A Group Therapy Program for Aboriginal Women and Children who have been Exposed to Family Violence

by

Patti Sutherland

A Practicum Submitted to the Faculty of Graduate Studies
in partial fulfillment of the requirements for the degree of

Master of Social Work

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of

MASTER OF SOCIAL WORK

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ABSTRACT

This practicum consisted of a two-phase group approach to working with Aboriginal women and children who had been exposed to partner abuse. The families were all headed by women who were parenting alone and who had been out of their abusive relationships for approximately a year or more. The women in the group had experienced many losses in their own childhood as a result of colonial systems such as residential schools and the child welfare system. The group goals included enhancing the parent and child relationship and breaking the secret of the family violence within and between families. A total of five parent-child dyads were involved with this practicum and three families completed the group. The treatment modality included an initial eight week parent group that focused on adult play and information related to theraplay, as well as information related to the effects of exposure to family violence on their children. Another eight weeks was spent in a multi-family group with both the parents and their children. Puppets were utilized as a means to present relevant themes and the families participated in theraplay activities together. Clinical impressions suggest that while the women's lives remained extremely stressful, they were able to support their children to discuss their feelings about the family violence. Families also expressed enjoyment in relation to the play time together and did demonstrate some improvements within their parent-child relationships.

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To my family, first and foremost, who always have a way of making me feel like I can do anything. To my many friends who have allowed me to disappear for long periods of time and then seem to welcome me back as though they just saw me yesterday. Thanks for believing in me, supporting me, making me dinner, and always being there to laugh with me.

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INTRODUCTION

The Elizabeth Hill Counselling Centre in partnership with Native Women's Transition Centre has developed a group format to meet the needs of Aboriginal women and their children. These children have been exposed to family violence and their mothers have since left the abusive relationship. For the purpose of this practicum report family violence will be defined as partner assault where the perpetrator has been male and the children have been exposed to the abuse directed toward their mother. The overall objective of the program is to strengthen the relationship between the parent and the child by helping mothers feel more competent in the parenting role and by providing children with an opportunity to break the secret of the violence they have witnessed. Children are given an opportunity to understand their thoughts and feelings about the violence and to develop healthier coping skills. In this practicum the parents' group and children's group ran simultaneously for the first eight weeks. Following this, a multi-family group was facilitated for the final eight weeks.

Intervention strategies and research pertaining to children exposed to family violence have increased dramatically over the last ten years (Jaffe, Sudermann, & Geffner, 2000). There have been numerous children's groups developed to meet the needs of children exposed to partner abuse utilizing themes such as the violence is not my fault, protection planning, understanding feelings and enhancing self esteem (Gruszznski, Brink, & Edleson, 1988; Peled & Edleson, 1995; Wilson, Cameron, Jaffe, & Wolfe, 1986).

There have also been parent groups developed for women who are parenting following the end of an abusive relationship (Peled & Edleson, 1995; Peplar, Catallo, & Moore, 2000; Thorton, Bartoletto, & Van Dieten, 1996;

Wolfe & Peled, 1992). While there have been fewer interventions utilizing a parent-child group format for mothers and children who have been exposed to family violence, there are some multi-family group strategies available (Kiernan, 1994; Rabenstein & Lehman, 2000; Rhodes & Zelman, 1986; Rubin, 2000).

Few intervention strategies, however, have taken into account the unique experiences of Aboriginal women and children exposed to family violence (Brown, Jameison, & Kovach, 1995; Mandamin, 1994). As well, most family violence parenting approaches have been psychoeducational in nature (David & Peled, 1992; Thorton et al., 1996). Themes which are adressed often include child development, the impact of violence on children, and parenting strategies to improve communication and behavior management. These are valid intervention strategies and there were psychoeducational components within this practicum. However, we also considered the historical impact of colonization on Aboriginal families, as well as the effect that family violence may have had on the parent-child relationship (Levendosky & Graham-Berman, 2000).

While statistics are high for all Canadians, it is estimated that 80% of Aboriginal women are abused (Ontario Native Women's Association of Canada, 1989). As a result, many Aboriginal children continue to experience the emotional and physical trauma associated with being exposed to family violence (Dumont-Smith, 1995; La Roque, 1994).

The destruction of the family and the loss of childhood experienced by many Aboriginal people due to the residential school system and the child welfare system has been profound (Bruce, 1998; Corrigan, 1992; Dumont-Smith, 1995; La Roque, 1994; , Mandamin, 1994). In the Native Women's Transition Centre in Winnipeg a residents' survey indicated that 20% of the

women reported that they themselves had attended residential school and 55% of the women reported that they had been taken into care of the child welfare system when they were children. They also reported that 74% of their children had been apprehended and taken into care by the child welfare system (Shackle, 1999). The multi-generational impact of colonization has meant that children have grown up without their traditions, their language, or their families (Downey, 1999; Dumont-Smith, 1995; France, 1997; Green, 1997; Mandamin, 1994; Ross, 1992). Thus, not only were the Aboriginal women and children we worked with affected by the exposure to family violence, but the relationships between parents and children had been profoundly affected by the impact of colonization.

Further to this, it is very difficult for the women to cope with the realities of being in an abusive relationship while at the same time trying to deal with the needs of their children (Abbott & Adams, 1986; Orava, McLeod, & Sharpe, 1996; Sato & Heiby, 1992; Spaccarelli, Sandler , & Roosa, 1994; Wagar & Rodway, 1995). Even when women have left an abusive relationship they may continue to be overwhelmed with their children's emotions and behaviors (Bilinkoff, 1995; Pepler et al., 2000; Sullivan et al. 2000).

A strong parent-child relationship becomes the foundation on which feelings and behaviors can be addressed (Bailey, 2000; Bratton & Ray, 1998; Guerney, Guerney, & Andonico, 1976; Simms & Bolde, 1991). Play is a crucial component in the development of a healthy parent-child relationship (Gil, 1994; Glazer, 1994; Gray, 1996; Guerney, Guerney, & Andronico, 1976; Haight & Miller, 1993; Johnson, Bruhn, Winek, Kreppes, & Wiley, 1999; McLaren, 1988; Sutton-Smith, 1974).

Jernberg (1999) has developed a therapeutic approach for enhancing parent-child relationships. She refers to this approach as theraplay (Jernberg, 1999). The four components of theraplay include nurturing, engagement, challenge and structure. Theraplay activities were utilized within the group with the intended goal of enhancing the parent-child relationship. While theraplay strategies have been utilized in a multi-family context, few have dealt directly with issues related to family violence (Finell, 2000; Manery, 2000; Sherman, 2000; Rubin, 2000).

As well as incorporating theraplay approaches into this practicum, a multi-family group format was utilized. A multi-family group format allowed for reduced isolation, information sharing, and also simulated somewhat the realities of parenting within the community. This format facilitated discussions related to concerns and feelings about parenting within the community, mediated the understanding of children's feelings related to their behaviors, and provided the opportunity to model parenting alternatives (Dennison, 1999; Foley, 1982; King, 1998; Hardcastle, 1977; Laqueur, 1980; Leichter & Schulman, 1972).

This group was also very relevant to the field of Social Work as it took into consideration the person-in-environment as its theoretical foundation. The environment considered included the family and community as well as the social, political, and cultural experience related to colonization. We recognized the importance of a personal network and developed a multi-family group to reduce social isolation and to strengthen the community connection between families with similar experiences of family violence. We also attempted to provide some of the teachings of the Medicine Wheel and to honour the teachings of the circle.

Information and education related to family violence and children exposed to family violence was provided. A group therapy model was utilized and emotional support was given and received between the facilitator and group members and among the group members themselves. The group also provided concrete support in the form of child care, transportation, and outside referrals for in-home supports. All of these components were combined with the intent of maintaining a comprehensive person-in-environment perspective.

This practicum began with an eight week group for parents that combined a psychoeducational and group therapy approach and provided information to enhance the women's understanding of a child's perception of the violence. These interventions were enhanced with a theraplay component for both the adults and the parent-child dyads. The children were attending their own group at this time. The parents and the children joined together in play for the final fifteen minutes of each group.

Following this parent group, a multi-family group was facilitated for an additional eight weeks. The group intervention included activities which promoted communication between parents and children about the violence to which the children had been exposed and facilitated theraplay activities with the parents and the children together.

As the group progressed, an outreach component evolved. It seemed that the needs of individual group members could not always be addressed within the group context. Visits to the family home and referrals to other community resources became necessary as various issues and crises arose.

Within this practicum report is a review of the literature as it pertains to a group approach for working with Aboriginal families who have been exposed to family violence. The information in the literature review formed

the theoretical foundation for the practicum format. The process of the multi-family group intervention is outlined within the practicum description. This is followed by the analysis of the group intervention and the evaluation of the results. Finally, a discussion of the themes that developed as a result of the intervention will be explored, as will the extent to which learning objectives were met.

PERSONAL LEARNING OBJECTIVES

My specific learning objectives were as follows:

- To develop group facilitation skills as they relate to an adult/parent play format.

- To strengthen an understanding of the dynamics of family violence within the context of the parent and child relationship.

- To develop knowledge in the area of parent and child relationships and the use of therapeutic techniques that enhance that relationship.

- To develop group facilitation skills necessary for leading a multi-generational and multi-family group.

- To develop group facilitation skills which integrate the history and culture of Aboriginal people.

- To develop an understanding of group themes and stages and an ability to be flexible within these stages, varying the group plan when necessary and being aware of the facilitator's role at each stage.

LITERATURE REVIEW

When working with Aboriginal families impacted by family violence it is crucial to consider the context of that violence. This literature review attempts to take into account the unique experiences of Aboriginal women and children. The impact of family violence on the parent-child relationship will be explored and further examined within the context of colonization. Current parent and child interventions related to family violence will be critiqued. The use of a multi-family format and theraplay intervention will be reviewed as strategies that may address some of the unique needs of Aboriginal women and children exposed to family violence. Finally, group intervention process, stages, and themes will be outlined in order to provide a structure for the analysis of the group experience.

Family Violence and the Parent-Child Relationship

Much research has been completed that suggests that exposure to family violence impacts upon a child's emotional, social, and physical health. These findings seem to indicate that children exposed to parental violence are more likely to experience both externalizing problems such as aggression, non-compliance, and delinquencies, as well as internalizing problems such as anxiety and depression (Christopoulas et al., 1987; Fantuzzo & Lindquist, 1989; Hughs, Parkinson, & Vargo, 1989; Jaffe Wolfe, Wilson, & Zak, 1985; Mathias, Mertin, & Murray, 1995; O'Keefe, 1994; Sternberg et al., 1993). In situations where there are family or individual factors that support resiliency in children, these externalizing or internalizing behaviors may not be as prevalent.

