of group process, but addressed conflict with regard to the content of the group.

During session eight, the facilitators introduced the topic of structure to the women. What became evident to the facilitators was that the women had difficulty with the concepts of power and authority and their ability to exercise them within their relationship with their children. Given the life experiences of the women and children within the group in relation to the abusive use of power and control, it is not surprising that members resisted conflict. The importance of structure within the parent-child relationship became central to the group discussion in session eight. For these members, the idea of exercising authority and power over their children was uncomfortable. For example, Wendy's son had a serious medical condition which required that his diet be monitored, but would indulge him on occasion as a way to settle his behavior. It is not uncommon for mothers affected by domestic violence to feel the need to overcompensate for prior harsh parenting and therefore avoid exercising parental authority (Levendosky & Graham-Bermann, 2001).

The discussions on structure, in terms of exercising power and authority over their children, not only permitted, but encouraged the mothers to think of it differently. The

facilitators encouraged the women to reframe their conceptions about structure as a way of benefiting the parent-child relationship. The discussion helped mothers recognize that structure was important and could enhance the parent-child relationship.

In addition, during sessions nine and ten, the women had a tremendously difficult time incorporating the concepts of "emotion-coaching," due to their lack of awareness of their own feelings. Given the high percentage of women who suffer from Post Traumatic Stress disorder after experiences with domestic violence, it is not uncommon for women to remain emotionally numb long after the incident (Levendosky & Graham-Bermann, 2001).

The role of the facilitator during this stage was to help the women maintain their connection through the expression of a full range of emotions, including anger and conflict (Schiller, 1997). As the members concluded the final working stage of group, the facilitators were preparing its termination. The preparation involved discussing the content of the remaining sessions and planning the celebration session.

The group dynamics of communication and interactional patterns continued to be open and group directed. The problem-solving format of session nine and ten provided increased dialogue, sharing of information, and reinforcement of knowledge and skills acquired. Evans and Shaw (1993) suggested that facilitators should attempt to capitalize more on individual member's strengths and utilize the group process to foster mutual support and challenge.

Group cohesion remained strong throughout the last working stage of group development despite the departure of one of the mother-child dyads. As previously stated, Olivia and Molly withdrew from the group prior to the eight session. Unfortunately they did not have an opportunity to say goodbye to the group members and

the members did not have a chance to say their farewells. As Evans and Shaw (1993) suggested, in hindsight the facilitators should have emphasized the importance of completing the group and assessed the reality of the family's ability to make that commitment during the pre-screening interview. They recommended that if a child must leave the group, it is important for the child and the group to have the opportunity to say goodbye. This discussion would have allowed parents to better understand the importance of endings and to discuss other endings in their lives. For the group, the loss of a group member is an opportunity for other members to connect with their own feelings of loss and endings. In turn, the facilitators could have made connections, and discussed their own feelings as related to both the loss of the group member and to the eventual ending of the group.

The parent-child multi-family group component continued to provide meaningful opportunities for the mother-child dyads to interact in playful ways. The Theraplay activities appeared to be having some effect within each parent-child dyad. In the beginning, Wendy and her son had difficulty engaging in the nurturing activities. By the end Wendy was able to make some adaptations to her behaviors which permitted some closeness. Benjamin continued to reject structure both from his mother and the facilitators; however, he was able to permit some structure in the eleventh session. For Cynthia and her daughter, a balance of nurture and engagement appeared to be more evident. Nicole and her son, and Deborah and her daughter, appeared to make progress within all of the Theraplay dimensions.

The puppet show continued to promote discussion regarding common issues that families encounter when domestic violence has occurred. Session eight and nine revolved around the themes of "Max's" feelings, particularly being afraid and angry. The

children were able to empathize with "Max" in his plight. During session ten, Max's mother began to plan for the future.

Stage Five- Termination.

Schiller (1997) believed that the termination phase is a critical stage, both for members and facilitators involved in the group experience. The facilitators' skills in this phase will determine the efficacy of the entire group experience. Facilitators began to discuss termination by the ninth session, to enable members to begin to prepare for the termination of the group experience.

The final stage of group development was characterized by a shift in attention from the group to the individual. During the session twelve final check-in, mothers were able to explicitly talk to other members about the ways in which they had helped them. The women were able to articulate their feelings about the group ending. Describing feelings of disbelief and sadness that the group was ending these feelings were recognized and normalized within the group. A final termination exercise was conducted which provided the members with an opportunity to both give and receive positive feedback from other members and the facilitators. This exercise symbolically represented the cutting of group ties and the celebration of individual strengths. The content of the final session provided members with an opportunity to summarize and evaluate the progress they and their children had made. Group cohesion remained high even during the final session.

Toseland and Rivas (2001) suggested six tasks of the facilitators associated with ending a group. First, facilitators want to ensure that individual group members maintain and generalize change efforts. As a final gesture, the facilitator wrote a letter to each

individual member commenting on the observed changes within the group and offered feedback about the member's positive attributes. Second, facilitators attempted to reduce group attraction and promote the independent functioning of members. This was reinforced through the termination activity. Third, facilitators helped members to work through their feelings about terminating their relationships with the facilitators and each other. In therapy groups, termination may be accompanied by intense emotional reactions. Mutual aid and support developed as members created relationships with one another and the group workers. The format of the final check-in and check-out was established to allow members to communicate their feelings about the group ending and say final goodbyes to one another. Fourth, the facilitators helped members plan for the future. In session eleven, the facilitator introduced the topic of "healthy relationships," to the women in an effort to disseminate knowledge about what characteristics to look for in a new potential partner. The majority of the women indicated that they were not ready to begin a new relationship anytime in the near future. Most recognized the need to continue to work on their own individual healing and continue to focus on enhancing the relationship with their child. Fifth, facilitators and members assessed the need for further intervention and made further referrals, if necessary. By the eleventh session, facilitators began to schedule individual follow-up appointments with members to review progress and to determine whether or not future intervention was warranted. Lastly, the facilitators conducted an evaluation of the group. Upon the completion of group, the majority of the women completed post-group measures and received feedback from the facilitators during post-group interviews regarding their progress throughout the group experience (Cassano, 1989).

The final two sessions of the parent-child multi-family group component were directed at assisting the members to prepare for, anticipate and commemorate the ending of group (Jernberg & Booth, 2001). In session ten, the facilitators announced that only two sessions remained and asked the children to select their favorite Theraplay activities (Jernberg & Booth, 2001). The children's favorite activities were repeated during session eleven and twelve, so that the children could contribute to their farewell and say goodbye. The mothers and children both expressed sadness about the group ending. However, despite these feelings of sadness, members appeared proud of the progress they had made. Session eleven concluded with a final appearance by "Max" where he revisited the past and looked forward to the future. All of the children gave "Max" a farewell hug and said good-bye.

The role of the facilitators was to normalize the members' feelings about the group ending. According to Evans and Shaw (1993), children may engage in regressive behaviors during this stage. The facilitators should help the group understand this behavior is an expression of their feelings about ending. Strong feelings are understandable because often the group has been the most nurturing, supportive and safe environment that the children have ever experienced. All of the members appeared to engage in the celebration, though there were some signs of regression among the members. For example, Ryan who was prone to episodes of encopresis had an accident during the final session.

A celebration and farewell party was planned for the final parent-child multi-family group component (Evans & Shaw, 1993). The farewell party was characterized with special activities including the sharing of a celebration cake, the creation of mother-child photographs, and decoration of individual family picture frames. The singing of the

closing song represented the completion of the group experience (Jernberg & Booth, 2001).

Summary

The Relational Model of group development suggested those women's groups' transition through a sequence of stages which emphasize different themes for each. For the most part, the group appeared to progress through these discernable stages. Contrary to the model's suggestion that conflict typically happens much later in women's groups, overt conflict did not arise anywhere throughout the group's development.

The level of intimacy and cohesion displayed within the group remained high throughout the sessions. Mutual support and empathy appeared to be successfully achieved. The establishment of group norms and the display of various roles and behaviors appeared more related to personalities, rather than a reflection of power and control. Overall the mother's group provided a context for the members to freely share their experiences and feelings and process them collectively.

Similar to the mother's group, the parent-child multi-family group also appeared to transition through the sequence of developmental processes. At the beginning, interactions within the group appeared to be mainly dyadic, however as the group progressed, there appeared to be more intra-familial interaction. This change reflected the development of an increased level of intimacy and cohesion among members of the parent-child multi-family group. The puppet show within the parent-child multi-family group reinforced the commonality of the experiences for mothers and children impacted by domestic violence. In addition, the Theraplay activities created a playful atmosphere

where the mothers learned from each other and interacted with their children in meaningful ways.

Theraplay Dimensions

The following section will discuss how the four dimensions of Theraplay (structure, nurture, engagement and challenge) were incorporated throughout the group intervention along with a critical analysis.

Theraplay theory and activities were inherent in the group's philosophy and integrated throughout the mothers'/ children's and the parent-child multi-family group sessions. Within the mothers' group, the warm-up activity provided the women an opportunity to practice the Theraplay activities prior to the parent-child multi-family group component. In addition, sessions six, seven and eight were dedicated specifically to discussion about the dimensions of Theraplay as it related to aspects of a healthy parent-child relationship. Theraplay activities were incorporated into every parent-child multi-family group session and provided an opportunity for meaningful interactions to occur between the mothers and their children. The parent-child multi-family context was established to provide an opportunity for mothers and their children to strengthen their relationship through play (Jernberg & Booth, 2001).

During the beginning phase of group, facilitators selected Theraplay activities that focused primarily on dyadic interaction between individual mother-child dyads, rather than on the multi-family group (Cassano, 1989). Simple, well-structured and non-threatening activities were selected so that members could increase their comfort with eye contact, touch and physical closeness (Jernberg & Booth, 2001). Each activity was chosen to represent one of the four (structure, nurture, engagement and challenge)

Theraplay dimensions (Jernberg, 1979; Jernberg & Booth, 2001; Rubin & Tregay, 1989). Although, initially slightly apprehensive about the Theraplay activities, mothers attempted to playfully engage with their children during these activities. A discussion will follow for each Theraplay dimension.

Structure.

The Theraplay model defines structure as "setting boundaries to ensure the child's safety, and to help the child to understand the world in which he or she lives," (Perry & Gerretsen, 2002, p. 56). Within the Theraplay model, a basic principle in a healthy parent-child relationship is demonstrated by the adult being in charge. Facilitators modeled this dynamic by being in charge of the group and directing the sessions. During the group sessions, the facilitators made decisions about what was going to happen, decided on the activities, made modifications and described how the Theraplay activities would be played. The facilitators explicitly stated that the parent-child multi-family sessions would be playful and fun. Implicitly, the facilitators demonstrated that the Theraplay sessions would be therapist directed; action rather than talk or insight oriented; and that sessions would be clearly delineated by time, space, and facilitator and member roles (Jernberg, 1979; Rubin & Tregay; 1989). Within the Theraplay model, structure is presented to children in such a manner that their sense of security will be enhanced and they will be reassured that the adult is meeting their needs (Perry & Gerretsen, 2002; Rubin & Tregay, 1998).

The Theraplay dimension of structure was addressed through the format of the sessions, the clearly stated rules ("Stick Together," "No Hurts!" "Have Fun!"), and through the structuring activities in the parent-child multi-family sessions (Jernberg &

Booth, 2001; Perry & Gerretsen, 2002; Rubin & Tregay, 1989). Sessions for the mothers'/ children's and the parent-child multi-family groups were structured with a predictable beginning, middle and end. The mothers' and children's groups respectively participated in routine opening activities, which consisted of a "sharing circle," and warm-up activity. The format of the parent-child multi-family group also followed a structured agenda so that members would feel comfortable and know what to expect (Jernberg, 1979; Jernberg & Booth, 2001; Rubin & Tregay, 1989). The opening of each parent-child multi-family group session included greeting activities. Mother-child dyads and facilitators sat together in a large circle, sang the "Hello song," and then participated in the ritual of snack-time (Jernberg, 1979; Jernberg & Booth, 2001; Rubin & Tregay, 1989). During snack-time a volunteer spokesperson from the children's group and the mothers' group would discuss what each group had done earlier in their individual group. This ritual of information sharing was intended to decrease secrecy and provide a forum for domestic violence to be talked about openly.