For the purpose of this practicum I focused on the mother-child relationship within families where partner abuse has occurred. The women involved in this practicum were Aboriginal women who had left abusive relationships and who were parenting their children alone. It seems that in families where there is domestic violence, the mother is the adult most likely to provide for the children's care, and to be the children's emotional support (O'Keefe, 1994). If we are to provide comprehensive service to women and children exposed to family violence we must understand the ways in which parenting has been inhibited as a result of partner abuse (Levendosky & Graham-Bermann, 2000). The parent-child relationship will be discussed in terms of the role of father, the mother's own experience of family violence, the mother's depression and emotional exhaustion, physical maltreatment of children in violent families, parenting skills, and the dynamics involved when leaving the abusive relationship.

It seems that we do not often discuss the role of the abuser as "father" in these violent households and the impact his abusive behavior has on his relationship with his children and on the children themselves. The literature has examined this double standard and has found that society often blames the woman for not leaving and for not protecting her children rather than making the man accountable as the perpetrator of the violence (Edelson, 1998). Sullivan et. al (2000) confirm this gender bias and agree that the perpetrator's role as father has essentially been ignored in the literature and in society. This negates fathers from taking responsibility for their role as parent. Women are left responsible for the day to day needs of their children as well as for their children's emotional and behavioral responses that occur as a result of the family violence (Bilinkoff, 1995; O'Keefe, 1994).

Further to this, mothers are often left dealing with child welfare agencies who have become involved because the women are seen as failing to protect their children (Magden, 1999). According to Magden (1999), the abusive partner seems to manage to escape the sanctions of the child welfare system even though in most cases the reality is that if he were not abusive there may not be a problem.

Women who are currently in abusive relationships may also have witnessed family violence in their childhood. Women who witnessed violence as children are also more likely to carry violence-tolerance roles to their adult intimate relationships, thus perpetuating the cycle of abuse (Cappell & Heiner, 1990; Rosenbaum & O'Leary, 1981). Henning and Leitenberg (1996) found that women who witnessed physical fighting between their own parents had higher levels of psychological distress and lower levels of social adjustment. Dutton (2000) suggests that witnessing a parent being abused by another parent may destroy a child's belief in the parent who is the victim as being able to protect and thus may reduce feelings of security with that parent. If a mother's own attachment experiences were disrupted by family violence, then it may become more difficult to form a healthy relationship with her own child. (Purvis, 1995; Solomon & George, 1996).

It is also very difficult for parents in a violent relationship to focus on the emotional needs of their children. Women caught in this cycle are often mentally and physically exhausted and may not have the emotional resources available to them to meet the developmental needs of their children. In recent studies abused women have reported significantly more depressive symptoms than other women in the control groups (Orava, McLeod, & Sharpe, 1996; Sato & Heiby, 1992).

The violence, then, may become the primary focus of the family. Wagar and Rodway (1995) have also viewed this focus on the violence, rather than on the needs of the children, as leading to neglect of the children's emotional and physical needs. The belief by the child that the parent who is the victim is able to offer security and protection is severely affected and the parent-child attachment may be weakened (Dutton, 2000; Meredith, Abbott, & Adams, 1986; Spaccarelli, Sandler, & Roosa, 1994; Wagar & Rodway, 1995). In Voices of Aboriginal Women parents share their thoughts about the impact of violence on their children. As one mother states, "I think the kids go through a lot of emotional things that mothers don't often have time to cope with and don't have the insight to see" ('Rose', Voices of Aboriginal Women, 1991, p. 14). It should be noted that there is some evidence that abused women do not differ in parenting style from parents in a control group (Hershorn & Rosenbaum, 1985; Holden & Ritchie, 1991).

Children may begin to avoid expressing their true feelings and develop negative behaviors in a desperate attempt to have their needs met (Stephens, 1999; Wagar & Rodway, 1995). Levendosky and Graham-Berman (1998) also point out that psychological abuse has a negative impact on a mother's stress and a child's adjustment - particularly for internalized coping behaviors. Wolfe, Jaffe, and Zak (1985) measured maternal stress and adjustment and found that maternal stress and family violence variables combined accounted for 19% of the variance in children's behavior problems. These behaviors become a further challenge to a parenting relationship that is already stressed due to the cycle of violence.

When a woman is parenting within an abusive relationship, she is constantly attempting to compensate for the malparenting of the abusive partner (Levendosky & Graham-Berman, 2000). Even if a parent has acquired

strong parenting skills, these skills may not be integrated into family life in any consistent way due to the ever-changing dynamics of the cycle of violence. Further to this, due to the stresses on the mother related to living within the cycle of violence, the parent-child relationship may not be healthy enough to provide a foundation for these skills to be effective (Bailey, 2000; Boyd-Franklin & Bry, 2000; Dutton, 2000; ; Purvis, 1995).

There is also evidence that suggests that children living in violent homes may be at risk of physical assaults directed at them. Some studies have shown that there is a greater chance of child maltreatment in families where violence is occurring. Straus, Gelles and Steinmetz (1980) found that there was 129% greater chance of child maltreatment in a home were domestic violence occurs. Other studies have also revealed that marital violence is positively correlated with child abuse (Hughes et al., 1989; Meredith et al., 1986). It seems that the question remains whether this parent-child violence occurs more frequently between father-child or mother-child or both. O'Keefe (1994) found that in violent homes marital violence is related to higher levels of father-child aggression, and that marital violence was not related to higher levels of mother-child aggression.

Further to this, even when a woman chooses to leave the abusive partner the children continue to experience the impact of living in a violent family. Wagar and Rodway (1995) discovered that although parents were not living together anymore the patterns inherent in the cycle of violence persisted. These patterns included numerous moves, fear of the abuser, and isolation.

When fathers are abusive to mothers and the abusive relationships end, children continue to have attachment issues in relation to their mothers. " Many of the children expressed the feeling that, although fathers

were physically abusive to the mothers, the children were angry at what they perceived as 'emotional power', 'betrayal', 'lack of protection', and 'inconsistency' that the mother exhibited with the children" (Wagar & Rodway, 1995, p. 303).

Some children remain loyal to their fathers, as their feelings of ambivalence about his behavior versus their love for him persist. This ambivalence (loving Dad, but hating the violence) makes it difficult for women to know if they have made the right choice to leave their abusive partners (Bilinkoff, 1995; Stephens, 1999). Women may also find that parenting alone is extremely stressful given the child's externalizing behaviors such as aggression, and the internalized behaviors such as depression and anxiety (Christopoulas et al., 1987; Fantuzzo & Lindquist, 1989; Hughs et al., 1989; Jaffe et al., 1985; Mathias et al., 1995; O'Keefe, 1994; Sternberg et al., 1993). These behaviors are often the result of children being exposed to a violent relationship. Dad may have been abusive, but his authoritarian parenting style is sometimes lamented when children's behaviors become difficult to manage.

According to these findings, then, it may be important to not only help women to understand the impact of the violence on their children, but to provide the women and children with an opportunity to enhance their relationship. This becomes particularly true when we consider the impact of colonization on Aboriginal families.

Colonization

It seems that one of the greatest losses experienced by Aboriginal people has been the loss of childhood. This loss was perpetuated through the installation of reserves, residential schools, and the apprehension and adoption of First Nations children into non-First Nations homes. This has resulted in suicide rates over three times the provincial rate and alcohol related deaths which are over six and a half times the national average (Green, 1997).

Many Aboriginal women who have experienced partner violence have also experienced childhood abuse or have been affected by the multi-generational impact of the residential school experience. Many Aboriginal children were removed from their homes and families at an early age and were sent to residential schools. "Only we survivors understand what it is to have suffered incarcerations, even as young children. A freedom to be the children we should have been was taken away from us" (Mandamin, 1994, p. 139). Aboriginal children in residential schools were forbidden to speak their language or observe their cultural practices (Bruce, 1998; Haig-Brown, 1998). Within the residential school system violence was a means of control and power over young children who were growing up in an institution, far away from the love and care of family or community (Dumont-Smith, 1996; English-Currie, 1990; Maracle, 1993).

As a result, the children who grew up in residential schools did not have a family to model love, care, and nurturing and this meant that cultural integration and family life was destroyed (English-Currie, 1990; Grant, 1996; Miller, 1997).

Not only was family life disrupted, but it was replaced with an institutionalized, and often abusive, alternative. The children in residential schools were not allowed to be playful or spontaneous. They were not allowed to explore their world. For almost all students daily life meant hard work, rigid structure, and physical abuse (Miller, 1997). Downey (1999) confirms this reality when he compares residential schools to prisons and speaks of the children essentially being incarcerated for most of their young lives. Miller (1997) describes the prison-like qualities of the residential school system. "Overwork, harsh punishment, and abuse were merely the tip of an iceberg of inadequate care that included poor food, lack of nurturing, shoddy clothes and cold formality" (p. 423). Further to this, children who grew up in residential schools were often physically, sexually and/or emotionally abused. (Bruce, 1998; Dumont- Smith, 1995; Hughs, 1999; Miller, 1997; O'Hara, & Treble, 2000; Ross, 1992).

The child welfare system also contributed to the loss of family. According to McKenzie and Hudson (1985) a 1980 review of foster care and adoption in Canada indicated that in Manitoba, where native people account for 12 percent of the provincial population, native children represented approximately 60 percent of the population in care or adopted. During the "sixties scoop", an enormous number of Aboriginal children were apprehended and placed in foster care or adopted out to Canadian and American non-native families (Green, 1997).

These apprehensions of Aboriginal children occurred following the closures of the residential schools, and further perpetuated the history of colonization and the destruction of the family. According to York (1990), the child welfare system essentially replaced the residential school system. As the residential schools closed more and more Aboriginal children were

apprehended. Many of these Aboriginal children were adopted into non-Aboriginal families - both in Canada and in the United States (York, 1990). Corrigan (1992) states that adopted Aboriginal children have a significantly poorer sense of self, and they are also more than three times as likely to have problems coping or suicidal ideas.

Aboriginal women and children who have been exposed to the multi-generational effects of colonization and the more immediate effects of family violence must find ways to reclaim their own childhood. "We were taught in very regimented ways. We were taught not to have feelings, not to talk, to be little soldiers and not to trust anybody" (Mandamin, 1994, p. 139). The children who experienced the child welfare system and the residential schools have become parents themselves and we need to consider how this impacts on their relationship with their own children. Given the history of colonization and the impact of family violence on the parent-child relationship, it seems that traditional parent and child interventions related to family violence issues would be complemented by strategies that work to enhance the parent-child relationship.

A History of Parent-Child Intervention Strategies

In order to understand the intervention strategies used within this practicum, it is necessary to review the history of group intervention strategies for parents of children exposed to violence. Interventions with parents and children exposed to family violence have included family violence groups for children, psychoeducational parent groups, concurrent parent and children groups, and multi-family groups.

Children's groups have included themes which deal directly with the reality faced by children exposed to family violence. Most of these groups have been highly structured with specific goals and activities (Peled & Edleson, 1995). Children who have been caught in the crossfire between their mother and the abuser believe they are responsible for the violence (Gibson & Gutierrez, 1991; Grusznski, Brink, & Edleson, 1989; Jaffe, Peplar, Catallo, & Moore, 2000; Wolfe, & Wilson, 1990; Wagar & Rodway, 1995;). A primary goal of a children's group is for children exposed to violence to recognize that they are not responsible for that violence.