Within the mothers' and children's groups, the middle phase of each session included discussion on content material. The mothers' group specifically addressed the topic of structure in session eight. Mothers expressed their difficulties implementing structure within their homes. In the parent-child multi-family group component structuring activities were incorporated throughout the middle phase of the sessions (see Appendix A). These activities gave mothers an opportunity to experiment with the concept of structure. However, when children engaged in testing behaviors, the mothers displayed an inability to exercise appropriate control of their children when they perceived them to be overly active or disobedient. The ending of each session included closing activities. Within the respective mothers' and children's groups, members

participated in a "check-out." The parent-child multi-family group component marked the end of the session by singing a "closing song."

The purpose of structuring activities was to "delineate time and space clearly and to teach mastery through the internalization of rules," (Jernberg & Booth, 2001, p. 90). Examples of structuring activities included, "Mother May I?" "Hokey Pokey," and "Zoom Erk" (Jernberg & Booth, 2001; Rubin & Tregay, 1989).

Nurture.

The second dimension, nurture, has been defined as an activity that makes "the child feel warm and secure, and reassures the child that the adults in his world will meet his emotional needs" (Perry & Gerretsen, 2002, p. 57). Within the Theraplay model, nurturing activities use physical touch as a means to soothe, calm, reassure, and comfort the child. These activities encourage the development of attachment and satisfy the child's needs for nurture, which can enhance the ability to self-soothe.

The Theraplay dimension of nurture was addressed through specific activities which occurred throughout group sessions. Within the children's and mothers' groups, the "sharing circle" provided members an opportunity to have other's undivided attention and have their emotional needs met. The mothers' group specifically addressed the topic of nurture in session six. Some mothers expressed difficulties being demonstrative toward their children because of their own family of origin experiences. At the conclusion of the mothers' group session, the women had an opportunity to have some of their needs for nurture met through the "lotioning" activity. In the parent-child multi-family group component nurturing activities were incorporated throughout the beginning, middle and end phases of the sessions (see Appendix A). Within the parent-child multi-

family group, the opening "hello song," acknowledged each member individually and then the ritual of snack-time ensured that member's basic physical needs were met (Jernberg & Booth, 2001). Near the end of the multi-family group session, mother-child dyads routinely engaged in the nurturing "checking for hurts" activity. Attachment difficulties became most apparent between individual dyads, particularly during the final Theraplay activity, "checking for hurts with lotion" (Jernberg, 1979; Jernberg & Booth, 2001; Rubin & Tregay, 1989). The level of intimacy and physical contact inherent within this activity created some discomfort for a few participants. The closing activities of the sessions included both a "check-out" and a "closing song." Members were provided with another opportunity to have other's undivided attention.

The purpose of nurturing activities was to communicate to the child that he or she could get what they needed without "always having to work for it, deny the existence of the need for it, or be rejected for expressing the need" (Jernberg & Booth, 2001, p. 91). Examples of nurturing activities included, "Checking for Hurts," "Feeding," and "Cotton Ball Touch," (Jernberg & Booth, 2001; Rubin & Tregay, 1989).

Engagement.

The third dimension, engagement, has been defined as an "interaction between parents and their children which involves activities that delight, stimulate and engage the child" (Perry & Gerretsen, 2002, p. 57). Within a healthy parent-child relationship, the parent who is attuned to his or her child will respond to the child's cue that he or she wishes to be engaged. Often adverse life experiences lead children to believe that their needs will not be met and that adults cannot be trusted to understand their needs.

Vulnerable children often withdraw and must be enticed to engage in a relationship (Jernberg & Booth, 2001; Perry & Gerretsen, 2002).

The Theraplay dimension of engagement was addressed through specific activities which occurred throughout group sessions. The opening greeting activities of every session acknowledged each member and reinforced the importance of their individual needs and feelings. The mothers' group specifically addressed the topic of engagement in session seven. In the parent-child multi-family group component engagement activities were incorporated throughout the beginning, middle and end phases of the sessions (see Appendix A). The playfulness of the activities effortlessly encouraged the mother-child dyads to engage with one another. The "checking for hurts" activity in the multi-family group component provided individual dyads an opportunity to meaningfully interact with one another separately. The closing activities of the sessions included both a "check-out" and a "closing song."

The purpose of engagement activities was to "draw the child into interaction with their caregiver and maintain an optimal level of arousal" and the activities were intended to be "unexpected, delightful, stimulating, and engaging," (Jernberg & Booth, 2001, p. 18). The goal of these activities was to teach the child to communicate, share intimacy, and enjoy interpersonal contact. Examples of engagement activities included, "Mirroring," "Hide the Notes," and "Row, Row, Row Your Boat," (Jernberg & Booth, 2001; Rubin & Tregay, 1989).

Challenge.

The last dimension, challenge, has been described as activities that "encourage the child to master new behaviors by providing opportunities for success" (Perry & Gerretsen, 2002, p. 56).

The Theraplay dimension of challenge was addressed through specific activities which occurred during the middle stage of each session regarding primarily the content. Within the mothers' and children's group members were encouraged to deal with material that was emotionally challenging. The mothers' group did not specifically address the topic of challenge as it related to a healthy parent-child relationship. However, mothers were encouraged to utilize the principles of emotion-coaching as a means to better empathize with their children. The majority of the mothers found these principles frustrating and quite complicated to implement. At times within the parent-child multi-family group, the members found the content of the puppet show emotionally difficult. Following the puppet show, the facilitators incorporated physically challenging activities into the session so that members could release emotional tension that was aroused during the play.

The purpose of challenging activities was to "enhance feelings of competence, provide the frustration that makes it possible for the child to master tension-arousing experiences, and teach playful combat, competition, and confrontation can release and focus pent-up tension and anger in a safe, direct, controlled way" (Jernberg & Booth, 2001, p. 91). Examples of challenging activities included, "Balloon between Two Bodies," "Musical Pillows," and "Taste Test" (Jernberg & Booth, 2001; Rubin & Tregay, 1989).

Summary

The manner in which the four dimensions of Theraplay were implemented within the group context proved to be quite useful on many levels. From an assessment perspective, the facilitators were able to observe the mother-child dyads during the Theraplay activities and could assess the intergenerational and attachment difficulties within the families. Initially, it became apparent that several of the mothers visibly struggled to reinforce structure, and to meaningfully engage and nurture their children during Theraplay activities. However, throughout the duration of the group mothers were given the opportunity to modify these behaviors. Also, within the multi-family group context, members were able to observe and learn from other mother-child dyads. Most importantly, members with insecure attachment styles were presented with an opportunity to modify these emotional and relational patterns in a safe and nurturing atmosphere. The Theraplay activities reinforced aspects of a healthy-parent child relationship in a non-threatening manner.

Within the mothers' group, discussion focused on the dimensions of Theraplay as it related to a healthy-parent child relationship and gave the women an opportunity to begin to formulate how they could apply these aspects to their parenting. The mothers benefited from the support and advice of other members.

All of the members stated that they appreciated the structure and routine of the group sessions. Members commented that the opening and closing activities were important for setting the tone of group. The children stated that they enjoyed the puppet show, and appeared to deeply appreciate the opportunity to interact with their mothers in such a meaningful way. Within the Mother-Child group, individual and multi-family

group therapy was combined to create an effective intervention that achieved the therapeutic goals.

CHAPTER FIVE: EVALUATION

This chapter will discuss how the intervention/ practice evaluation and personal learning objectives occurred throughout the practicum experience.

Intervention / Practice Evaluation

This section will present and analyze for each mother-child dyad the data obtained from the pre- and post-test measurements including the *Parenting Stress Index* (PSI), *Child Behavior Checklist* (CBCL), and the *Kansas Parental Satisfaction Scale* (KPS). In addition to these standardized measures, the findings from the *Client Satisfaction Questionnaires* and post-group interviews will be discussed.

Wendy and Benjamin

On the *Parenting Stress Index*, Wendy's scores pre- and post-test on the Child Domain increased from 108 to 131, the Parent Domain increased from 122 to 127, and Total Stress increased from 230 to 258, whereas Life Stress decreased from 19 to 11, as reported on Table 1. Scores for Child Domain increased from the normative range to within the clinically significant range, above the 85th percentile. Despite the increase, Parent Domain scores remained within the normative range between the 15th and 80th percentile. Total Stress scores increased from within the normative range to the clinically significant range, above the 85th percentile. These results suggested that Wendy's perception of Benjamin did not initially represent clinically significant emotional or behavioral problems at the beginning of group, however problematic behaviors emerged later in the group. Wendy's increased perception of problematic behaviors could be correlated to her perceived increase in parenting stress. However, there was a reduction

in Life Stress which dropped from 19 to 11, from the clinically significant range to within the normative range.

My clinical observations of Wendy only partially fit with the *PSI*, pre- and post-test findings. Based upon my clinical observations I would have expected Wendy to have scored within the clinically significant range in all of the domains of the *PSI,* which suggests that there may have been some social desirability in Wendy's responses at pre-test. McKay and Pickens (1996) proposed that the Total *PSI* score could predict the quality of the parent-child interaction. She stated that parents who reported normal levels of parenting stress, below 260, tended to engage in more optimal parent-child interactions. Initially, at pre-test, Wendy reported a total score of 230 and at post-test 258. Despite, their normal *PSI* scores, Wendy and Benjamin did not observably engage in optimal interactions. Perhaps Wendy's own early experience of foster care contributed to a disrupted attachment style which may have transmitted from mother to child.

With regard to the Child Domain, Wendy consistently reported clinically significant scores within the subscales: adaptability; reinforces parent; demandingness and acceptability. The "adaptability" subscale is associated with characteristics that makes the role of parenting more difficult by virtue of the child's inability to adjust to changes in his or her physical or social environment (Abidin, 1995). This was consistent with my clinical impressions of Benjamin as he displayed immense difficulty adjusting to new situations and activities throughout the duration of the group. The "reinforces parent" subscale indicates that the parent does not experience his or her child as a source of positive reinforcement. The interactions between the parent and the child do not elicit positive feelings by the parent about him or herself. Essentially the parent may feel rejected by the child and these feelings may threaten the parent-child bond (Abidin,

1995). My clinical impression of Wendy was that while she was initially overtly rejecting towards Benjamin, she appeared to become more accepting as the group progressed. The "demandingness" subscale suggests that the parent experiences significant demands by the child. For example, the child frequently attempts to physically engage with the parent, displays a high frequency of minor problem behaviors, and exhibits a lack of involvement with peers (Abidin, 1995). Benjamin often would attempt to physically engage with his mother, but she only intermittently reciprocated. Throughout the group experience, Wendy and Benjamin had a difficult time participating in the "checking for hurts" lotioning activity which was intended to be a nurturing exercise. The difficulty within this pattern of interaction represents an anxious/avoidant attachment style. Benjamin chronically sought the attention of the group and did so in a disruptive manner. His activity level also appeared to be very high and he was difficult to settle and focus. The "acceptability" subscale indicates that the child possesses physical, intellectual, and emotional characteristics that do not match the parent's expectations. This is indicative of poor attachment and rejection within the parent-child relationship (Abidin, 1995). Wendy and Benjamin appeared to be the mother-child dyad that most overtly struggled with issues of attachment. During the group Wendy admitted to being raised for the first year and a half of her life in foster care, which may account for some of her difficulties with attachment and bonding with Benjamin.