Children who experience family violence are also very isolated and feel shame about what is happening within their family (Grusznski et al., 1988). They have likely been told not to speak about the violence to anyone. Within group intervention another goal is to break the secret about the violence between mothers and children, and among families who have had similar experiences. Further to this, children who live in violent families have learned not to express how they feel (Grusznski et al., 1989; Meredith et al., 1986; Spaccarrelli et al., 1994; Wagar & Rodway, 1995). Group provides an opportunity to recognize, express, and cope with difficult feelings. Finally, a protection plan is often developed with the children (Peled & Edleson, 1995; Stephens, McDonald, & Jouriles, 2000; Sudermann, Marshall, & Loosley, 2000).

Jaffe et al. (1986) found that such group interventions have some success in improving self-esteem, changing attitudes about the violence and enhancing practical skills in emergency situations. Wagar and Rodway (1995) found that an educational children's group resulted in significant improvements in children's understanding about responsibility and in their ability to cope with difficult feelings such as anger. Peplar, Catatallo, and

Moore (2000) studied a peer group counselling program and found it to be effective in providing support to children exposed to violence, particularly in the areas of depression and anxiety. Sudermann et al. (2000) found that 74% of of caregivers indicated they noticed a change in their child as a result of the children's group intervention. An analysis of the Domestic Abuse Project (DAP) found that short term children's educational groups merely served as a starting point for the child's healing journey (Peled & Edleson, 1995).

There have been parenting groups designed specifically for parents of children exposed to violence. Peled and Edleson (1995) discusses a ten week voluntary parenting group for parents of children exposed to violence. They outline the group topics which include providing information, challenging beliefs and attitudes, and developing child behavior management skills. Other psychoeducational parent intervention strategies specific to family violence include The Domestic Abuse Project Parenting Manual (Wolfe & Peled, 1992), and Women's Group Facilitation Manual: Growing Together: Parenting Children Who Have Survived Violence in the Home (Thorton, Bartoletto, & Van Dieten, 1996). Within Winnipeg there are similar parent groups which have been facilitated at Evolve, Mamawiwichiitata, and Family Centre.

O'Keefe (1994) states that in families characterized by marital violence, the mother is of paramount importance for the child's well- being and that she is most likely the child's primary caregiver and source of emotional support. According to Purvis (1995), programs providing counselling and therapeutic options for children exposed to violence are needed in conjunction with their parents.

A program in Winnipeg that services Aboriginal families, Wahbung Abinoonjiiag, uses a multi-family approach for working with women and

children exposed to violence together with activities that includes parent-child play. The Elizabeth Hill Centre in Winnipeg has also utilized a multi-family approach to working with Aboriginal families affected by family violence. This group has included a separate parent and child program for eight weeks followed by a multi-family program for another eight weeks.

Rhodes and Zelman (1986) developed an open multi-family group within a shelter setting where the first forty-five minutes were devoted to "talking" and the last fifteen minutes were for playing. Themes included dealing with issues related to domestic violence, separation and loss, new and ongoing stresses, and parent and child issues (Rhodes & Zelman, 1986). Kiernan (1994) evaluated a multi-family 'Say No to Violence' group that included group time alone for the mothers and time together with their children. Rabenstein and Lehman (2000) have also used a mother-child format as an intervention with children exposed to family violence. Goals of this group include supporting the restructuring of the family, talking about abuse in safe ways, debriefing traumatic stories, and creating a non-violent future.

Kiernan (1994), in a one year qualitative follow-up study of a "Say No to Violence" parent/child concurrent group, found that the parents said they were uncertain as to the effects of the program, that in some ways their children's behaviors intensified following group, and that they had difficulty "staying on track" following the end of group. The women did say they were interested in their children's perception about the violence and that meeting together helped to normalize their experiences. Many of the women wished they could have had ongoing follow-up support.

Peplar et al. (2000) used a pre-post comparison group design that included participants in twelve, ten week children's group programs for

children exposed to violence. Peplar et al. (2000) found that there was no relationship between mothers being involved in concurrent counselling and the impact of group intervention on the child.

Wendy Ruhnke (Personal communication, December 26, 2001) a facilitator from D.A.P., in Deluth, Minnesota, stated that 100 percent of the parents involved in the parent-child multi-family group have all initiated a referral to counselling for their children. Ruhnke (2001) went on to say that the women attending the visitation centre, who were not involved in the multi-family group, were much less likely to initiate referrals for their children. Perhaps Peplar et al. (2000) and Runke's findings indicate that multi-family groups may be an effective intervention with children who have been exposed to violence and their children, although there is virtually no empirical evidence to support this theoretical assumption.

Multiple Family Therapy (MFT)

One of the criticisms of family therapy has been that it takes the family out of its context and does not draw on the natural support systems in a family's life. Therapeutic intervention such as family therapy are not as effective because they do not duplicate society, and are not transferable to the "real world", thus only partially influencing the child-parent relationship (O'Shea & Phelps, 1985; Sherman, 2000). There are many ages, various life stages, different socio-economic backgrounds, and many types of relationships represented within the multi-family group. Szymanski and Kiernan (1983) agree with this viewpoint when they discuss that the outside world is represented in a multi-family group, given the different generations and various family styles that are evident within the group. Absolon (1993)

believes that social work practice ought to include the role of Elders, the family and the community resources. The community circle is so powerful and its focus is so great that it intensifies healing exponentially (Absolon, 1993; Cahill & Halpren, 1990).

When families come together in a multi-family group they can find strength and healing within their family, and their community (Laube & Trefz, 1994). Dennison (1999) concurs with this viewpoint when she states that MFT provides an opportunity for families to reduce the sense that they are the only people who are experiencing difficulties. Dennison (1999) found that families were able to support one another within the group through role modeling, sharing life stories, or by providing concrete aid such as traveling to group together. As families see one another make changes it may promote feelings of hope for all (Lau Yuk King, 1998; Leichter & Schulman, 1968).

Leichter and Shulman (1968) formed a MFT group in order to facilitate communication and understanding between the generations. Leighter and Shulman (1968) go on to discuss the importance of the child's role in MFT groups. Children are given an opportunity to be heard or to have their ideas put into action. According to McKay et al. (1995), parents described being surprised by what their children understood about the family dynamics, and that their ideas for change were often creative and well-grounded. Those experiences thought to be the same for all members of the family are perceived differently by the children and their parents. This exchange of experiences between parents and children is particularly helpful for families where the secret of the violence has been kept for long periods.

Parents in a multi-family group can also model for one another. Seeing another parent enjoy your child may help to demonstrate the child's strengths that have thus far been minimized (Rhodes & Zelman, 1984).

Families, then, become supports to one another and this somewhat alleviates the necessity of "professional" support. This also relieves the therapist of being the role model for parents in the group (Leichter & Schulman, 1968; McKay, Gonzales, Stone, Ryland, & Kohner, 1995).

Hardcastle (1977) completed a study of an MFT group used with parents and their children who were exhibiting behaviors which included social withdrawal and aggressiveness. According to his findings, there were reports by mothers and fathers of increased positive behavior and decreased negative behavior in children. Their satisfaction with family life had also increased. McKay and Gonzales (1999) found that after the completion of an MFT group 70% of the parents reported that their child's aggression or negative behaviors had decreased. The same study reported that in families that were involved with individual or family therapy only 54% of parents said they noticed improvements in their child's behavior. There are challenges to facilitating a MFT group, however, and these should be taken into consideration.

For a therapeutic MFT group it is best to keep the numbers manageable in order to work effectively with individual families and the group dynamics. Many practitioners have found that this approach usually requires an ideal group size of three to four families (Dennison, 1999; McKay et al., 1995).

Within a multi-family group there are often a large numbers of participants who vary in age and developmental stages (Dennison, 1999). This makes planning and implementing activities more challenging. Different interests and energy levels may exist. As well, group members in MFT may know one another. The facilitator will need to be aware both of cliques that may form and conflicts that may come from outside the group time. This

would be particularly true for women and children who are living in residence together.

Many types of MFT groups have utilized theraplay strategies within their groups. These have included groups for withdrawn children (Manery, 2000), for homeless mothers and children (Rubin, 2000), and for adoptive families (Finnell, 2000). The multi-family group creates an opportunity for parents and children to team up in theraplay activities in order to improve social skills and promote healthy community interactions (Steffans & Gorin, 1998).

Facilitating theraplay within a multi-family group could enhance the already established parent-child group format utilized in some family violence therapy groups with women and children. While theraplay has not been utilized within a family violence context, the intervention components of this therapy method fit well with the goal of re-establishing a positive parent-child relationship following exposure to family violence.

Theraplay

Theraplay is a playful method of treating attachment difficulties between parents and children (Jernberg, 1999). Munns (2000) suggests that we should be using non-verbal methods of treatment when working with attachment concerns. Play, then, becomes the medium of therapy that is necessary for both adults and their children to heal from their past traumas and begin to re-build their relationship together. Munns (2000) reinforces the need for fun and playfulness to be at the centre of parent-child interactions.

In pre-colonial times Aboriginal children learned through play, exploration, and creativity. According to Miller (1997), play was the inherent

process by which children learned who they were and how they were connected to the world around them and the spirit world within them.

Play is an essential to healthy child development. At the centre of this healthy development is a parent-child relationship that sanctions play (Sutton-Smith, 1974; Gil, 1994; Gray, 1996; Guerney, Guerney, & Andronico; Haight & Miller, 1993; Johnson, Bruhn, Winek, Kreppes, & Wiley, 1999; McLaren, 1988).

Jernberg has identified four components to healthy attachment at the centre of which is playfulness (Jernberg, 1999). The four components include structure, challenge, engagement and nurture. For the purposes of this practicum the four components of theraplay were explored and adapted to fit within the parameters of a group intervention for building relationships between Aboriginal women and their children who have been exposed to family violence.

Structure

Every child needs there to be a sense of predictability within his/her world (Guerney et al., 1976). When children know what to expect, they can then build a trusting relationship with others in their life. Guerney et al. (1976) state that parents benefit from knowing and practicing setting limitations on their children's behavior while balancing this with an understanding of their children's feelings. Munn (2000) supports this notion of structure and discusses the importance of the adult being in charge of the child's safety and well being.

Structure does not include imposing limits for the purpose of power and control. When adults use punishment as a means of controlling their child's behavior and exploration this is a imposition that may in turn inhibit his/her creativity and personal growth (Gil, 1994). This imposition of limits,

then, should always be implemented in a way that respects the child. Within this structure there must be room for flexibility and spontaneity. Play provides an opportunity for parent and child to explore and create within these limits, and should be fun for both (Caldwell, 1986).

Children exposed to family violence will likely be living with ongoing safety concerns and unpredictable explosive behaviors from their caregivers. The rules may change from day to day depending on where the family is in the cycle of violence (Wagar & Rodway, 1995). This can be very difficult for the children as a secure attachment depends on predictability and consistency (Jernberg, 1999; Munn, 2000). When in the honeymoon stage a parent may be more attentive, more flexible. During the tension building or the explosion phase there is likely to be a different set of rules and expectations.