In the Parent Domain, Wendy initially only reported clinically significant scores within the "spouse" subscale. This subscale suggests that parents are lacking emotional and practical support from the other parent in the area of child management (Abidin, 1995). However, Wendy stated that her ex-husband and mother would regularly provide child care for the children. Based upon my clinical impressions of Wendy, I would have

suspected that she might have struggled within multiple subscales, particularly with competency, isolation, attachment, and depression. Abidin (1995) stated that mothers can remain truthful while responding to stressors associated with their children's characteristics, however may be less honest when responding to their own characteristics or stressors. I would suspect that Wendy was concerned about the social desirability of some of her responses which may have accounted for her surprisingly low scores within the Parent Domain. According to Mash and Johnston (1990), "in most abusive families, the primary source of interactive stress appear to reside in parental characteristics and adverse life and situational circumstances, with the child characteristics playing an important secondary role," (p. 314). I would suspect that Wendy's difficulties bonding with her son emanates from her own disrupted attachment and Benjamin's problematic behaviors and difficulties with his peers is characteristic of anxious/avoidant attachment transmitted from previous generations.

The increase in the Total Stress score was accounted for by the elevated Child and Parent Domain Scores. The reduction in Life Stress could be partially accounted for by the fact that at shortly before pre-test Benjamin had been hospitalized due to a life threatening medical condition; however by post-test his health had stabilized.

On the *Child Behavior Checklist,* Wendy's perceptions of Benjamin's T scores pre- and post-test for Internalizing Behaviors decreased from 58 to 52, Externalizing Behaviors decreased from 63 to 59, and Total Problem decreased from 61 to 55, as reported on Table 2. The T scores for Internalizing Behaviors remained within the normative range, below 63. The T scores for Externalizing Behaviors declined from the clinically significant range to the normative range and the T scores for the Total Problem declined from the borderline clinically significant range to within the normative range.

These results would suggest that the group intervention produced some positive effects as evidenced by the Internalizing and Externalizing Behaviors and Total Problem scores. Perhaps these perceived changes could be a result of Wendy's enhanced sense of empathy towards Benjamin as a result of examining interactions in her own family-of-origin.

The *CBCL* pre- and post-test findings moderately fit with my clinical observations of Benjamin. Throughout the group, Benjamin presented as a very challenging child. He appeared to be defiant toward his mother's and the facilitators' directions and demonstrated significant externalizing behavioral problems within the parent-child multi-family group. Initially, his disruptive behavior would lead the other children to distance themselves from him, often causing him to disengage from the group entirely. However, as the group progressed, Benjamin was able to befriend Ryan and his social skills improved and he became slightly more engaged with the group process. The group experience provided Benjamin an opportunity to work on his social skills by learning appropriate behaviors that generated positive attention.

On the *Kansas Parental Satisfaction Scale*, Wendy's scores pre- and post-test relating to the degree to which she was satisfied with the behavior of her child decreased from 6 (Very Satisfied) to 4 (Mixed), her satisfaction with herself as a parent decreased from 5 (Somewhat Satisfied) to 4 (Mixed), and her satisfaction with her relationship with her child remained constant at 5 (Somewhat Satisfied), as reported on Table 3. These responses provided evidence that Wendy answered more honestly at post-test as a result of the empathy from the group. Perhaps the decrease in Wendy's satisfaction with Benjamin's behavior and with herself as a parent was upset when she began to develop an

awareness of how her own family-of-origin experience had impacted her ability to parent, resulting in their relationship difficulties and her child's problematic behaviors

The *KPS* pre- and post-test findings fit with my clinical observations to some extent. Benjamin's behavior was overtly more difficult then the other children's in the group and Wendy struggled to adequately manage his misbehaviors. Wendy's parenting approach vacillated between being either passive or aggressive and Benjamin was usually unfazed by her endless threats. Throughout the group, Wendy struggled to meaningfully nurture Benjamin during the "checking for hurts" exercise and required guidance by the facilitators. Wendy also had difficulty implementing structure, particularly as observed during snack time around the issue of his special diet. The multi-family group component was difficult for both Wendy and Benjamin. In the group context, Wendy was able to observe other children's behaviors and compare her and Benjamin's interactions with that of the other mother-child dyads. This context may have accounted for the increased dissatisfaction with Benjamin's behavior and subsequently a reduction in her satisfaction with herself as a parent.

Wendy completed a post-group written *Client Satisfaction Questionnaire* and a post-group interview as a final component of the evaluation. With respect to the Mother's group component, Wendy responded positively on the written questionnaire and indicated that she had enjoyed participating in the group. She commented that she had appreciated the opportunity to talk with other women who shared similar experiences. She indicated that the topics permitted her to talk about the past and gain different perspectives from the other women. Overall, she commented that she felt the group had satisfied both her and Benjamin's needs. She indicated that as a result of the group,

Benjamin was able to identify his feelings of anger and she has learned how to recognize his feelings and provide ways to assist him in dealing with them.

Wendy did not provide any feedback regarding what she felt could have been changed about the group. In the post-group interview, Wendy described the group as a positive and satisfying experience.

Cynthia and Chelsea

Cynthia was unavailable to complete the *Parenting Stress Index*, *Child Behavior Checklist,* and *Kansas Parental Satisfaction Scale* both at pre- and post-test. Upon completion of the group, Cynthia did not complete a written *Client Satisfaction Questionnaire* and did not participate in a post-group interview as a final component of the evaluation.

My clinical impression of Cynthia was that as the group progressed she developed an increased awareness of the impact of domestic violence on both herself and Chelsea. This enhanced awareness allowed her to become visibly more tolerant and patient with Chelsea, as observed during their interactions during the Theraplay activities. Cynthia implemented structure so much so that she was regimented and often struggled to give up control and playfully engage with Chelsea. However, the facilitator observed that Cynthia had become somewhat more relaxed and empathic towards her daughter which made it more acceptable for Chelsea to express her feelings. At the end of group, Cynthia commented that Chelsea had learned to better communicate her feelings and as a result had been behaving better at home and at school.

Nicole and Ryan

On the *Parenting Stress Index*, Nicole's pre- and post-test scores increased from 150 to 161, on the Child Domain and decreased from 150 to 145 on the Parent Domain. Her score on the scale called Total Stress increased from 300 to 306, and Life Stress decreased from 26 to 15, as reported on Table 1. These scores all remained within the clinically significant range, above the 85th percentile. These results would suggest that the group intervention was not related to significant change within the Child, Parent and Total Stress Domain. There was a slight reduction in the Parent Domain which dropped from 150 to 145 and a more noticeable decrease in Life Stress which dropped from 26 to 15. According to McKay and Picken's (1996) theory, Nicole and Ryan typically should have engaged in less optimal interactions due to their high pre- and post-test scores, 300 and 306, respectively.

My clinical observations of Nicole only moderately fit with the *PSI*, pre- and post-test findings. Based upon my pre-test clinical observations I would not have expected Nicole to have scored within the clinically significant range in all of the domains of the *PSI*. Overall, Nicole's presentation at intake and throughout the beginning phase of group was that of a confident and non-distressed parent. Nicole's post-test measures reflected a negative result with an increased score across the Child Domain. As the group progressed, Nicole expressed growing concerns about her child's behaviors and began to doubt her effectiveness as a parent, which may have accounted for this negative change. Nicole commented that it had been difficult for her to become a parent as a teenager and at times she felt ill-equipped parenting as a result.

With regard to the Child Domain, Nicole consistently reported at pre- and post-test clinically significant scores within the subscales: distractibility/hyperactivity, adaptability, demandingness, mood and acceptability. The "distractibility/hyperactivity" subscale is associated with children who display many of the behaviors related to Attention Deficit Disorder with Hyperactivity (ADHD). Abidin (1995) identified behavioral symptoms such as: over activity, restlessness, distractibility, limited attention span and difficulty concentrating. On various occasions, Ryan was observed to display these symptoms during the children's group. Prior to the commencement of the group, Ryan was diagnosed by his physician with ADHD and was prescribed medication. In most families hyperactive children are the primary contributors to stressful parent-child interactions and that stress appears to emanate from child characteristics (Mash & Johnston, 1990). As previously mentioned, the "adaptability" subscale is associated with characteristics that make the role of parenting more difficult due to the child's inability to adjust to changes in his or her physical or social environment (Abidin, 1995). Over the course of the past few years, Ryan has had to adapt to numerous changes within the family unit and remained fearful of his mother's ex-partner. Ryan presented as a very anxious and worried young boy. The "demandingness" subscale suggests that the parent experiences significant demands by the child and the child may display a high frequency of minor problem behaviors which was observed in Ryan on occasion (Abidin, 1995). The "mood" subscale is associated with children whose affective functioning shows evidence of dysfunction (Abidin, 1995). This was consistent with my clinical observations which noted that Ryan clearly struggled to identify and be able to articulate his feelings. The "acceptability" subscale indicates that the child possesses physical, intellectual, and emotional characteristics that do not match the parent's expectations.

Poor attachment, rejection, or both may consciously or unconsciously be issues within the parent-child relationship (Abidin, 1995). These scores were contrary to my clinical observations, which viewed Nicole and Ryan as having a relatively strong attachment when compared to other mother-child dyads.

In the Parent Domain, Nicole reported clinically significant scores within the "competence" and "attachment" subscales. The "competence" subscale is related to parents who lack practical child development knowledge and possess a limited range of child management skills. In addition, high scores in this subscale are found among parents who do not find the role of parent as reinforcing as they had expected (Abidin, 1995). During session six, Nicole was overwhelmed and frustrated with Ryan's behavior and appeared helpless to rectify the situation. The "attachment" subscale may also reflect a dysfunction in the parent's real or perceived ability to observe and understand the child's feelings and/or needs accurately (Abidin, 1995). This was consistent with the facilitator's observations that Nicole struggled to accurately and empathetically respond to Ryan's emotional needs. Similarly, Nicole disclosed how her own family-of-origin had not been empathetic or able to respond to her emotional needs when she was a child who had experienced a personal trauma.

The increase in the Total Stress score was accounted for by the elevated Child Domain Score which may suggest that maternal cognitions of children's behaviors contribute significantly to overall parenting stress. The reduction in Life Stress might suggest that there was a decrease in the amount of stress outside the parent-child relationship. Throughout the group, Nicole commented that she was receiving significant support from multiple agencies which may have contributed to a reduction in her overall life stress.

On the *Child Behavior Checklist,* Ryan's T scores pre- and post-test for Internalizing Behaviors increased from 65 to 67, Externalizing Behaviors remained constant at 72, and Total Problem increased from 72 to 84, as reported on Table 2. These scores all remained within the clinically significant range, with T scores all above 63. These results would suggest that the group intervention did not produce significant positive effects on the Internalizing Behaviors, Externalizing Behaviors and Total Problem subscales. It was evident that Nicole had a difficult time empathizing with Ryan's behavior. Perhaps maternal cognitions significantly impacted Nicole's perception of Ryan's behavior and skewed her reporting of his problematic behavior.

The *CBCL* pre- and post-test findings did fit with my clinical observations of Ryan. He did not present as an overly challenging child at the start of group, however his behaviors appeared to intensify as the group progressed. Ryan appeared quite compliant to his mother's directions and did not demonstrate significant externalizing behavioral problems within the parent-child multi-family group, but the therapists for the children's group reported that he had some problematic externalizing behavior. Ryan did display significant internalizing behavioral problems. He frequently appeared overly anxious and fearful during discussions about domestic violence. During the children's group, the facilitators observed that Ryan had difficulty focusing his thoughts and maintaining attention. Within the parent-child multi-family group, on two occasions during sessions with intense emotional content, Ryan had accidents with enuresis and encopresis.

On the *Kansas Parental Satisfaction Scale* (KPS), Nicole's pre- and post-test scores in relation to the degree to which she was satisfied with the behavior of her child decreased from (2) Very Dissatisfied to (1) Extremely Dissatisfied, her satisfaction with herself as a parent remained constant at (3) Somewhat Dissatisfied, and her satisfaction

with her relationship with her child remained constant at (1) Extremely Dissatisfied, as reported on Table 3. Perhaps the limited degree of change in Nicole's sense of satisfaction with Ryan's behavior, herself as a parent and their relationship could solely be attributed to her fixed maternal cognitions.

The *KPS* pre- and post-test findings did fit with my clinical observations of Ryan. Ryan presented as a more challenging child as the group progressed. Nicole indicated that she was displeased with the lack of positive changes with Ryan's behavior reported at post-test. This could be a reflection of Nicole's perception that problematic behaviors were intensifying, or the possibility that Ryan's behavioral problems reflected the heightened stress which his mother experienced at the end of group. These behaviors were indicators to the therapists that their insecure/anxious attachment was becoming more evident. For example, towards the later part of group Ryan was reported to have increasing problems with peers at school and further difficulties with enuresis and encopresis at school. Nicole was quite disturbed and frustrated with the occurrence of these incidents. Nicole was replicating a pattern of attachment learned from her own family-of-origin and as a result could not empathetically respond to Ryan effectively. Overall, it was my clinical impression that Ryan appeared more settled in the presence of his mother within the group context, the two appeared to have a strong emotional bond, despite their adversities. However, what the therapists were observing in the group was an unusual situation whereby Nicole was able to focus her undivided attention on Ryan however this was not the case when the two were at home.

Nicole completed a post-group written *Client Satisfaction Questionnaire* and a post-group interview as a final component of the evaluation. With respect to the Mother's group component, Nicole responded positively on the written questionnaire and

indicated that she had enjoyed participating in the group. She commented that she experienced a sense of closeness among the women and group facilitators. She indicated that she learned different games and strategies within the group which she felt she could use at home with her child. Also, she stated that the group helped to normalize her concerns about her son's behaviors as she saw other parents struggling with their children. Overall, she commented that she felt the group had satisfied her needs; however she did not feel that Ryan had benefited as much from the group as she had.

Nicole did not provide any feedback regarding what she felt could have been changed about the group. In the post-group interview, Nicole described the group as a positive and meaningful experience.

Deborah and Rebecca

On the *Parenting Stress Index*, Deborah's pre- and post-test scores on the Child Domain decreased from 113 to 107, her scores on the Parent Domain decreased from 116 to 105. Her scores on the scale, Total Stress decreased from 229 to 212, as reported on Table 1. Similarly, Life Stress decreased from 37 to 27. Scores declined within all domains and remained within the normal range, between the 15th and 80th percentile, with the exception of the Life Stress domain which remained within the clinically significant range, at the 99th percentile. These results would suggest that the group intervention produced significant positive effects within the Child, Parent, Total Stress and Life Stress Domains.

With respect to Deborah my clinical impressions fit with the results of the measure. Deborah presented at intake with moderate parenting issues which would account for her normative score on the pre-test measure. At intake, she indicated that

both she and her daughter attended therapy previous to the group and were receiving significant support from the long-term women's shelter where they lived. Deborah's pre- and post-test scores remained fairly constant for all domains. Deborah was a leader in the group and often supported members when they were distressed. This may have contributed to the increase in her sense of competence with regard to her own parenting. At the end of group, Deborah and her children continued to reside within a long-term shelter, which may have accounted for the decrease on the Life Stress Domain.

Deborah's score on the scale Total Stress was below 260 in the pretest and posttest. This suggests that they would engage in more optimal interactions (McKay & Pickens, 1996). Interestingly, however, at post-test Deborah reported clinically significant scores within "reinforces parent" subscale within the Child Domain, suggesting that she did not experience her child as a source of positive reinforcement. The interactions between the parent and the child do not elicit positive feelings by the parent about him or herself. Essentially the parent may feel rejected by the child and these feelings may threaten the parent-child bond (Abidin, 1995). However, Deborah did not appear to be overtly rejecting towards Rebecca. Two theories could account for this variation. The first; Deborah may have been depressed and was projecting her negative responses onto Rebecca. Deborah did admit during group that she had entered treatment for substance abuse, which may have affected the quality of her relationship with Rebecca, as she devoted more energy into her recovery. The second theory is that Deborah was experiencing difficulty in understanding her daughter's feelings and needs accurately (Abidin, 1995). The high score within this subscale could account for her surprising responses later in the *KPS*.

On the *Child Behavior Checklist,* Deborah's perceptions of Rebecca behavior, as reflected in her pre- and post-test T scores decreased from 61 to 52 for Internalizing Behaviors, decreased from 72 to 58 for Externalizing Behaviors, and decreased from 95 to 54 for the Total problem, as reported on Table 2. The T score for Internalizing Behaviors was in the borderline clinically significant range, and the T scores for Externalizing Behaviors and the Total problem were in the clinically significant range, at the start of treatment. By group completion, the T scores for Internalizing, Externalizing Behaviors and the Total problem had decreased well within the normative range. These results would suggest that the intervention produced positive changes on Deborah's perceptions of Rebecca's Internalizing and Externalizing Behaviors and Total Problem domains.

The *CBCL* pre- and post-test findings fit with my clinical observation of Rebecca. At the beginning of group, Rebecca was probably the most inconspicuous child. Rebecca presented as quite introverted and cooperative within the group setting. As the group progressed, Rebecca was better able to verbalize her thoughts and feelings. She appeared compliant to her mother's requests and remained on task during group tasks.

On the *Kansas Parental Satisfaction Scale*, Deborah's scores pre- and post-test in relation to the degree to which she was satisfied with the behavior of her child, decreased from (3) Somewhat Dissatisfied to (2) very dissatisfied, her satisfaction with herself as a parent remained constant at (2) Very Dissatisfied, and her satisfaction with her relationship with her child decreased from (4) Mixed to (2) very dissatisfied, as reported on Table 3.

For Deborah, I was somewhat surprised by the reported negative changes with her satisfaction with Rebecca's behavior and their relationship given the reported positive

changes in the *PSI* and *CBCL.* Deborah's reported negative changes could be attributed to Rebecca's parentification (she was the oldest of four siblings) and Deborah's participation in treatment for substance abuse. Perhaps as Rebecca became more assertive, she was less compliant with Deborah's need for her to be the caregiver to the younger siblings.

Deborah completed a post-group written *Client Satisfaction Questionnaire* and a post-group interview as a final component of the evaluation. With respect to the Mother's group component, Deborah responded positively on the written questionnaire indicating that she appreciated the sharing circles and focus on self-care activities. She indicated that the group helped to normalize and validate her feelings and experiences. Overall she commented that she felt the group had satisfied her needs, and that she learned about the importance of nurture, engagement, structure and challenge in a healthy parent-child relationship. Deborah commented that she felt that the group experience had helped modify Rebecca's behavior and helped her learn to express her feelings in a positive and appropriate manner.

Deborah did not provide any feedback regarding what she felt could have been changed about the group. In the post-group interview, Deborah described the group as a positive and meaningful experience for both herself and her daughter.

Olivia and Molly

On the *Parenting Stress Index*, Olivia's scores pre-test on the Child Domain, Parent Domain, Total Stress and Life Stress were all clinically significant, well above the 85th percentile, as reported on Table 1.

With respect to Olivia, my clinical impressions totally fit with the results of the measure. Olivia presented at intake with substantial parenting issues that would account for her score on the pre-test measure. The high scores across all domains suggested that the stress was emanating from all dimensions - the parent, child and environment. McKay and Pickens (1996) indicated that *PSI* scores above 260 would result in less optimal parent-child interactions. Olivia and Molly were observed to be interacting uneasily during the parent-child multi-family group.

Throughout the group sessions that Olivia attended, it appeared as though the group experience intensified her fears and increased her feelings of inadequacy as a parent. Although the group did not intentionally contribute to escalation of Olivia's feelings of ineffectiveness, the Mother-Child program had been the second time she attempted group therapy. During intake, Olivia disclosed that she had previously attended group therapy, but felt compelled to withdraw due to the emotional intensity, which may have been consistent with this experience as well. I think that Olivia was not in a place to work on parenting issues. When she entered the Mother-Child group she had too many personal issues, and was still caught up in the cycle of violence.

Andra and Thomas (1998) studied unsuccessful therapeutic outcomes and premature termination among families who presented for therapy with emotionally troubled children and other significant problems. Their research indicated that parents, who reported more parenting stress, received welfare, were single, had more than three children, and who did not refer their children for therapy attended fewer group therapy sessions and withdrew prematurely. This reflected Olivia's entire circumstances and she scored the second highest Total Stress pre-test score on the *PSI* at 319 (See Table 1).

On the *Child Behavior Checklist,* Molly's T scores pre-test for Internalizing Behaviors, Externalizing Behaviors, and Total Problem were all clinically significant, with T scores above 63, as reported on Table 2.

The *CBCL* pre-test findings totally fit with my clinical observations of Molly. She presented as an extremely distressed and emotionally needy child. As a result Molly sought emotional and physical contact from strangers. At the initial session, she appeared visibly worried and anxious and brought her protective blanket to group, despite the fact that this behavior was unusual in a child of her age.

On the *Kansas Parental Satisfaction Scale*, Olivia's scores on the degree to which she was satisfied with the behavior of her child at pre-test was (2) Very Dissatisfied, her satisfaction with herself as a parent was (4) Mixed, and her satisfaction with her relationship with her child was (4) Mixed, as reported on Table 3.

The *KPS* pre-test findings were consistent with my clinical observations of Molly and Olivia. Olivia appeared visibly dissatisfied by Molly's behaviors and uncertain about both her parenting abilities and relationship with her daughter. Olivia did not complete a post-group written *Client Satisfaction Questionnaire* or attend a post-group interview as the final component of the evaluation.

Teresa and Danielle

On the *Parenting Stress Index*, Teresa's scores pre-test on the Child Domain, Parent Domain, Total Stress and Life Stress were all clinically significant, all at the 99th percentile, as reported on Table 1.

With respect to Teresa, my clinical impressions totally fit with the results of the measure. Teresa presented at intake with considerable parenting issues that would

account for her score on the pre-test measure. The high scores across all domains suggested that the stress was emanating from all dimensions - the parent, child and environment. Teresa's Total *PSI* score was above 260, which suggested that she and Danielle would likely have engaged in less optimal interactions (McKay & Pickens, 1996). In relation to Andra and Thomas' (1998) research, Teresa scored the highest Total Stress pre-test score on the *PSI* at 352 (See Table 1) suggesting that she would likely terminate from the group prematurely. Subsequent to the second session, she withdrew from the Mother-Child group, perhaps as a result of the multitude of stressors.

On the *Child Behavior Checklist,* Danielle's T scores pre-test for Internalizing Behaviors, Externalizing Behaviors and Total Problem were all clinically significant, with T scores above 63, as reported on Table 2.

Unfortunately, since Danielle only attended the pre-screening interview and one session of the Mother-Child group, I am unable to offer any clinical impressions of her.

On the *Kansas Parental Satisfaction Scale*, Teresa's scores on the degree to which she was satisfied with the behavior of her child at pre-test was (2) Very Dissatisfied, her satisfaction with herself as a parent was (3) Somewhat Dissatisfied, and her satisfaction with her relationship with her child was (3) Somewhat Dissatisfied, as reported on Table 3.