A child's sense of safety is also threatened due to the often punitive ways in which limits may be set. Parenting styles in violent families are often more authoritarian and sometimes even abusive (Fantuzzo & Lindquist, 1989; Meredith, Abbott, & Adams, 1986 & O'Keefe, 1994; Strauss et al., 1980). When women leave an abusive relationship, they are often uncertain how or when to set limits for their children. These issues must be taken into consideration when dealing with structure as a dimension of the relationship between abused women and their children.

Challenge

All children look for challenges as they begin to explore their world and take new risks to play and learn. Challenge is only helpful to a child in the parent-child relationship if the challenge is within a child's realm of capabilities, thus providing an opportunity for the child to experience accomplishment (Munn, 2000).

Within violent families, parents may have unrealistic expectations of their children, relative to normal child development. Wager and Rodway (1995) describe how some children feel that their parents often asked things of them that they were unable to do. One boy said, "It happens so often that most of the time I don't feel I'm able to do much and get it right - so I learned to just do what is asked and I don't feel" (Wagar & Rodway, 1995, p. 303).

Stephens (1999) discusses adultification of children in violent households as being very detrimental to the child because she/he does not have the capacity or the impulse control to deal with complex adult issues. This adultification may also take the form of becoming a parent's confidant (Bilinkoff, 1995; Stephens, 1999). It is confusing and damaging to children to be expected to be an emotional support to either of their parents.

When challenging children as a component of attachment we must be cognizant of the fact that their self esteem has already been diminished due the violent environment in which they have been living (Arroyo & Eth, 1995; Peled & Edleson, 1995; Lehmann, 1997). This environment of fear and criticism will often create children who do not think positively about themselves (Gruszski et al., 1988).

Further to this, children may still be experiencing post-traumatic stress symptoms as a result of being exposed to family violence. These symptoms may include avoidance or numbing, re-experiencing, autonomic hyper arousal (Silvern, Karyl, & Landis, 1995), internal and external resources are overwhelmed and/or ineffective (Arroyo & Eth, 1995), and feelings of fear, helplessness and terror (Lehmann, 1997). In addition, Ferick and Haugaard (1999) found that exposure to family violence, and childhood abuse had additive effects on post-traumatic stress symptoms. Munn (2000) states it is possible to use a kind of hybrid model with families such as those exposed to

family violence, that incorporates a primary focus on nurturing with a secondary focus on structure, and when appropriate, some challenge.

Engagement

Engagement involves encouraging children to be playful and to look for surprises so that life can be adventuresome and fun (Munn, 2000). These activities require attention and involvement. Eye contact and some non-intrusive touch can be used to stimulate and engage the parent with the child (Bailey, 2000). Kamerman (1995) comments that adequate stimulation is as necessary to child development as basic needs such as food, shelter and clothing.

Guerney et al. (1976) discuss the value of this engagement when used by parents in filial therapy. Uninterrupted time between parent and child would, at the very least, give the child the message that she/he is important and worthy of attention. Roopnarine and Mounts (1985) concur with the importance of engagement between parents and children that includes elements of stimulation and creative fantasy play.

As part of the engagement process a parent should also be able to accept some leadership from the child in relation to play (Haight & Miller, 1990; McDonald, 1992; Wipfler, 1990). This allows children to have an opportunity to feel some mastery over their world, to develop some leadership skills, and to know that their parent truly wants to spend time with them because they enjoy their ideas and initiatives (Wipfler, 1990). This type of playful engagement between parent and child will not only improve the parent-child relationship, but will improve both the parent's and the child's self-esteem (Bailey, 2000; Caldwell, 1986; Cecil, Frank, 1976; Guerney et al., 1976; McPhail, Thornburg, & Ispa, 1986).

Children who are living in families where they have been exposed to family violence may not have had the opportunity to experience engagement play with their mother. Research has indicated a positive correlation between partner abuse and depressive symptoms in the female partner (Levendosky & Graham-Berman, 1998; Orva, McLeod, & Sharpe, 1996; Sato & Heiby, 1992). Maternal depression has been found to negatively affect parenting capacities (Levendosky & Graham-Berman, 1998; Rutter, 1990).

This does not preclude that women will be unable to engage with their children in play. It does mean that we need to be cognizant of both the parent's and the child's trauma related to the violence and the impact this may have had on the child's ability to trust and a parent's ability to engage her child (Meredith et al., 1986; Spaccarelli, 1994; Strauss et al., 1980; Wolfe et al., 1985)

Further to this, a parent who has been in an abusive relationship may not be attuned to her child's need to release stress and tension through the engagement process (Munn, 2000). The parent may have minimized the impact of the partner violence on the child and has come to accept her children's over-active or aggressive behaviors (Spaccarelli et al. 1994). A parent may therefore need encouragement to engage in more active, tension releasing exercises with her children.

Nurture

Munn (2000) notes that parents need to demonstrate their love and caring for a child in many ways. These activities include feeding, bathing powdering, cradling, rocking, singing, caressing, hugging, kissing and praising. Bailey (2000) discusses the necessity of touch between parents and children as touch is essential to healthy growth and development. Children

who experience appropriate and loving touch will be calmer, more relaxed and better able to attend to tasks (Bailey 2000; Gray, 1996).

Mandamin (1994) discusses the importance of maternal love in the Aboriginal community and describes the losses incurred through the process of colonization. This maternal love and nurturing is of paramount importance to a child's physical, social, and psychological development (Kamerman, 1995).

Green (1997), in her search to understand the impact of colonization on Aboriginal peoples, reviews the principles of personal self-worth. She found that it is elements such as mutual respect, unconditional positive regard, encouragement, and reflective listening that are of paramount importance to a sense of self-worth.

Once again, then, we find support for the notion that in order for children to grow they must have a relationship in their life that provides unconditional nurturing. Securely attached children feel free to express negative feelings, and they expect to be reassured by their caregiver during times of distress (O'Hara & Treble, 2000).

Many of the children living in violent homes have their feelings stifled, as it is not safe to share openly with the adults in the family (Grusznski et al., 1988; Stephens 1999; Wagar & Rodway, 1995; Wilson et al., 1989). Children learn to turn off their feelings, to effectively "tune out" the fighting. Sometimes these children come to have attention difficulties and have a lesser ability to read social cues (Bailey, 2000). All these factors should be taken into consideration when nurturing activities are introduced with these parents and their children.

Most research pertaining to theraplay has been anecdotal or qualitative in nature and has included feedback from parents, and teachers, and clinical

assessments of therapists. Morgan (1989) found in a qualitative study that two thirds of her clients, after a theraplay intervention, improved in the areas of self-confidence, self-control, self-esteem, and trust.

There is little empirical evidence as to the effectiveness of theraplay. Munns et al. (1997) completed a pre- and post-test design using the Achenbach Child Behavior Check-list (Achenbach, 1991) and found that the children's aggressive subscores in particular, and their externalization scores in general, were significantly lowered. Another study was conducted in Germany (Ritterfield, personal comunication, in Munns, 2000). This study included three groups which all contained children with identified language challenges. One group received speech and language therapy, one group received arts and crafts activities, and one group received theraplay intervention. It was found that those children receiving theraplay had a significantly higher score on emotional/behavioral measures, and also had higher scores with regards to improved language expression. There is a definite need for further research regarding the effectiveness of the theraplay intervention.

However, given some of the clinical regard for theraplay and its perceived effectiveness in working within families where the parent-child relationship has been challenged, theraplay in the multi-family group context was utilized as a further contribution to traditional forms of group work with parents and their children who have been exposed to family violence.

In order to assess the dynamics of a multi-family group that includes theraplay, knowledge of group development is crucial as it provides the structure for the discussion of the group process and group analysis.

Group Stage Themes

While I will attempt to present group life in a series of stages, these stages only refer to major themes in group life. Ephross and Vassil (1988) state that group stages are not distinct, as concerns at one stage often reappear in other stages. Glassman and Kates (1990) have developed seven group stage themes. These themes become useful in providing a structure to assess the group experience.

Stage Theme 1: We're not in Charge

In this stage the group members are feeling dependent on the group leader. Garland, Jones, and Kolodny (1983) refer to this as the pre-affiliation stage. Bennis and Sheppard (1962) view this stage as the dependence-flight stage. Members look to the facilitator for cues as to how they should respond in the group, often trying to please the facilitator.

A facilitator needs to be aware that the group members may be tenuous about their commitment to the group. They will watch for the group structure and try to understand the apparent group norms in order to decide how they should act (Glassman & Kates, 1990). Northern (1969) describes this stage as the orientation stage, while Tuckman (1965) refers to this stage as forming. The group members are observing others and searching for answers to unasked questions as members become accustomed to one another and the facilitator. In a therapy group where the task may be more difficult to define, the orientation phase may last longer than in other groups (Lacoursiere, 1993). In this first stage the facilitator can identify members' individual reasons for attending the group and reinforce the commonalties between group members (Glassman & Kates, 1990).

Stage Theme 2: We are in Charge

This group stage is marked by the possible disagreement among members about the group rules. Standards or norms will develop within this group stage, as members test out the role of facilitator and their role as the group members. Anxiety decreases as the group begins to develop some sense of mutuality (Glassman & Kates, 1990).

The facilitators may feel threatened, or ineffectual at this stage - uncertain about how to handle dissension and the ambiguity of roles (Glassman & Kates, 1990). Glassman and Kates (1990) caution facilitators against trying to defuse conflict by becoming too authoritarian, or, conversely, not providing enough structure in order to satisfy and calm the group. The facilitator will also want to check out the group members' expectations of the facilitator (Hunter, Bailey, & Taylor, 1995).

The facilitator can name this struggle by raising obvious issues of divergence and disagreement among members and the facilitator. If a group is to mature it will need to deal with conflict, not avoid it (Hunter et. al., 1995). Garland et al. (1983) refer to this as the power and control stage, while Bennis and Sheppard (1962) view this stage as the counter dependence-fight stage.

Stage Theme 3: We're Taking You On

In this stage the group members begin to question who the facilitator is, what skills she/he brings to the group and how they can utilize these skills and experiences (Glassman & Kates, 1990). Group members begin to react to and engage the facilitator. Bennis and Sheppard (1962) view this as the resolution-catharsis stage. Lacoursiere (1993) points out that if this stage becomes too entrenched, work on the group goals can be delayed or seriously disrupted.

As the facilitator is challenged, and questions are becoming more direct, the facilitator runs the risk of thinking this is a reflection of her poor skills or a lack of professional experience. Glassman and Kates (1990) warn against this personalizing of the natural group process. Tuckman (1965) refers to this tumultuous stage as storming.

If fully engaged in addressing the group members' questions and concerns, the members will then become more aware of how to utilize the facilitator's (and one anothers') strengths, skills, and experiences. This is a stage designated by Northern (1969) as exploration and testing. The group may come to recognize the group process and eventually contract with the facilitator to be their guide (Hunter et al., 1995).