Table 1

Raw Scores and Percentile Ranks of the Pre- and Post-test Measures of the Parenting Stress Index

GROUP MEMBER		CHILD DOMAIN	PARENT DOMAIN	TOTAL STRESS	LIFE STRESS
WENDY	Pre-Test	108	122	230	19
		70%	53%	63%	93 % *
	Post-Test	131	127	258	11
		95% *	63%	85% *	75%
CYNTHIA	Pre-Test	N/A	N/A	N/A	N/A
	Post-Test	N/A	N/A	N/A	N/A
NICOLE	Pre-Test	150	150	300	26
		99% *	87% *	97% *	99% *
	Post-Test	161	145	306	15
		99% *	85% *	97% *	87% *
DEBORAH	Pre-Test	113	116	229	37
		77%	43%	60%	99% *
	Post-Test	107	105	212	27
		67%	23%	37%	99% *
OLIVIA	Pre-Test	161	158	319	34
		99% *	93% *	99% *	99% *
	Post-Test	N/A	N/A	N/A	N/A
TERESA	Pre-Test	171	181	352	28
		99% *	99% *	99% *	99% *
	Post-Test	N/A	N/A	N/A	N/A

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

* Indicates a clinically significant score (above the 85th percentile).

Table 2

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

GROUP MEMBER		INTERNALIZING	EXTERNALIZING	TOTAL PROBLEM
BENJAMIN	Pre-Test	58	63**	61*
	Post-Test	52	59	55
CHELSEA	Pre-Test	N/A	N/A	N/A
	Post-Test	N/A	N/A	N/A
RYAN	Pre-Test	65**	72**	72**
	Post-Test	67**	72**	84**
REBECCA	Pre-Test	61*	72**	95**
	Post-Test	52	58	54
MOLLY	Pre-Test	63**	82**	74**
	Post-Test	N/A	N/A	N/A
DANIELLE	Pre-Test	79**	74**	74**
	Post-Test	N/A	N/A	N/A

NOTE:

* Indicates a borderline clinically significant score (between 60-63).

** Indicates a clinically significant score (above 63).

Table 3

Scores for the Kansas Parental Satisfaction Scale at Pre- and Post-Test

GROUP MEMBER		SATISFACTION WITH CHILD'S BEHAVIOR	SATISFACTION WITH SELF AS A PARENT	SATISFACTION WITH RELATIONSHIP WITH CHILD
WENDY	Pre-Test	6	5	5
	Post-Test	4	4	5
CYNTHIA	Pre-Test	N/A	N/A	N/A
	Post-Test	N/A	N/A	N/A
NICOLE	Pre-Test	2	3	1
	Post-Test	1	3	1
DEBORAH	Pre-Test	3	2	4
	Post-Test	2	2	2
OLIVIA	Pre-Test	2	4	4
	Post-Test	N/A	N/A	N/A
TERESA	Pre-Test	2	3	3
	Post-Test	N/A	N/A	N/A

NOTE:

1 = Extremely dissatisfied

2 = Very dissatisfied

3 = Somewhat dissatisfied

4 = Mixed

5 = Somewhat satisfied

6 = Very satisfied

7 = Extremely satisfied

As previously stated, it was difficult to formulate a clinical impression of Teresa and Danielle due to the limited time in which they participated in group. Teresa prematurely withdrew from the group after session two. As a result she did not complete a post-group written *Client Satisfaction Questionnaire* and did not attend a post-group interview as a final component of the evaluation.

Summary

Overall the results of the *PSI* at pre-test were varied. Pre-test Total Stress scores suggested that most of the mothers were beyond the normative range at the outset of the group. At the completion of the group, two members' scores remained in the clinically significant range (See Table 1). High scores on the *PSI* are consistent with various studies that suggest that domestic violence increases women's maternal stress and that this stress combined with child behavior problems can undermine the mother-child relationship (Abidin, 1995; Anderson & Cramer-Benjamin, 2000; Andra & Thomas, 1998; Gougeon, 2002; Graham-Bermann & Edleson, 2001; Graham-Bermann & Hughes, 2003; Holden & Ritchie, 1991; Levendosky & Graham-Bermann, 2001; Mash & Johnston, 1990; McKay & Pickens, 1996; Morgan et al., 2002; Morrel et al., 2003; Salcido Carter et al., 1999).

In general, high parenting stress scores correlated with lower quality parent-child interactions. In McKay and Pickens (1996) study, socio-economic and marital status appeared to be important factors in determining the quality of parent-child interactions. They indicated that parents with high parenting stress levels tended to have lower socio-economic status and were more likely to be single-parents. The majority of the women in this practicum group were from lower socio-economic statuses, only one received wages

from an employer. The remainder of the members was subsidized by either Employment and Income Assistance or Employment Insurance. All of the women were single-parents. McKay and Pickens (1996) suggested that future research should investigate how economic hardship, marital status and social support are associated with parenting stress and the quality of parent-child interactions and this recommendation seem reflective with the Mother-Child group clientele.

The comparison of pre- and post-test scores provides an evaluation of the group's effectiveness in reducing the stress within the parent-child system. The majority of mother-child dyads who participated in this practicum remained in the clinically significant range, with scores above the 85th percentile, at pre- and post-test. These results indicated that most members had significant stress prior to and following group intervention. One of the mother-child dyads reported scores within the normative range, between the 15th and 80th percentile throughout the duration of the intervention. The marginal changes need to be interpreted with caution as other influences, outside the group, could account for these results. Mash and Johnston (1990) proposed a model for assessing the stress in parent-child interactions. Their model assessed the direct impact of child and environmental characteristics on parent-child interactive stress; indirect effects of these variables as mediated through parental characteristics; and finally acknowledged the reciprocal connections from parent-child stress to parent, child, and environmental characteristics.

Past studies typically focused on the behavioral characteristics of children and neglected the psychosocial and family environment. However, current research has begun to examine the determinants of parenting stress and children's behavioral difficulties from a broader ecological approach (Mash & Johnston, 2003; Morgan,

Robinson & Aldridge, 2002). Mash and Johnston (1990) concluded that in abusive families, parental characteristics, particularly maternal cognitions, and adverse environmental situations appear to exert the most impact on parent-child interactive stress, with minimal effects emanating from child behavior.

Morgan et al. (2002) also indicated that parents of children with problematic externalizing behaviors report significantly higher levels of parenting stress than parents of children who did not have problematic externalizing behaviors. Often these parents perceive themselves as having less parenting knowledge, less parental competence, and fewer emotional and instrumental supports than parents of non-externalizing children. Parents' perceptions of child behavior can mediate the relationship between parent stress and parent behavior, and interventions should be directed toward these attributions. Parents experiencing high levels of parenting stress are more likely to focus on negative aspects of their child's behavior and attribute that behavior to the child rather than the situation. This speaks to the parent's difficulties with the material on emotional intelligence and identifying their children's feelings. Combined with a lower threshold for tolerance of behavioral problems, these factors increase the chance of dysfunctional parenting behavior (Morgan et al., 2000; Snarr, Strassberg & Slep, 2003).

Andra and Thomas' (1998) findings suggested that intervention programs should focus on reducing the level of parenting stress prior to enrolling the children in group therapy, particularly for socio-economically disadvantaged parents with high levels of parenting stress. Specifically, preliminary interventions should focus on reducing parental depression, increasing parental competence and enhancing the level of attachment between the parent and the child. It was believed that these changes would enable the child to begin to positively reinforce the parent, which would hopefully

increase therapy attendance and subsequently improve the therapeutic outcome. Hembree Eisenstadt, Eyberg, Bodiford McNeil, Newcomb and Funderburk (1993) examined the impact of stage sequencing and found support for the notion of providing parent-directed interaction therapy prior to child-directed interaction therapy. When this occurred, mothers' reported greater improvements in their children's behavior and reported more satisfaction with therapy.

Overall, the results of the *CBCL* at pre-test reflected a variation in children's scores with most children in the clinically significant range on (See Table 2) (Anderson & Cramer-Benjamin, 2000; Graham-Bermann & Hughes, 2003; Holden, 2003; Prinz & Feerick, 2003). These results were consistent with studies that reported elevated internalizing and externalizing scores for children who were exposed to domestic violence (Boyd Webb, 1999; Fainsilber Katz, 2001; Gil, 1991; Graham-Bermann & Edleson, 2001; Levendosky & Graham-Bermann, 2001; Levendosky et al., 2000; Morrel, Dubowitz, Kerr & Black, 2003; Stiles, 2002; Wolfe et al., 2003).

The findings of this practicum were not consistent with the literature in regards to gender (Anderson & Cramer-Benjamin, 2000; Cummings et al., 1999; Graham-Bermann & Hughes, 2003). Within the group, the male and female children both experienced clinically significant internalizing and externalizing behavioral problems to varying degrees (See Table 2).

The comparison of pre- and post-test scores on the *CBCL* provides an evaluation of the group's effectiveness in reducing the internalizing and externalizing difficulties experienced by the children. Positive changes were observed for the majority of the children which would suggest that the group intervention was beneficial in decreasing the children's behavioral problems.

Overall, the results of the *KPS* at pre-test reflected a range in scores for the women (See Table 3). On average, the women indicated that they were very dissatisfied with their children's behavior, somewhat dissatisfied with themselves as parents, and somewhat dissatisfied with their relationship with their child (Anderson & Cramer-Benjamin, 2000; Cox et al., 2001; Margolin et al., 2001).

The comparison of pre- and post-test scores on the *KPS* provided an evaluation of the group's effectiveness in enhancing the mothers' perceptions of their child's behavior, their satisfaction with themselves as parents, and their relationship with their child. The evaluation contained a complete data on three mothers who reported improvement, whereas two mothers noted deterioration.

Group members provided written feedback through the *Client Satisfaction Questionnaires* and verbally during the post-group interviews. The information that was collected added to the evaluation of this intervention. Members shared their perceptions about how the group experience had benefited themselves and their children. In general, the mothers reported positive outcomes as a result of the intervention and satisfaction with their experience.

Conclusion

The intention of this practicum was to acquire knowledge and proficiency in the implementation, facilitation and evaluation of a therapeutic group intervention designed to enhance the parent-child relationship for mothers and children affected by domestic violence. The results of the *PSI, CBCL* and the *KPS* suggest the group intervention provided marginally beneficial results for the mothers and their children.

The findings of this practicum must be cautiously interpreted due in part to the small sample size which limited the generalizability of the results; as well, the clinical measures relied solely upon maternal reports (Kirst-Ashman & Hull, 1997; Toseland & Rivas, 2001). The veracity of maternal reports may be biased by the effects of social desirability (Abidin, 1995; Holden & Ritchie, 1991).

Despite the fact that the standardized measures reflected moderate positive changes, the *Client Satisfaction Questionnaires* and post-group interviews feedback indicated that the group was a positive and meaningful experience and provided beneficial outcomes for the mothers and their children (Gougeon, 2002).

Interestingly, as a result of the evaluation of the intervention, three families committed to ongoing therapeutic involvement. Nicole and Ryan, who continued to present with mother-child relational difficulties post-group, committed themselves to ongoing family Theraplay. Deborah enrolled herself and another daughter for the next Mother-Child group. Wendy elected to participate in individual treatment. Cynthia and Chelsea, who had repeated the group, indicated that they were satisfied with their progress and did not request additional services at this time. The purpose of the Mother-Child group is to provide initial interventions to families interested in addressing parent-child attachment issues within the context of domestic violence.

Personal Learning Objectives

Several personal learning objectives were identified at the outset of the practicum and were achieved by its completion. The first learning objective was to enhance my knowledge and understanding of the risk and protective factors associated with domestic violence for women, children and the mother-child relationship. The clinical and

empirical literature reviewed formed the basis for my understanding of how women and children are affected by domestic violence. However, the implementation of the Mother-Child group provided the context for the most significant learning to occur. The women and children courageously shared their personal experiences of domestic violence and allowed me to observe and clinically analyze their dyadic interactions. The group experience facilitated the integration of my understanding of the real life experiences of families impacted by domestic violence with the theories that I had learned.