Stage Theme 4: Sanctuary

As power and authority issues are addressed, the members become more cohesive and may develop feelings of caring and closeness (Glassman & Kates, 1990). Bennis and Sheppard (1962) view this as the intimacy stage. Members may wish the facilitator to become comfortable and resist the pressures they feel to make changes in their lives (Glassman & Kates, 1990). As new skills are acquired in this stage self-esteem of members is improved (Lacoursiere, 1993).

Facilitators become vulnerable to this feeling of closeness and may become passive in terms of re-voicing the group goals and activities (Glassman & Kates, 1990). Conversely, a facilitator needs to feel comfortable with some of the closeness and not emotionally withdraw from the group. Maintaining a balance between helping the group members remain emotionally connected, and encouraging members to make changes in their lives is the challenge for the facilitator at this stage in group development (Glassman & Kates, 1990).

Stage Theme 5 : This isn't Good Anymore

When group members find it difficult to make changes or deal with issues, they may become angry with other group members or with the facilitator (Glassman & Kates, 1990). If this negativity becomes overwhelming to the group it may prevent the other group members from moving forward, as sometimes change requires a community approach. Bennis and Sheppard (1962) view this as the differentiation stage, while Glassman and Kates (1990) view this as the disenchantment-fight stage.

Facilitators need to address these avoidance strategies, by identifying the negative reactions and exploring them. This will help the group members to feel competent and supported in their desire to move forward. The facilitator must trust that the group will have the necessary strengths and skills to achieve its goals and work through the process issues (Hunter, et al., 1995).

Stage Theme 6: We're O.K. and Able

Group members are now more comfortable dealing with conflicts within the group and feel competent to cope directly with new issues as they arise (Glassman & Kates, 1990). Members are not only more accepting of the various opinions and strengths within the group, but have also come to rely on one another for support in meeting their objectives (Glassman & Kates, 1990). At the same time, group members are readily able and willing to ask for strategies, and opinions from the facilitator. Garland et al. (1983) refer to this as the consensual validation phase.

The facilitator can help the members share feelings of vulnerability and of strength. She can also confront the members about using these strengths to activate the changes they wish to make in their lives. Northern

(1969) refers to this as the problem-solving stage, while Tuckman (1965) refers to this stage as performing.

Stage Theme 7: Just a Little Longer

At this time the group members may attempt to convince the facilitator that they need "just a little longer" to deal with their issues. Issues may arise that had previously been dealt with in the group (Glassman & Kates, 1990). Conversely, some group members may connect to the process of termination, share their fears, sadness or anger about the group ending, and also be able to celebrate their accomplishments (Glassman & Kates, 1990; Lacoursiere 1993; Northern, 1969; Tuckman, 1965).

Facilitators may also experience difficulty letting go or may interpret the "regression" of the group members as a reflection of their group facilitation skills (Glassman & Kates, 1990). Helping the group members recognize and deal with an imperfect ending will provide further affirmation and coping strategies for members' experiences with other endings in their lives.

Conclusion

While there have been many intervention strategies utilized for women and children exposed to family violence, most of the group approaches for parents have been psychoeducational in nature. Given the impact of family violence and colonization on the parent-child relationship, I have utilized a multi-family group approach which includes a theraplay component.

According to a review of the literature, some parents who are living in abusive situations seem to have difficulty meeting the emotional needs of

their children. This may be due to the stress of the violent relationship and the reality that the children cannot rely on their caregiver to be consistently available to them. The literature also revealed that women in abusive relationships may experience depression and anxiety which impedes upon their emotional and physical availability to their children. Even when women have left the abusive relationship, they may remain overwhelmed by the responsibilities of parenting alone, given the emotional trauma both they and their children have experienced. All of these factors may affect the strength of the parent-child relationship.

Further to this, it seems evident from the literature that colonization has greatly affected the experience of many Aboriginal families. Many children grew up without their parents or the positive influence of family and community. It would seem that a parent or parent-child intervention must take into consideration the multi-generational effects of colonization on Aboriginal families.

Currently, most groups for parents who have children that have been exposed to family violence have included the parents meeting without their children present. There has been very little research in this area. The one study that was found indicated that concurrent parent counselling for parents whose children were in a group had no impact on their child's progress in group.

There is some evidence that a multi-family group format that encourages healing within the community is of value to women and children who have been exposed to family violence. A multi-family group allows for the parents to share ideas and experiences, and to support their children break the secret of the violence within a supportive community context. Some empirical studies have revealed that a muli-family

intervention has positive effects related to improvement in children's negative behaviors and in overall family satisfaction.

In order to address the issue of the parent-child relationship, theraplay is viewed as a valuable complement to the psychoeducational approaches utilized within this multi-family approach. Munn (2000) comments that theraplay is well suited to changing negative family relationships from one generation to the next, whereby the violence is replaced by caring and playful interactions. Empirical research in the area of theraplay is very limited, as there has been little research done using a control group. The research using pre- and post-test designs seems to indicate that theraplay interventions that occur between parents and children have had positive outcomes related to children's aggressive and acting out behaviors, as well as their self esteem.

This literature provided the background for the intervention developed in this practicum. This parent group intervention included both a traditional psycho-educational component as well as the complementary components of a multi-family group format and theraplay activities. The teachings of the Medicine Wheel were integrated throughout the content and structure of the group.

THE PRACTICUM DESCRIPTION

Setting

This practicum was initiated from the Elizabeth Hill Counselling Centre, which is a community based agency operated by The University of Manitoba. The Elizabeth Hill Counselling Centre provides supervision opportunities to Social Work students in the Bachelor, Masters and Doctorate programs. Services provided to the community include individual, family, and group therapy, as well as specific therapies such as play therapy and theraplay for children. There is no fee for services. Clients are voluntary and are self-referred or referred through community agencies.

The Elizabeth Hill Counselling Centre has specific recording requirements which include demographic information, pre-group interviews and screening, permission for observation and parent consent forms, intake reports, contact and process notes, and closing summaries. Group sessions were videotaped and there were weekly supervision meetings with Diane Hiebert-Murphy, whereby the children's group co-facilitators and the co-facilitators of the parents' group met together to de-brief, evaluate, and plan for pending group sessions. For my own purposes, I kept weekly notes pertaining to the group process and the individual group members' experiences.

Committee members included Dr. Diane Hiebert-Murphy, a professor in the Faculty of Social Work at the University of Manitoba, Linda Perry, a therapist at The Elizabeth Hill Counselling Centre, and Belinda Vandenbroeck, the project coordinator of Wahbung Abinoonjiiag.

Overveiw of the Intervention

In the first eight weeks the parents met seperately from their children for the greater part of group time, to discuss issues related to their own childhood experiences, play and child development, and the impact of exposure to violence on their children. The children joined their mothers for theraplay activites the last fifteen minutes of group. In the final eight weeks of group the parents spent the first half hour of group preparing for the group topics that were pending with their children each week. The children then joined the group for an exploration of family violence themes whereby they had an opportunity to share experiences using a puppet play as a means of facilitating discussion. Following this, the parents and children engaged in theraplay activities together. Closing activities always involved a song and a prayer. It was within this structure and format that the practicum description was developed and the ensuing group experience and analysis evolved.

Referral Process

Dates for the group were established and notices were sent out to many community agencies. The notices included the criteria for referrals, the structure of the children, parent and parent-child groups, and the goals of the groups. Referrals were first solicited from a residential program for Aboriginal women leaving abusive relationships. Other referral requests were then extended to external agencies. These requests for referrals were done in the form of phone calls to known appropriate agencies, and mail-outs/faxing to external agencies. Clients already known to Elizabeth Hill Counselling Centre were also considered.

Inclusion Criteria

This program targeted mothers who were parenting alone after leaving an abusive relationship. There was only one latency age child (ages 7-10) who

attended the program with his/her mother. To be eligible, the mother was to be currently living with the child and likely to continue as the custodial parent. Clients were voluntary; mothers needed to have some motivation to improve their parenting relationship and the children needed to be prepared to attend programming.

Exclusion Criteria

Families were excluded if there were active substance abuse problems, or a psychiatric problem which would interfere with the mother's ability to engage in treatment. If the family was continuing to live in a family situation in which there was a risk of violence, they would not be considered for the program. As well, if it was determined that there were developmental delays in the emotional or behavioral functioning of the child or the child's behaviors indicated that other children involved in the intervention would be at risk, the families were referred to other intervention services.

Response

We had few referrals from the residential family violence program, and there was only a limited response from other external agencies. I then solicited my colleagues within the Winnipeg One School Division and they referred a few families who met the referral criteria.

Client Selection

The family assessment and intake process ran from December 1999 - January 2000. During the intake process Linda Perry and I met with the women and children together for a screening and assessment interview (See Appendix A). The purpose of the assessment was to provide clients with information about the program, to collect information necessary to understand the nature of their concerns, to determine the fit between client

needs and the goals of the program, to identify goals for intervention, and to establish a rapport between the family and the program staff.

Initially we met with the women and children together. We spent some time describing the goals of the group and the rationale for incorporating play into the group agenda as a means to enhance the parents' relationships with their children. We also asked the women to speak about the violence that their children may have witnessed. This allowed the children to hear their mothers "break the secret" of the violence and gave them permission to speak about the violence within the intake session and in the pending group sessions (Peled & Edleson, 1995; Pepler et al., 2000; Rabenstein & Lehman, 2000; Suderman, Marshall, & Loosley, 2000). As part of the intake process we gathered information about family history and current family life and attempted to assess the safety of each of the families (Suderman et al., 2000).

We then met with the women alone to complete the pre-test measures and to answer further question or concerns. The measures for the parents included the Child Behavior Check List (Achenbach, 1991) and The Parenting Stress Index (Abidin, 1991). These measures were also completed after the end of the parent group and at the end of the multi-family group. The women were also informed as to group activities, their own involvement in direct play activities, and were screened as to their commitment to the sixteen week program. The children were given an opportunity to tour the Centre, to hear about some of the activities that would occur in the group, and to ask any questions they may have. They also were administered pre-test measures. When the intake process was complete we had five families which were appropriate for the group. All the children chosen for the group were boys.

It would have been helpful to have more than one interview with all of the families before the start of the group. This would have allowed for further discussion about group process, group expectations, and the rationale and goals of the group. Another intake meeting would have provided a better opportunity for information gathering with regards to each of the families' experience of the violence and their current living situation. As well, the group expectations for participation such as confidentiality, group attendance, and being on time for the group could have been better addressed. Other "housekeeping" tasks such as transportation and child care could also have been clarified. Peled and Edelson (1995) refer to such a meeting as a group orientation meeting. Because of the difficulty receiving referrals and the fact that the intakes were occurring over the Christmas holidays, the intake process was reduced to one meeting in most cases.

The Goals of the Parents'Group

The parents' group ran simultaneous to the children's group. The parents' group was facilitated by myself and Sarah Cummings. The goals of the parents' group were as follows:

- To help the women understand the impact that exposure to family violence has had on their children.
- To help the women enhance their understanding of the multi-generational nature of family violence as caused by colonization.
- To provide an opportunity for women to share their own childhood memories of play.
- To provide an opportunity for women to play and to experience the thoughts and feelings related to playing.