The second learning objective was to enhance my group facilitation skills, my ability to work with a co-facilitator and to learn more about group dynamics and processes within this population. The Mother-Child group was conducted from December 2003 to April 2004 and involved numerous duties involving the pre-group tasks, group facilitation, and post-group tasks. As a facilitator, it was my responsibility to ensure the completion of the pre-group tasks which involved advertising for the group, scheduling and conducting pre-screening interviews, planning for the group sessions and administering the pre-group evaluative measures. The recruitment of members was rather straightforward because of the established waiting list, which was comprised in part by past members who had requested to return to the group. However, the scheduling of pre-screening interviews and pre-test measures was much more difficult. This task required that the facilitators display a high degree of availability and flexibility to accommodate appointments to potential members' schedules. In December 2003, potential members' interest in the group declined as the holiday season approached, and most did not attend their scheduled appointments. Luckily, by January 2004, potential members became re-connected with a renewed sense of enthusiasm about their participation.

Another task was the preparation of the group sessions which was an evolving process. While the Mother-Child group did have a framework prior to commencement, sessions were modified to better meet the needs of the group.

The facilitation of the Mother-Child group reinforced prior skills that I had acquired in group facilitation and provided an opportunity to work with a new co-facilitator. I learned the importance of establishing a working relationship with a co-facilitator prior to the outset of the group. I did not have a working relationship with any of the co-facilitators prior to group, which at times heightened my anxiety and inhibited the exchange of feedback about my facilitation skills and the depth to which the group experience was processed among facilitators. Pre-existing working relationships would have elevated my level of comfort, reinforced my ability to request guidance and encouraged constructive feedback, enriching my learning experience.

The post-group tasks involved the evaluation of the group intervention through the administration of standardized measures, qualitative client satisfaction questionnaires and post-group interviews. Of special interest, I learned how to administer standardized measures and how to interpret the results. The standardized measures aided in the assessment process by identifying areas for intervention both at the beginning of the group and subsequent to the completion of group. The measures quantified behavioural targets which permitted a comparison of pre- and post-group functioning and provided a measure of the degree of improvement. The qualitative client satisfaction questionnaires and post-group interviews highlighted the limitations of the standardized measures and provided a richer depiction of women and children's experiences and growth within the group. Unfortunately, several members of the group withdrew prior to the administration of post-group measures and were unable to offer feedback or comparative post-test

scores. This missing data prohibited facilitators from making an assessment of whether or not the intervention was useful to members for the time they attended the group. Furthermore, as a facilitator I speculated whether there was anything further I could have done to ensure their completion of the group. However, the literature review aided my understanding into the myriad of external factors that can prevent members from completing the Mother-Child group.

The clinical supervision provided by Dr. Brenda Bacon, Ms Linda Perry and debriefing sessions with the additional co-facilitators provided opportunities to discuss additional clinical insights which facilitated my understanding of group dynamics and processes within this dyad. Personal reflection and self-evaluation occurred through the analysis of weekly videotaped sessions, and the use of a learning log was beneficial as a means of recording my thoughts and feelings about the therapeutic process. As the group intervention progressed throughout the various stages, I began to recognize and appreciate the amount of time and energy required by such an intervention.

The final learning objective was to develop intervention skills in attachment based therapy, multi-family group therapy and Theraplay techniques. With respect to attachment based therapy, I learned how important it is to enhance the mother-child relationship as a means of reducing children's problematic internalizing and externalizing behaviors and mothers' perceived level of stress. It is particularly important to help mothers modify their own emotional and relational patterns through the resolution of their own attachment issues. At times, mothers within the group struggled to empathize with their children, which may have been rooted in their own histories of attachment. With regard to multi-family group work, the mothers and their children used the opportunity to meaningfully interact with one another and with others families affected

by domestic violence. Multi-family group work provided a setting for members' experiences to be normalized and validated and members felt empowered by the process of mutual aid. The parent-child multi-family component provided an opportunity to directly assess the style of attachment between the mother and child and the intergenerational dynamics. Also, the activities provided a context for mothers to practice modeling the four dimensions of Theraplay within their relationship. As a facilitator, the incorporation of Theraplay activities within the parent-child multi-family group was most challenging. Similar to the mothers, I had to evaluate my own personal experience (e.g. less experience with children and play activities) and overcome my uneasiness with the demands of such an interactive therapeutic modality. Compounding this challenge was the fact that Theraplay activities are typically facilitated by a therapist who has received substantial training and certification. Prior to the start of group, I did not have exposure to Theraplay training and in response I had immersed myself in the literature to develop a comprehensive understanding of the main characteristics of Theraplay. It was essential to develop a thorough understanding of the four elements, nurture, engagement, structure and challenge within a healthy-parent child relationship. By understanding these elements I was better able to assess mother-child dynamics and plan interventions to address the identified issues. The puppet show provided the context for children to process their experiences with domestic violence in a non-threatening manner and provided a meaningful framework for parents to identify with their children's level of understanding.

In summary, this practicum provided me a rich and challenging experience that contributed significantly to my personal and professional learning. As a social work practitioner, I feel that this experience enhanced my skills within the area of family

assessment and intervention planning. This intervention approach has broadened my perspective and reaffirmed the importance of systemically treating mother and child dyads in cases of domestic violence. I feel immense gratification in having undertaken and accomplished the challenge of this practicum.

CHAPTER SIX: CONCLUSION

This final chapter will offer commentary regarding the inherent strengths and limitations of the parent-child model that emerged throughout the implementation and evaluation of the practicum.

Strengths of the Model

The facilitator identified numerous strengths in the application of an attachment-based group therapy model for mothers and children affected by domestic violence. Most importantly, the facilitator appreciated how the model viewed domestic violence from a systemic perspective. As the literature stated, domestic violence affects individual member's functioning, relationships between members, and the well-being of the whole family unit (Levendosky et al., 2000; Mash & Johnston, 1990; Sanders, 1999). The intervention offered treatment to mothers and children concurrently and then conjointly in the parent-child multi-family group. Researchers have indicated that the impact of domestic violence is a complex phenomenon that may be determined by a host of factors within the parent/child's environment, family and individual characteristics (Mash & Johnston, 1990; Wolfe, et al., 2003). The parent-child model was inclusive to these factors and did not individualize the problem. Within this model there were multiple interacting risk and protective factors that could influence the future outcomes for mothers and their children (Morrel et al., 2003). Furthermore, Gougeon (2002) suggested that the parent-child multi-family group recognized the interrelated and reciprocal nature of parent-child issues. The model recognized the importance of including mothers in the change and healing process.

The ramifications of this intervention on future program planning would suggest that organizations begin to treat mother-child dyads systemically rather than individually. In addition, consideration should be given to the multi-family parent-child model which could be viewed as alternative to traditional forms of group therapy were abused women and children are seen individually. The multi-family group capitalizes on the strengths of peer support and models healthy parent-child interactions.

Attachment theory provided a useful framework for understanding the physiological, psychological, and cognitive adaptations made by the women and children affected by domestic violence (Bolen, 2000). The intervention was preventative and attempted to interrupt the intergenerational transmission of attachment difficulties and the future incidence of violence (Bolen, 2000). Systems theory emphasizes the social and relational context and unique patterns of interaction that recur within relationships over time and in multiple generations (Anderson & Cramer-Benjamin, 2000). This approach is consistent with the literature that suggests that treatments are most effective when they provide dyadic mother-child intervention to decrease children's behavioral problems and improve mothers' parenting abilities (Campbell & Palm, 2004; Schicke Athanasiou & Gunning, 1999).

Within this particular parent-child model, the content and Theraplay activities were directed toward children between the ages of 7 to 10. Research suggests that it is beneficial for children to receive intervention at an earlier age (Graham-Bermann & Edleson, 2001). In general, Theraplay activities can be utilized and adapted for children of a younger age. However, due to the mature content within this group format it was necessary for the children to be of latency age to ensure that the children had mastered certain developmental tasks to participate effectively in group. Interestingly, it has been

observed by therapists that parents often do not present their children for therapy until the children have reached school-age, often when their problematic symptoms have become reconfirmed by others; such as daycare providers, teachers or social workers. The parent-child multi-family model utilizing Theraplay techniques could be a useful preventative program for families with younger children who have been identified as high risk. For example, for children who have witnessed domestic violence but have not yet developed internalizing or externalizing behavioral problems. The mothers' group would focus on the four Theraplay dimensions of a healthy parent-child relationship; however the multi-family group component would not focus on the domestic violence content, but rather the Theraplay activities.

Bolen (2000) cautioned clinicians not to be too myopic in their views about the properties of abuse and violence, by focusing only on the dyadic level, and failing to recognize and assess those critical variables at the societal level. The parent-child model used at Elizabeth Hill Counselling Centre recognized that the families interacted within a broader social context. After leaving abusive relationships, many of the families faced systemic barriers most often associated with poverty, and as a result became involved with multiple social service agencies. The majority of the women highlighted financial concerns, ongoing fears about safety, and the need for adequate housing. Families became engaged in the legal system regarding protection orders, custody and access. Transportation and childcare needed to be arranged so that members could attend sessions. Within the group context, members could discuss and problem-solve issues related to these external stressors. Levendosky and Graham-Bermann (2001) suggested that parents' psychological functioning can be affected by environmental stressors and mediated through social support, which can contribute to the quality of parent-child

interactions. Studies have shown that the level of parenting stress is associated with the degree of children's functioning (Holden & Ritchie, 1991; Levendosky et al., 2000). As the group progressed, families' needs emerged that the model could not address, for example housing and financial issues. Throughout group, facilitators were able to refer some families to additional social service agencies to lessen the impact of environmental stressors and promote treatment adherence (Andra & Thomas, 1998). The pre-screening assessment may be the best time to assess systemic barriers faced by individual families and to coordinate appropriate resources where possible.

The results of the evaluation, particularly the qualitative measures which were based upon the personal experiences and comments of the group members, suggested that the group format was meaningful and valuable to them. These findings support the literature which suggests that a group format is recommended for women and children affected by domestic violence (Anderson-Cramer-Benjamin, 2000). The quantitative measures, particularly the scores within the *Parenting Stress Index* should be incorporated more fully as a screening tool to identify which families may be at risk for attendance difficulties and premature termination. Additional external supports could be established in an effort to retain highly stressed families in the treatment process.

Gougeon (2002) stated that the models used for this group intervention consisted of a mothers' support group and a parent-child multi-family group that primarily utilized Theraplay activities. The mothers' group was offered in a support group format which addressed the mothers' need for support as well as their need for parent education (Campbell & Palm, 2004). Throughout the group, mothers frequently disclosed parenting struggles and solicited support and feedback from other members. The support group format enabled women to share their experiences in a caring and supportive environment,

which appeared to be the most significant component of the intervention for meeting the women's individual needs. The children's group helped children to explore their feelings and thoughts in more socially appropriate ways by normalizing their experiences. The model intended to alleviate the children's internalizing and externalizing symptoms (Morrel, et al., 2003).

As Gougeon (2002) indicated, the parent-child multi-family group component was a valuable extension of the mothers' and children's group. Theraplay theory and techniques were utilized both in the mothers' group and in the parent-child multi-family group component. Within the mothers' group discussion focused on the four dimensions of Theraplay as it related to aspects of a healthy parent-child relationship and the impact of domestic violence. Within the parent-child multi-family group, Theraplay activities provided an opportunity for meaningful interactions to occur between the mothers and their children. Overall, it appeared as though mother-child dyadic intervention enhanced the parent-child relationships.

Limitations of the Model

The facilitator observed some limitations in the application of an attachment-based group therapy model.

The primary limitation became evident during the initial few sessions of group. The format was intensive and there appeared to be too much content designated for each weekly session. The mothers' group was an hour in duration, which posed a challenge to the facilitators to incorporate adequate time for group discussion between the opening and closing tasks (see Appendix B). With regard to the content, by the time that session two had concluded, the group was already behind the group outline. For the most part,

this remained a weekly constant. Sessions two, three and four proved to be beneficial in enhancing the mothers' understanding of the impact of domestic violence, however seemed hurried.

In the facilitator's opinion, additional time was required in session five, during discussion about attachment and the parent-child relationship. Given the concept of intergenerational transmission of attachment difficulties, the mother's own attachment history has been theorized to influence her ability to accurately empathize and respond to her distressed child (Bacon-Richardson, 2001; Byng-Hall, 2002; Finzi et al., 2001; Johnson, et al., 2003; Vadas, 2002). By session five, members had routinely begun to disclose information about their families-of-origin, as they processed the educational material. Perhaps it would have been advantageous to the mothers to have explored these issues more fully. As the group progressed, particularly in sessions nine and ten, during discussions on "emotion-coaching," several of the mothers struggled to accurately empathize and soothe their children. In my opinion, it would have been beneficial to have explored more in-depth the mothers' attachment and victimization histories to assist them in resolving their own issues. Attachment-based therapy is intended to help individuals modify their emotional and relational patterns which may stem from their own families-of-origin.

The next limitation occurred during the pre-screening interviews. In hindsight, the facilitator should have assessed more thoroughly the mother's experience within her own family, possible history of additional victimization, discussed the relationship between the parents and focused more on intergenerational cycles of violence (Perry & Gerretsen, 2002). It may have been beneficial to have offered individual sessions to the mothers to process these issues concurrently with the group intervention. In the future, as

a therapist I would even recommend that women attend individual sessions prior to the onset of group to begin to focus on family-of-origin issues. The research of Hembree Eisenstadt et al. (1993) confirmed the importance of providing parent-directed therapy prior to child-directed interaction therapy as a means of enhancing therapeutic outcomes.

The last limitation relates to the integration of Theraplay. The facilitator questioned how much the Theraplay activities were generalized to the mother and child's home life. In hindsight, perhaps the facilitator could have assigned supplementary homework tasks to ensure that the mothers and children routinely engaged in the Theraplay activities and dimensions outside of the group. Sessions six, seven and eight occurred more in a discussion format; the mothers may have learned more through examples of practical application.

General Commentary

The facilitator experienced both the strengths and limitations inherent in the clinical application of the attachment-based group model. Even though there were several identifiable limitations, it can generally be stated that the facilitator found the model to be a reasonably effective intervention. Given the identified needs of this population the strengths of this intervention outweighed the limitations.

To summarize, this practicum provided a valuable service to a population at risk for experiencing further emotional, behavioral and attachment difficulties. Without intervention, the adverse impacts of domestic violence could affect women and children throughout their lives, inhibit the parent-child relationship, transmit to future generations and increase future demand on social service systems. Given the co-occurrence of child abuse and domestic violence, and the risk of intergenerational transmission, it is

imperative to address dual violence at a policy level to advocate both for clients and for additional funding, resources, and collaborative efforts to ensure adequate safety and assistance to *all* victims (Folsom et al. 2003).

In conclusion, this practicum has enhanced the knowledge base for future interventions with mother-child dyads and may be influential with regard to program and policy development around the systemic barriers encountered by families in the aftermath of domestic violence.

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APPENDIX A
Outline of Group Sessions

Session # 1
Getting to Know Each Other

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

Mother's Group

Check-In and Introductions

- Welcome and introduction of facilitators and members.
- Use a Sharing Circle and Talking Stone

Housekeeping Issues

- Distribute calendars and list of group topics
- Explain format, structure and purpose of the group

  The format of the group will be twelve weeks in duration starting tonight, January 29th and ending April 15th, 2004.

  Each group session is structured and is approximately 2 hours long. Each session will have a portion of the group which is mothers only and children only time followed by a portion that is for mothers and children (multi-family) time. As the group progresses, the portion of the multi-family time will increase.

  The mothers' group portion will be approximately one hour and 15 minutes followed by snack time and the mother-child group portion.

  The group has three main purposes:

  1.) To learn how violence affects children, women and mother's ability to parent; how to support your child more effectively as he/she deals with the impact of domestic violence;
  2.) To learn how to be more effective in dealing with children's difficult behaviors;
  3.) To learn how to use play to strengthen your relationship with your child.

Group Rules

- Brainstorm what women need to feel safe in the group…
- Emphasis regular attendance – It is important for everyone to attend sessions and to be punctual. If you are unable to attend or anticipate being late we would appreciate a telephone call from you prior to the group.
- Emphasis confidentiality – Discuss the limits of confidentiality – child protection, threats and self-harm.

Warm –up Activity

- Name Game

Why Break the Secret?

- Discuss the importance of breaking the secret of the violence with their children.

Theme of the Week – Why we are here?

Facilitators review the purpose of the group.

- The mothers group will allow the women to share experiences and gain an understanding of the impact that family violence has had on the parent-child relationship. The group will enable women to develop an understanding of the importance of play in strengthening the parent-child relationship.

- The children's group will allow children to develop social skills and to express feelings in a socially appropriate manner. The group will provide children with a positive experience that will increase their self-esteem and an opportunity to experience positive peer relationships.

- The Mother's and Children's group will provide an opportunity for the mothers and their children to learn to have fun together using play and activities to strengthen the parent-child relationship.

Group Discussion -Importance of Play

- Brainstorm with the mothers the definition and the importance of play.
- Why is play important in families where there has been violence?
- Share psycho-educational material regarding the four functions of play, including: biological, intrapersonal, interpersonal and social-cultural

Theraplay Activity

- Cotton ball throw

Nurturing and Check-Out

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

Multi-Family Group

Check-In, Sharing, Snack Time and Hello Song

Group Rules for Theraplay

Stick Together No Hurts Have Fun!

Theraplay Activities

- Cotton Ball Throw
- Balloon Toss
- Balloon Between Two Bodies

Closing Song

Session # 2
Impact of Family Violence on Women

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

Mother's Group

Check-In

Housekeeping Issues

- Request volunteer spokesperson to share with the children
- Children's Theme – Becoming a Group- Building a sense of security and commonality between the children

Warm-up Activity

- Name and animal and why?

Theme of the Week – Effects of Family Violence on Women

Using the Parent Wellness Wheel - Draw a circle and divide the circle into four quadrants, each quadrant will represent the spiritual, emotional, physical and mental aspects of a woman's life.

- Inside the circle, brainstorm with the women what a woman needs to be physically, emotionally, spiritually, and intellectual well.
- Outside the circle, brainstorm with the women what happens to a woman in an abusive relationship.
- After the circle has been completed, brainstorm with the women on what strengths a woman must have to survive an abusive relationship.
- Provide educational material on the effects of family violence on women.

Theraplay Activities

- Zoom Erk
- Simon Says

Nurturing and Check-Out

- Request a volunteer to summarize our activities and share this information with the children in the multi-family group.
- Nurturing – "Pass the lotion." Prepare mothers to check their children for hurts, co-facilitators demonstrate on each other for the group
- Have each woman check-out with a brief comment about what she will be taking from the group tonight.

Multi-Family Group

Check-In, Sharing, Snack Time and Hello Song

Group Rules for Theraplay

Stick Together No Hurts Have Fun!

Theraplay Activities

- Name Game
- Zoom Erk
- Simon Says
- Hi! My Name is Joe
- Lotioning- Check for Hurts

Closing Song

Session # 3
Parenting in an Abusive Relationship

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

Mother's Group

Check-In

Housekeeping Issues

- Request volunteer spokesperson to share with the children
- Children's Theme – Feelings

Warm-up Activity

- Feeling Charades – "Pass the funny face"

Theme of the Week – Effects of Family Violence on Parenting

- Have Parent Wellness Wheel (from previous week) available and ask the women to brainstorm about what happens to women's needs (intellectual, spiritual, emotional and physical) when involved in an abusive relationship.
- After the circle has been completed, brainstorm with the women on what strengths a woman must have to survive an abusive relationship.

- Have Parent Wellness Wheel available and ask the women what happens when a parent is in abusive relationship. Are those wellness needs being met? Discuss how the abuse affects a woman's ability to parent.
- After the circle has been completed, brainstorm with the women on what strengths a woman must have to survive and parent in or after an abusive relationship.

Theraplay Activity

- Musical pillows
- Demonstrate Nose-clucking

Nurturing and Check-Out

- Request a volunteer to summarize our activities and share this information with the children in the multi-family group.
- Nurturing – "Pass the lotion." Ask mothers to pair up and check one another for hurts with lotion.
- Have each woman check-out with a brief comment about what she will be taking from the group tonight.

Multi-Family Group

Check-In, Sharing, Snack Time and Hello Song

Group Rules for Theraplay

Stick Together No Hurts Have Fun!

Reminder that Max will be coming next week!

Theraplay Activities

- Musical pillows
- People to People
- Nose-clucking
- Checking for hurts with lotion

Closing Song

Session # 4
Impact of Family Violence on Children

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

Mother's Group

Check-In

Housekeeping Issues

- Request volunteer spokesperson to share with the children
- Children's Theme – Different Kinds of Hurting

Warm-up Activity

- Cotton Ball Touch

Theme of the Week – Effects of Family Violence on Children

Using the Child Wellness Wheel - Draw a circle and divide the circle into four quadrants, each quadrant will represent the spiritual, emotional, physical and mental aspects of a child's life.

- Inside the circle, brainstorm with the women what a child needs to be physically, emotionally, spiritually, and intellectual well.
- Outside the circle, brainstorm with the women what happens to child who is exposed to an abusive relationship. Are those wellness needs being met? Complete the wheel by including the impact of exposure to violence on children.
- After the circle has been completed, brainstorm with the women about what the strengths their children have.
- Provide educational material on the effects of family violence on children.

Demonstrate Puppet Show – "Mixed Up Feelings"

Theraplay Activity

- Squeeze comes around

Nurturing and Check-Out

- Request a volunteer to summarize our activities and share this information with the children in the multi-family group.
- Nurturing – "Pass the lotion." Ask mothers to pair up and check one another for hurts with lotion.
- Have each woman check-out with a brief comment about what she will be taking from the group tonight.

Multi-Family Group

Check-In, Sharing, Snack Time and Hello Song

Group Rules for Theraplay

Stick Together No Hurts Have Fun!

Puppet Show with Max- "Mixed Up Feelings"

Theraplay Activities

- Move Your Body
- Cotton Ball Touch
- Squeeze Comes Around
- Checking for hurts with lotion

Closing Song

Session # 5
Enhancing the Relationship with our Children

Goal: To provide education and facilitate discussion regarding the development of attachment between a mother and her child.

Mother's Group

Check-In

Housekeeping Issues

- Request volunteer spokesperson to share with the children
- Children's Theme – Fighting in Families

Warm-up Activity

- Hokey Pokey

Theme of the Week – Enhancing the Relationship with our Children

- Discuss Basic Principles of Attachment
- Discuss the Formation of Attachments
- Discuss Parent, Child & Environmental Risk Factors to Secure Attachment
  Factors can interfere with the development of a secure attachment between the child and the parent.

Demonstrate Puppet Show – "Breaking the Secret"

Theraplay Activity

- Hide the Note
- Toilet Roll Bust Out

Nurturing and Check-Out

- Request a volunteer to summarize our activities and share this information with the children in the multi-family group.
- Nurturing – "Pass the lotion." Ask mothers to pair up and check one another for hurts with lotion.
- Have each woman check-out with a brief comment about what she will be taking from the group tonight.

Multi-Family Group

Check-In, Sharing, Snack Time and Hello Song

Group Rules for Theraplay

Stick Together No Hurts Have Fun!