- To provide information about enhancing the parent-child relationship through play while utilizing the theraplay components of nurture, structure, engagement, and challenge (Jernberg, 1999).
- To provide an opportunity for women to put these theraplay strategies into action with their children.
- To provide an opportunity for mothers to increase their social networks and form relationships with parents in similar circumstances.

The Goals of the Children's Group

The children's group ran concurrent to the parents group. It was facilitated by Linda Perry and Christina Green. The children joined their mothers for the last fifteen minutes of each parent group for the first eight weeks. The goals of the children's group were as follows:

- To help the children develop social skills and strengthen their abilities to interact with peers in a positive manner.
- To provide the children with the opportunity to experience positive peer relationships over a period of time.
- To help the children deal with their emotions by expressing feelings using words rather than behavior.
- To provide the children with a positive experience that will increase their self-esteem.

The Goals of the Multi - Family Group:

Following the completion of the separate parents' and childrens' group, the parent-child dyads were brought together for a multi-family group. The children and parents met separately for the first half hour of the group and then joined together for the remainder of the time. This group was facilitated by myself, Linda Perry, Sarah Cummings, and Chrisitine Green. In

the final six sessions of the multi-family group Chrisitina was unable participate and Sarah joined Linda in the children's group for the first half hour when the children and women met separately. The Goals of the multi-family group were as follows:

- To provide an opportunity for parents to understand their child's perception and feelings related to the violence they have witnessed.
- To provide an opportunity for parents to respond with empathy to the feelings expressed by their children.
- To provide an opportunity for parents and children to discover play activities that will enhance their relationship.
- To encourage the women and their children to practice these play activities at home once/day. That is, to transfer the group experience into family life.

Assumptions of the Intervention

The assumptions of the intervention were as follows:

- Low-income, single mothers often experience considerable stress in their parenting role and lack sufficient supports to deal effectively with parenting issues.
- Aboriginal women and children must be understood within their social context, which includes an understanding of the impact of colonization.
- Mothers can benefit from the opportunity to share experiences with each other and by playing together.
- Children exposed to violence can benefit from breaking the secret of the violence they have witnessed in a therapeutic setting.
- A healthy parent-child relationship is the foundation for healthy behavioral change.

- Bringing families together can create a therapeutic environment in which behavioral change can occur.

Overview of the Group Intervention

The parent group included an eight week group session that was facilitated from January 11 - March 15, 2001. The multi-family group ran from March 22 - May 17, 2001. Each group was one hour and a half. Throughout the initial eight weeks the children joined their mothers for the final fifteen minutes of the group. In the last eight weeks of the multi-family group the children joined their mothers for the final hour of the group. We began the group with five families. Two of the families were unable to complete the group.

The method of intervention within the parents' group included the following : a traditional circle format that included a smudge, and passing of the grandfather rock within a sharing circle; a psycho-educational group which included information about play and child development, colonization, family violence and its impact on children, and the relevance of the four theraplay components; and an experiential group component that included play and theraplay interventions both for the adults and the adults and children together.

The structure of the parent group included a circle sharing or check-in, an introduction of the theme of the day, play time for the adults, snack, and further discussion or activities related to the theme. The children would join the parents' group for the final fifteen minutes of group to share what they had done in their groups, to play together and to share the closing song and prayer together (See Appendix B).

Themes within the parents' group included play and its meaning in the relationship with our children, childhood memories of play, the impact

of family violence on children, providing nurturing to our children, providing structure to our children, noticing our children's strengths, and engaging with our children.

The method of intervention within the multi-family group included a traditional circle format (that included a smudge and passing of the grandfather rock within a sharing circle) with the parents alone; the use of puppetry as a means to break the secret of the violence with the women and children; a psycho-educational component which included information about family violence and the important messages about responsibility, expression of feelings and safety planning; and an experiential group component that included play and theraplay interventions with the adults and children together.

The structure of the multi-family group included a parent circle that consisted of sharing or check-in, an introduction of the theme of the day in order to prepare the women for the puppet show content and the responses they may expect form their children. The children then joined the group and we shared a snack together. Following snack, the opening Hello! song welcomed everyone in the group. A puppet presentation that represented the experience of family violence from a child's perspective then occurred, followed by a discussion. Theraplay activities were then facilitated both as large group activities and as dyad activities between parents and children. We closed with a song and prayer (See Appendix C).

Themes within the multi-family group included my family tree and me, all kinds of feelings, breaking the secret, the violence is not my fault, protection planning, peaceful plans, hopes for our own family and saying good-bye.

Evalution Plan

Therapeutic changes were assessed in a pre-test/post-test design. Assessment measures were administered during the assessment, following the completion of the parents'and children's' groups, and at termination. The instruments administered to the parents included:

- The Child Behavior Check-List
- Parenting Stress Index
- The Mother's Evaluation and the Mother's /Caretaker's Evaluation

The Child Behavior Check-List

The Child Behavior Checklist (CBCL), 1991 edition, was designed by Achenbach (1991). The CBCL is intended to serve as only one piece of information within the context of a comprehensive therapeutic assessment of children and families and is a standardized measure of children's competencies and problems as reported by their caregivers (Achenbach, 1991).

There are 113 items on the CBCL problem scale and a range of three possible responses to each question which include not true, very true, and often true. It is the problem scale and the eight cross-informant syndromes that are identified within the scale that were relevant to an assessment of behavioral changes among the children who participate in this family violence group.

Within the syndrome scales there are internalization and externalization groupings of behavioral/emotional problems identified. The internalizing grouping includes the subscales of Withdrawal, Somatic complaints, and Anxious/Depressed scales (Achenbach, 1991). The externalizing grouping includes the subscales of Delinquent Behavior and Aggressive Behavior scales (Achenbach, 1991).

The reliability of the CBCL was tested for the inter-interviewer and test-retest reliability of the CBCL item scores and was found to have "intra-class correlations in the .90s for the mean item scores obtained by different interviewers and for reports by parents on two occasions, seven days apart" (Achenbach, 1991, p. 81). The test-retest reliability was also supported, with a mean score of r = .89 for the problem scales over a seven day period (Achenbach, 1991).

Content validity was supported by the fact that non-referred children could be distinguished from referred children (Achenbach, 1991). Construct validity was confirmed as the CBCL was analogous with other similar scales (Achenbach, 1991). Criterion based validity was supported by the fact that the CBCL could distinguish between referred and non-referred children when controlling for demographic effects. Criterion validity were also all supported according to evidence of associations with other scales (Achenbach, 1991).

In terms of scoring syndrome scales, any sub-score with a T score between 67 and 70 is considered to be in the borderline clinical range. Any sub-score above a T score of 70 is in the considered to be within the clinical range. When tested, T scores of 67 significantly discriminated between referred and non referred children accross all eight syndromes. There were significant differences between the proportion of referred and non-referred children scoring in the normal, borderline and clinical ranges.

For the purposes of this practicum, the total internalization and total externalization as well as the total problem scores were calculated. The T scores for these total scores are considered to be borderline if they fall between 60 and 63, and clinically significant if the T score is 64 and above. Achenbach (1991) warns that any score a child receives is merely a reflection of the child's behavior as viewed by a certain reporter at the time of filling out the measure.

These scales are of particular value for assessing changes brought about by interventions related to working with children exposed to family violence. That is, children exposed to family violence are at a risk for demonstrating internalized and/or externalized behavioral responses to the violence (Christopoulas et al., 1987; Fantuzzo & Lindquist, 1989; Hughs et al,, 1989; Jaffe et al., 1985; Mathias et al., 1995; O'Keefe, 1994; Sternberg et al., 1993)

As an assessment tool the CBCL allows the group facilitator to determine possible goals for the group, depending of the needs of its members. If children are identified as demonstrating aggressive behaviors, for example, the parents group discussed the impact of family violence on children's ability to express feelings such as anger and how parents might intervene with such behaviors. The children's group may develop goals pertaining to appropriate expression of feelings and needs.

The CBCL makes it possible to compare children's responses before and after an intervention. The CBCL was completed by the children's parents before the first group, at the midpoint before the multi-family group, and at the completion of the group experience.

The Parenting Stress Index

Abidin (1991) has developed the Parenting Stress Index (PSI) as a standardized measure to profile the level of stress experienced by parents. This measure asks parents to respond to 120 statements on a questionnaire that provides a Likert scale with five possible responses. These responses include strongly agree, agree, not sure, disagree, and strongly disagree.

Within the measure there are Child Domain (CD) scores which measure the stress related to the children's behavior as experienced by the parent. The sub-scales for the Child Domain include Distractibility (DI),

Adaptability (AD), Reinforces Parent (RE), Demandingness (DE), Mood (MO), and Acceptability (AC) (Abidin,1991).

There are Parent Domain (PD) scores that measure the parent's functioning. While an ecological perspective must recognize the interactive reality of the parent-child relationship, it is possible to analyze some of the parent's stress as independent from his/her child. The Parent Domain scores include Competence (CO), Isolation, (IS), Attachment (AT), Health (HE), Role Restriction (RO), Depression (DP) and Spouse (SP). The Total Stress (TS) score is a combination of the Child and Parent Domain score (Abidin, 1991).

The PSI also includes a Life Stress (LS) score that measures 20 stressful circumstances that are beyond the control of the parent. These include items such as loss of job and death of a relative.

The PSI has a defensive responding score which indicates whether the individual is responding in a defensive manner. A score 24 or lower on the defensive responding score could indicate that caution should be used when scoring the PSI.

Content validity was determined by relevant research in the areas of child development, parent-child interaction, child abuse and neglect, child psychopathology, childbearing practice, and stress. The questions were piloted to assess for readability and administration time. A panel of professionals in the area of parent- child relationships were consulted, and field tests were conducted. Items not shown to contribute to subcales or domains were removed.

The reliability coefficients for the child and parent domain are .89 and .93 respectively. These coefficients are large enough to indicate a high degree

of internal consistency for these measures. The stability of the PSI scales is also supported by the test-retest reliability data.

The parents in the norm group were primarily recruited from well child care pediatric clinics. The sampling procedure was not random and parents who participated were volunteers who were approached by various health care professionals. The current norm sample consists of 534 parents from the initial norm group (1983) and 2, 099 additional parents between 1983 and 1989. The mothers' ages ranged from 16-61 with a mean age of 30.9. The mean number of children at home was 2.1. The children ranged in age from one month to 12 years.

In terms of interpretation of the measure, any score above the 85 percentile is considered clinically significant and parents with scores in this range require intervention for themselves and their family.

Women who have left abusive relationships are often dealing with the residual impact that the violence has had on their children. The women in this group are all parenting alone. Many of their children are experiencing post-traumatic stress symptoms related to being exposed to the violence. The PSI allows for an assessment of the amount of stress the parents are experiencing relative to their relationship with their child and in relation to their own individual experiences of being aparent.

At assessment, an analysis of this data assisted me in determining whether group was appropriate for the parent. It also provided an opportunity to make referrals to other resources that may further assist the family. For example, if the PSI indicated that a woman was feeling depressed and isolated, a referral to individual counselling or a community outreach program was considered. Further to this, the subscales such as Attachment, Reinforces Parent and Acceptability assisted me in setting goals which met the

relationship needs of the parents and children within the group while at the same time determining if the group goal of an enhanced parent-child relationship was achieved somewhat within families.

The Mothers/Caretaker Evaluation &The Mother's Group Evaluation

This evaluation form was used as a qualitative measure for the mothers to complete at the end of the group. Questions that asked the mothers to consider the impact that the group has had on themselves and their children were included (See Appendixes D and E).

Limits of the Evaluation

The administration of the CBCL and the PSI included a pre-, mid- and post- test design with no control group. The outcome scores of the CBCL and PSI are also limited by the small numbers of families in this group. It was understood that these factors make it difficult to determine if behavioral changes or reduced stress scores were the result of the group intervention or the result of other external influences.

As well, some of the CBCL's were filled out by parents alone and some were administered by the group facilitator. Some parents did not return their CBCL forms. Parents also had their own perception of their children's behavior relative to their parental level of stress and their age appropriate developmental expectations of their children.

Some of the difficulties within the PSI included its class and cultural biases. The measure seems to make the assumption that two heterosexual parents are heading the family in question. The women we worked with are parenting alone. This reality required a number of the questions in the spouse sub-scale to be eliminated, which affected the parent domain and total stress score. Further, while the scale makes adjustments for Hispanic families, it may not be a culturally appropriate measure of Aboriginal parent stress.

For some families whose life stress scores were quite high, their child and parent domains scores were relatively low. It would be helpful if there was some way to determine when life stress has remained so constant in a person's life that the stress has become normalized.

Finally, some of the questions on the PSI measure are difficult to understand and require clarification. It was unclear at times, for families with many children, to decide which child some of the questions refer to. There are also questions that seemed to relate to children younger than those who attended this group.

THE GROUP EXPERIENCE AND ANALYSIS

Group Member Profiles

There were five families in total at the start of group. Each mother had one son between the ages of eight and eleven who attended the children's group and the multi-family group together with their mothers. At the end of the group there were three families who had completed the entire sixteen week session.

Gillian is a mother of four children (ages 6 months to 8 years) who attended the group with her eight year old boy, Jeff. She identifies herself as being of Metis origin. Gillian had been out of her violent relationship for two years and her ex-partner continued to have contact with the children sporadically. Gillian's oldest three children witnessed a great deal of the violence, which consisted of ongoing physical and emotional abuse. Apparently, Jeff did well in the school setting, but Gillian said he was angry at home and often aggressive with his younger siblings. Gillian and Jeff attended 14 out of 16 sessions.

Linda is an Aboriginal woman who has four children, ages 3 to 12 years. Her oldest child lives with his father and visits the family occasionally. Grant (age 8) attended the group. He had witnessed a great deal of physical and emotional violence and was apprehended and placed with his grandmother when he was four years old. Grant shared many memories from his early experiences of witnessing physical and emotional violence. Linda said her current partner's drinking was a problem for all of the family. Her youngest child's father was recently released from jail and had threatened to take his child from Linda's care or to move into a nearby neighborhood. There were constant difficulties within the neighborhood and Linda felt she

and her children were unsafe. Linda and Grant attended 9 out of sixteen sessions and were sometimes late for the sessions they did attend.

Samantha is an Aboriginal woman who only recently moved with her seven children (aged 3 to 13) to the city. Samantha lived on a northern reserve all of her life and describes her partner as giving her "daily beatings". Her son Alan (age 9) attended the group with her. Samantha said Alan was witness to most of the violence, but that he never talks about it. Her children were returned to her care one year ago, after living in a foster family for several months. Samantha has in-home support form various social service agencies within the city. The children have no contact with their father. Samantha and Alan attended 10 out of 16 sessions.

Maya is a woman who has two grown children and one other child, Luke, age 7. Maya grew up in Europe and spoke of her early years there when she lived with the physical and emotional abuse with no support from her family. She also received little support from the authorities who viewed domestic violence as a private matter. She immigrated to Canada with her two oldest sons and her partner. Luke continues to have visits with his Dad. According to Maya, these visits are stressful given the ongoing controlling behavior of her ex-partner who is constantly threatening to take Luke away. This family did not complete the group and only attended 3 sessions.

Mary has three grown children and two children from her most recent relationship. Three children currently live with her (age 3 years to 20 years). Mary is a Cree woman who grew up on a northern reserve and lived there with her oldest children and her first partner after she was first married. Mary said that her first husband was extremely physically and emotionally abusive. Mary identifies herself as a recovered alcoholic who has been sober for three years. She grew up in the child welfare system, as did her adult children who

were apprehended when they were toddlers. Mary's youngest two children were also exposed to physical and emotional abuse and have only recently been returned to Mary's care. Josh (age 11 years) attended the group with Mary. Josh witnessed physical and emotional abuse and has no contact with his birth Dad. Mary was unable to complete the group. She and Josh attended 4 out of six sessions and left the group after the sixth session.

Planning

Planning involved the initial development of group goals and implementation plans. These meetings were held with Linda Perry, who facilitated the children's group and with Sarah Cummings, who co-facilitated the parents group. The parents' and children's group facilitators met with Diane Hiebert-Murphy once a week to discuss the group dynamics and to share information pertinent to making any changes in the parents' or children's group interventions. We made adaptations based on the outcome from each group session and from the supervision meetings.

It was decided that the larger group room would be utilized for the parent and parent-child components of the group. The children's individual group was facilitated in a smaller room on the same floor. The groups occurred in the evenings which allowed for a quiet setting at the agency. As well, participating in the evening did not disrupt the children's school day. There were safety concerns for families who were traveling at night, and bus tickets or transportation by car was offered to families as needed. Child care was also provided at The Elizabeth Hill Centre.

Facilitation Roles

The children's group was facilitated by Linda Perry and Christina Green. The parents' group was facilitated by myself and Sarah Cummings. As facilitators we decided that my role would be to take on the leadership of the

group. I planned the initial outline of the groups, and took the lead in the group as to the content, rituals, and processes within the group. As lead facilitator, I assisted the parents in remaining focused on the goals of the group, shared information, and provided emotional support. It was also my responsibility as lead facilitator to challenge the parents when necessary and to deal with any group conflict or crisis that arose. I co-led the theraplay activities with Linda Perry and Sarah Cummings, who both have experience as theraplay therapists.

As co-facilitator, Sarah provided additional information and insight within group discussions and her perspective of the group dynamics was integral to the post-group supervision meetings. Sarah was able to provide a third eye or facilitate a "scanning" (Glassman & Kates, 1990) as to the group dynamics that I may have missed.

Sarah's strong playful spirit encouraged the women take the risk to play within the group. Her experience utilizing theraplay techniques provided important expertise and enhanced the theraplay time with both the women and the children. Finally, Sarah provided a great deal of emotional support for the women and the children throughout the sixteen-weeks of the group.

When the children joined the parents' group the facilitators from the children's group joined as well. This meant that when we were facilitating a multi-family group there were often four facilitators available to the families. Given the unique composition of multi-family therapy, family members may bring more conflicted types of issues to the group. It was necessary, then, to have a number of facilitators to lead the group, support the group members, intervene during conflict, and be aware of the ongoing group dynamics and

individual processes of the participants (Dennison, 1999; Meezan & O'Keefe, 1998).

When the children and parents joined together, the expertise of Linda Perry was integral to the co-facilitation of the multi-family group. Linda and Christina had a strong relationship with the children and this helped the boys to feel settled within the multi-family group. Linda's expertise with regard to group dynamics, theraplay, and her understanding the dynamics of family violence all contributed greatly to the facilitation of the group. Linda also provided expertise in the area of dealing with children's behaviors and parental responses and modeling parenting within a group setting. Each of the facilitators contributed to the implementation of the family violence puppet show, the ensuing discussion with the women and children, and the facilitation of the theraplay activities.

I utilized the group stage themes as outlined in the literature review to analyze this group experience. It is important to note that each group experience is unique and does not necessarily reflect the time lines or the realities of the group themes as presented. I will try to be cognizant of this as I present this information. If I seem to move back and forth in terms of themes and group stages, this is representative of the reality of this group experience.

Stage Theme 1: We're not in charge

Certainly in the early stages of the group, the women were dependent on the group leaders to provide structure and meaning for the group. I recognized that because this was a unique means of intervention, I was uncertain of how to provide that structure. I was trying to integrate the theory of the trauma related to exposure to family violence, the women's early childhood experiences of play, and the rationale for introducing play with their children as a means of enhancing their relationship. While the

rationale for this group and its methodology was becoming more clear in my mind, it seemed difficult to articulate my thoughts to the women. I did attempt to provide a solid rationale in the intake process and to use the first group to be very clear about "why we are here". Dennison (1999) suggests that it is crucial to clearly articulate goals and objectives to the group members. As time went on it became more clear to all of us how these components fit together. This is likely the reality for most new group intervention strategies, as the facilitator is also "in process" with understanding how her/his theory will fit with practice and how to then articulate this to the group members in a cohesive way.

I attempted to demonstrate the group purpose and rationale using the Medicine Wheel. Using the Medicine Wheel we discussed the value of play in the women's lives and the developmental needs of their children. The Medicine Wheel was also used as a tool for describing the four components of theraplay, and as a health and wellness model for discussing how this related to the impact of family violence on their children (See Appendix F). Bruce (1998) discusses the Medicine Wheel as being congruent with a holistic and a culturally appropriate approach to working with families affected by partner assault.

As stated earlier, in a therapy group where the task may be more difficult to define, the orientation phase may last a longer percentage of time (Lacoursiere, 1993). The difficulty of articulating group goals, as well as the sporadic nature of attendance, made focusing the group and group plans and structure more difficult. As this is a time when the facilitator is supposed to be enabling entry and acceptance within the group, poor attendance did likely stagnate the group process (Glassman & Kates, 1990). Dennison (1999) suggests

that discussions about being on time and calling when not able to come to the group are necessary from the beginning of the group.

The women in the early stages of the group appeared to be very trusting. They began to share intimate details of their lives with one another and to laugh and tease one another within the first group. While Gillian and Jeff were known to me, most of the women were unfamiliar with both me and the group process. Even Maya, who could be described as a shy member of the group, teased me about my art work on the Medicine Wheel. She also felt comfortable enough to ask me if I had children or if I was married. This was likely a way for Maya to decipher how credible my information and suggestions were relative to her own life experience.

Group members may be more compliant at this stage and this may be misinterpreted as trust. Sheppard (1962) describes this as the dependence-flight stage, as members try to watch for cues and want to please the facilitator. However, the trust may also have been due to the group environment. The group setting was warm and inviting. There were pillows for the participants to sit on, dimmed lights and a quiet, enclosed space where we were not interrupted. Glassman and Kates (1990) highlight the importance of a meeting environment that has symbolic significance. At the end of our first group session one of the women said "This was as relaxing as a night at bingo."