Puppet Show – "Breaking the Secret"

Theraplay Activities

- Move Your Body
- Cotton Ball Touch
- Squeeze Comes Around
- Checking for hurts with lotion

Closing Song

Session # 6
Nurturing

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

Mother's Group

Check-In

Housekeeping Issues

- Request volunteer spokesperson to share with the children
- Children's Theme – Breaking the Secret of Fighting

Warm-up Activity

- Pop the Bubble

Theme of the Week – Nurturing- Hugs, back rubs and combing hair

- Review Risk Factors to Secure Attachment / Parent Risk Factors / Child Risk Factors / Environmental Risk Factors.
- Discuss Resiliency Factors
- Discuss Goals of Theraplay and How it Works
- Read engagement excerpt from Theraplay
- Brainstorm ways in which we nurture with our children? With others?
- How does it feel for us to nurture? Does it feel easy or difficult?
- How easily do our children let us nurture them?

Theraplay Activity

- X- Marks the Spot
- Donut on Finger

Demonstrate Puppet Show – "Max Goes to Shelter"

Nurturing and Check-Out

- Request a volunteer to summarize our activities and share this information with the children in the multi-family group.
- Nurturing – "Pass the lotion." Mothers' pair up and lotion each others hands.
- Have each woman check-out with a brief comment about what she will be taking from the group tonight.

Multi-Family Group

Check-In, Sharing, Snack Time and Hello Song

Group Rules for Theraplay

Stick Together No Hurts Have Fun!

Puppet Show with Max "Max Goes to Shelter"

Theraplay Activities

- Pop the Bubble
- Ladder
- Donut on Finger
- Checking for hurts with lotion

Closing Song

Session # 7
Engagement

Goal: To introduce the four Theraplay dynamics and to establish the element of engagement as an important component of a healthy parent-child interaction.

Mother's Group

Check-In

Housekeeping Issues

- Request volunteer spokesperson to share with the children
- Children's Theme – Mixed up Feelings

Warm-up Activity

- Feeling Charades

Theme of the Week – Engagement –Eye contact, laughs and giggles

- Brainstorm ways in which we engage with our children? With others?
- Read engagement excerpt from Theraplay

Theraplay Activity

- Mirroring
- Row, Row, Row Your Boat

Demonstrate Puppet Show- "Max in Shelter"

Nurturing and Check-Out

- Request a volunteer to summarize our activities and share this information with the children in the multi-family group.
- Nurturing – "Pass the lotion." Mothers' pair up and lotion each others hands.
- Have each woman check-out with a brief comment about what she will be taking from the group tonight.

Multi-Family Group

Check-In, Sharing, Snack Time and Hello Song

Group Rules for Theraplay

Stick Together No Hurts Have Fun!

Puppet Show with Max "Max in Shelter"

Theraplay Activities

- Row, Row, Row Your Boat
- Mirroring
- Lifesaver on a Stick
- X- Marks the Spot
- Belly Laughter
- Checking for hurts with lotion

Closing Song

Session # 8
Structure

Goal: To introduce the four Theraplay dynamics and to establish the element of structure as an important component of a healthy parent-child interaction.

Mother's Group

Check-In

Housekeeping Issues

- Request volunteer spokesperson to share with the children
- Children's Theme – Feeling Afraid

Warm-up Activity

- Feeling Charades

Theme of the Week – Structure – Setting Limits, Keeping Children Safe

- Read structure excerpt from Theraplay
- Brainstorm ways in which we create structure for our children.
- How do we perceive structure? As a good thing? A bad thing? Why?
- Why is providing structure difficult?

Theraplay Activity

- Mother May I?
- Measuring with Fruit Tape
- Lotion Prints

Demonstrate Puppet Show- "Feeling Afraid"

Nurturing and Check-Out

- Request a volunteer to summarize our activities and share this information with the children in the multi-family group.
- Nurturing – "Pass the lotion." Mothers' pair up and lotion each others hands.
- Have each woman check-out with a brief comment about what she will be taking from the group tonight.

Multi-Family Group

Check-In, Sharing, Snack Time and Hello Song

Group Rules for Theraplay

Stick Together No Hurts Have Fun!

Puppet Show with Max "Feeling Afraid"

Theraplay Activities

- Mother May I?
- Three Legged Race
- Measuring with Fruit Tape
- Lotion Prints
- Checking for hurts with lotion

Closing Song

Session # 9
Mother's Group
Problem Solving our own Children's Behavior (Part I)

Goal: To assist women to identify positive problem solving/ behavioral management strategies to assist their children.

Mother's Group

Check-In

Housekeeping Issues

- Request volunteer spokesperson to share with the children
- Children's Theme – Anger- What is it?

Warm-up Activity

- Elephant

Theme of the Week – Problem Solving our own Children's Behavior (Part I)

- Discuss purpose of "Emotion Coaching" and effect on children (self-regulation)
- Assessing Parenting Style (Dismissing, Disapproving, Laissez-Faire & Emotion Coach)
- Five Key Steps for Emotion Coaching:
    - Being aware of child's emotion;
    - Recognizing the emotion as an opportunity for intimacy and teaching;
    - Helping the child verbally label emotions; and
    - Setting limits while helping the child problem solve.

Theraplay Activity

Demonstrate Puppet Show – "Max gets Angry"

Nurturing and Check-Out

- Request a volunteer to summarize our activities and share this information with the children in the multi-family group.
- Nurturing – "Pass the lotion." Mothers' pair up and lotion each others hands.
- Have each woman check-out with a brief comment about what she will be taking from the group tonight.

Multi-Family Group

Hello Song, Check-In and Snack Time

Group Rules for Theraplay

Stick Together No Hurts Have Fun!

Puppet Show with Max –"Max gets Angry"

Theraplay Activities

- Peanut Kick
- Elephant
- Taste Test
- Checking for hurts with lotion

Closing Song

Session # 10
Mother's Group
Problem Solving our own Children's Behavior (Part II)

Goal: To assist women to identify positive problem solving/ behavioral management strategies to assist their children.

Mother's Group

Check-In

Housekeeping Issues

- Request volunteer spokesperson to share with the children
- Children's Theme – Getting Along with Others

Warm-up Activity

- "Sit in your spot like …"

Theme of the Week – Problem Solving our own Children's Behavior (Part II)

- Review "Emotion Coaching", "Parenting Style Questionnaire," "Personal Awareness Questionnaire to Anger & Sadness"
- Use Five Key Steps for Emotion Coaching with participants scenarios
    - Being aware of child's emotion;
    - Recognizing the emotion as an opportunity for intimacy and teaching;
    - Helping the child verbally label emotions; and
    - Setting limits while helping the child problem solve.
- Practice Emotion-Coaching with participant's examples.

Theraplay Activity

- Mirroring
- Cotton Ball Touch

Demonstrate Puppet Show – "Max on Spring Break"

Nurturing and Check-Out

- Request a volunteer to summarize our activities and share this information with the children in the multi-family group.
- Nurturing – "Pass the lotion." Mothers' pair up and lotion each others hands.
- Have each woman check-out with a brief comment about what she will be taking from the group tonight.

Multi-Family Group

Hello Song, Check-In and Snack Time

Group Rules for Theraplay

Stick Together No Hurts Have Fun!

Puppet Show with Max –"Max on Spring Break"

Theraplay Activities

- Princess Pat
- Tangle
- Shoe Race
- Pretzel Challenge
- Checking for hurts with lotion

Closing Song

Session # 11
Healthy Relationships

Goal: To assist women to identify positive characteristics of healthy relationships and negative characteristics of unhealthy relationships for themselves and their children.

Mother's Group

Check-In

Housekeeping Issues

- Schedule Follow-up appointments
- Request volunteer spokesperson to share with the children
- Children's Theme – Worries

Warm-up Activity

- Read "Autobiography in Five Short Stories"

Theme of the Week – Healthy Relationships

- Discuss Three Styles of Love (Romantic, Addictive, and Nurturing)
- Discuss "Loving Again" (Self-Exploration: "What to Look For and What to Avoid")
- Discuss Power & Control Wheel and Equality Wheel

Demonstrate Puppet Show – "Max Says Goodbye"

Nurturing and Check-Out

- Request a volunteer to summarize our activities and share this information with the children in the multi-family group.
- Nurturing – "Pass the lotion." Mothers' pair up and lotion each others hands.
- Have each woman check-out with a brief comment about what she will be taking from the group tonight.

Multi-Family Group

Check-In, Sharing, Snack Time and Hello Song

Group Rules for Theraplay

Stick Together No Hurts Have Fun!

Puppet Show with Max "Max Says Goodbye"

Theraplay Activities

- People to People
- Zoom Erk
- X-Marks the Spot
- Donut on Finger
- Checking for hurts with lotion

Closing Song

Session # 12
Closing and celebration

Goal: To celebrate the completion of group

Mother's Group

Check-In

Housekeeping Issues

- Schedule follow-up interviews
- Discuss children's possible termination reactions

Warm-Up Activity

- Farewell Exercise

Theme of the Week – Termination (Past, Present & Future)

- What progress do you feel you and your child have made?
- What issues remain for you, your child, and your family?
- How will you address these?

Nurturing and Check-Out

- Request a volunteer to summarize our activities and share this information with the children in the multi-family group.
- Nurturing – "Pass the lotion." Have each woman lotion her hands
- Participants briefly comment about what they learned from group

Multi-Family Group

Hello Song, Check-In and Snack Time (Celebration Cake)

Farewell Activities

- Picture Frames

Theraplay Activities

- Move Your Body
- Cotton Ball Throw
- Toilet Paper Bust Out
- Hide the Notes
- Checking for hurts with lotion

Closing Song

Appendix B

Activity	Time Frame	# Clinical Hours
Submit Practicum Proposal	October 2003	
Approval of Proposal	November 2003	
Development of Program	December 2003	40 hours
Recruitment of Participants	December 2003 / January 2004	
Administrative Tasks		40 hours
Interview of Parents		25 hours
Interview of Children		25 hours
Group Implementation	January 2004	
Weekly Sessions		35 hours
Pre Session Preparation		40 hours
Post Session Reflection		40 hours
Supervision Meetings		35 hours
Evaluation / Follow-up	April 2004	
Score/ Analyze Measures		10 hours
Interview Parents		20 hours
Interview Children		20 hours
Follow-up Sessions		100 hours
Summarize / Analyze Data		20 hours
Complete Practicum Report	May 2004	
Final Defense & Approval	July 2004	

Clinical Hours	**450**

Appendix C

Client Satisfaction Questionnaire

Please take this opportunity to provide the Elizabeth Hill Counselling Centre with feedback about the experience you and your child had while attending the Mother-Child Group. Please answer the questions honestly and remember that both positive and negative feedback is valuable.

1. What aspects of the group experience did you most like?

_____

_____

_____

2. What aspects of the group experience did you most dislike?

_____

_____

_____

3. What sessions or features of counselling did you find most helpful?

_____

_____

_____

4. What sessions or features of counselling did you find least helpful?

_____

_____

_____

5. Do you think the group helped your child? Yes No

   If you answered "Yes," what changes did you notice?

_____

_____

_____

6. Do you think the group helped you? Yes No

If you answered "Yes," what have you learned as a result of group?

_____

_____

_____

7. Is there anything that you would like to see changed in the way the service was delivered to you at the Elizabeth Hill Counselling Centre?

_____

_____

_____

8. Did the counselling you received at Elizabeth Hill Counselling Centre meet your needs?

_____

_____

_____

9. Would you refer a friend or family member who has experienced similar life experiences to this group?

_____

_____

_____

10. Do you have any other further comments or suggestions?

_____

_____

_____

Thank you for your participation in the Mother-Child Group and for providing valuable feedback about the group experience.