I was immediately surprised at the women's willingness to take risks and to participate in the group activities. Most notable was their willingness to play. Perhaps they were prepared for the play as we had discussed the rationale for play within the intake process and had suggested wearing comfortable clothes and shoes. Not one of the women ever said "This is silly" or "I'm not doing that". Blatner and Blatner (1997) discuss play as often

leading to feelings of shame and vulnerability related to negative childhood experiences of play. We wanted to be aware of the women's vulnerability and tried to incorporate more group games that did not single people out. We tried to be gentle in our encouragement of play and to be aware of the judgment and negative teasing that may have been part of their childhood experiences.

The women became more vocal about their experience playing in the group as the weeks passed. I believe that the group members needed some time to process their experiences. Sometimes being in action is more important than the analysis of the experience (Blatner & Blatner, 1997). Thus the de-briefing about what it felt like to play was left to come naturally in the later stages of the group.

Another reality in this early stage of the group was that there were cultural differences among the women, varied understanding of the impact of colonization, and diverse ways in which culture and history were integrated into the women's lives. Maracle (1993) warns against a stereotyped approach because the cultural ways of Aboriginal people are as diverse as the issues related to family violence. Glassman and Kates (1990) talk about the necessity of identifying members' individual reasons for attending the group and to reinforce the commonalties within the group.

Maya was non-Aboriginal and we had discussed in the intake that the group had been designed for Aboriginal women and their children. We also discussed that the group would have an Aboriginal focus in its content and in its process. However, there may not have been enough information given in the intake about what this would look like within the group. A discussion of the smudge or the sharing circle may have been appropriate here, as well as the reality of different cultural experiences. It is not clear if the cultural

differences were uncomfortable for Maya and Luke. She chose not to smudge, but was very interested in the other women's stories and did share about her childhood experiences and the realities of being in an abusive relationship in a country where family violence was essentially condoned. We did try to point out common elements of the group members' experiences of the family violence, or of childhood experiences. However, by group five Maya said she could not return, as she felt it was too difficult with her shift work, her son seemed to be doing fine, and she felt that the group was not a priority for her at this time.

Having said this, the women were welcoming of one another and respectful of each other's experiences early in this group stage. According to Glassman and Kates (1990), the facilitator is watching for each member's contribution to group cohesion through the enactment of listening to one another and empathizing with other group members. The group rules or "honoring each other" were representative of this mutual respect. These were developed together and included: What is said here, stays here; we honour each other's feelings and experiences; we will work to make each other feel welcome and comfortable; and we will try to understand one another.

At the end of each group we would invite the children to join for the last fifteen minutes of the group. This allowed for play time together, a sharing of individual group experiences and a closing ritual of a song and prayer. The singing within the group was a wonderful way to start and finish the group. Sherman (2000) confirms that singing provides an opportunity for group cohesion and seems to energize and ground the group members. Rituals such as group time with the mothers and children for fifteen minutes at the end of the group, play time together, and the closing song and prayer all facilitated group cohesion and helped to build trust through structure and

predictability. Families who are exposed to violence often require some structure and predictability in order to feel safe. This is due to the post traumatic stress symptoms which cause high anxiety and hyper-vigilance to their environment (Levendosky & Graham-Bermann, 2000; Silvern, Karyl, & Landis, 1995).

In the early stages of this mother and child time the boys were also fairly willing to follow the facilitator's lead and direction. There was virtually no verbal or physical aggression directed at their peers or their parents at this stage. They enjoyed the play time with their parents, although Jeff and Grant had some difficulty with the nurturing or the touch and seemed to stiffen when their mothers put their arms around them. Rubin (2000) reports that nurturing may be as difficult for the parents as for the children and that the women in her theraplay group often sought to avoid intimacy. It is possible that the boys' discomfort with the nurturing activities were related to their parents' own comfort levels.

Alan and Josh were the quieter members of the children's group, waiting for others to take the lead. Alan's mother, Samantha, was also tentative when contributing to the group, but when she spoke her sharing was intense and thoughtful. Josh's mother, Mary, was quiet as well, but had a leadership presence, and when she spoke the other women were very attentive to what she had to say. Josh seemed to take care of his mom somewhat, which is often an outcome of parenting in a violent relationship as the child becomes parentified (Bilinkoff, 1995; Grusznski et al., 1989)

Grant needed to be in control and tried to lead the group in different directions and we tried to provide him with clear structure in a nurturing, but firm manner, keeping in mind the "adult in charge" structure of the group (Jernberg, 1999; Munn, 2000; Rubin, 2000; Rubin & Tregay, 1989). Some

of these dynamics probably arose because the boys were still finding their place in the group and were aware of their peers - they too were looking for cues from one another regarding acceptable behavior and responses. Glassman and Kates (1990) discuss this early stage and the trust or mistrust that begins to form as participants are "checking out" each other and the facilitator.

Stage Theme 2: We are in Charge

At this stage in the group we began having difficulty with attendance. Gillian and Jeff were the most consistent and attended all but one session in the first half of the group. Maya was working shift work and missed sessions due to her schedule. Linda was experiencing a serious crisis in her immediate and extended family related to safety and health. Mary had an immediate family member die. Many of the women were simply dealing with the day to day issues of sick children, household responsibilities, and school/ community commitments.

It became apparent that intervention and support for the families needed to occur during the week as well as during group time. There were issues arising that required immediate attention. These issues included community violence, sexual abuse disclosures, ongoing safety concerns for families, new abusive partners the women were involved with, and ex-partners who were resurfacing due to jail terms ending or moves back to the families' vicinity. It seemed that many of the families in the group were living with immense challenges and crises on a perpetual basis. This can be common for families who have survived multi-generational abuse, loss, and violence (Boyd-Franklin & Hafer-Bry, 2000; Kagan & Schlosberg, 1989; McNeil & Herschell, 1998).

According to the group literature, members will sometimes have a particular crisis that detracts from the group purpose (Glassman & Kates, 1990). The women were coming to the group with immediate needs and we found that it was becoming increasingly difficult for the women to attend to the group within the confines of the planned structure. Check-ins were becoming longer and less focused on the topic at hand. It was not so much that the women needed to be in charge at this stage of the group process, but that their lives were such that they had little outside support and the group was often the only place they could share their day to day realities. Bruce (1998) highlights the isolation often faced by Aboriginal women who move from small communities into unfamiliar urban centers as a result of family violence.

In order or deal with this, I needed to structure the check-ins with a topic or question that fit with each week's theme. This entailed re-focussing the women and still respecting their experiences. McNeil and Herschell (1998) refer to this as "avoiding putting out fires" and recommend redirecting to an emphasis that working on the goals of the group will help to possibly prevent some future crises.

After some consultation with other facilitators and my advisor, methods for dealing with this were suggested. They included requesting that we discuss certain issues at break or following the end of the group, using the presented issues to connect back to the group topic, asking the woman who was presenting another issue what she needed from this group today, or assertively bringing the group back to focus using some humour and being clear about structure and the group goals. Glassman and Kates (1990) suggest a strategy of dropping the eye contact with a participant who is taking the group

off track. Cultural differences would need to be taken into account before this strategy was utilized.

A written group agenda from each week was helpful and was utilized in later sessions. Agendas needed to be clear and one of the other risks at this stage was that play time could get lost in the midst of ongoing heavy discussion. There were times when I needed to simply say that we needed to stay on topic and re-state the goals for this week's group. On other occasions I would use humour and say "That's enough talk - let's play" ! The women were usually fairly willing to abide by these re-directions, although Gillian would often comment that she wished there was more time to just talk about what was happening in their present lives. Linda would often share critical incidents within the group, but she was receptive to having these dealt with individually. However, in one of the first groups where I tried to re-direct Linda she said " Wait - I'm not finished my story !" Glassman and Kates (1990) discuss the balance between becoming too authoritarian at this stage versus not providing enough structure to satisfy the group's feelings of security.

Another issue was the level of anxiety that seemed to be felt by Gillian, in particular, who was needing to lead conversations and anticipate facilitator reactions. This hyper-vigilance, which is often a result of living with violence (Levendosky & Graham-Berman, 2000; Silvern et al., 1995) meant that as facilitators, we needed to be clear about our role as group leaders, and to continue to be directive in terms of group topics. This was necessary in order to stay focussed on the goals of the group. This was a personal struggle for me as a facilitator as I tend to want to avoid conflict when possible and to keep things running without needing to challenge or re-direct.

I believe that this difficulty with remaining on topic was sometimes a challenge for me because of my experience facilitating sharing circles. In a sharing circle it is viewed as disrespectful to interrupt or re-direct people. In the case of this group, however, structure and leadership was important, particularly in the early weeks when we wanted to create safety and predictability.

As the weeks went on, the importance of play with the adults became more and more clear. Play was a way to help all of us relieve the stress of intensive discussions, to move our bodies, and to open up to each other through laughter. Play also provided the participants with a gentle challenge to take the risk to be silly, or to lead the group in games such as Simon Says or Feeling Charades. As the women took the risk to play, they made themselves vulnerable to one another, made eye contact, held hands and laughed together. Blatner and Blatner (1997) discuss using play within therapy as a means to move away from problem solving towards holistic healing and personal growth and development.

Playing helped the women to discover new strengths and enhanced cohesion within the group. Samantha, who was more introverted, had an opportunity to lead Simon Says or to act out a feeling charade in front of the group. The other members were encouraging of Samantha. Samantha, while still shy in her demeanor, would smile and laugh as she took these risks. Including activities that gave everyone a chance to lead was important as the play evolved. Gillian, a natural leader, then had the opportunity to have the other group members lead her. This was a challenge for her throughout the group, but she was willing to relinquish some control and to encourage others.

The women now began to talk about the play experience within the group. They said they had felt self conscious at first, checking to see if others were playing too (Rubin, 2000; Sherman, 2000). They came to look forward to the play time with one another and with their children at the end of the group.

Discussions such as the reality of each woman's childhood experiences began to occur in this phase. They shared about the family violence they had been exposed to as children and the responsibilities they had for their younger siblings that disallowed the freedom of play. Many of the women grew up in numerous foster homes, were physically or sexually abused, and had struggled with alcoholism in their adult lives. This fits with the literature that states that many women leaving abusive relationships have experienced numerous traumas throughout their lifetime (Blanchard & Breuer, 2000; Henning & Leitenberg, 1996; Levendosky & Graham- Bermann, 2000; Rubin, 2000).

While the women required time for their own healing, their children needed their mother's support and attention immediately (Sudermann & Jaffe, 1999). I tried to resolve this tension by relating discussions of their own childhood experiences to the feelings of their own children who had been exposed to violence. We brainstormed the feelings their children may have had when they witnessed the violence in their family, using the Medicine Wheel of health and wellness. I asked the women what they may have needed as children in order to feel safe and then asked what they felt their children needed to feel safe. These discussions evolved slowly, as I attempted to make the links between their own childhood, their children's experiences of the violence, and what their children may need from them now. For some of the women I think these links could have been clarified, particularly when

some group members were missing the beginning of group or not coming at all.

The children were beginning to truly look forward to their play time with their moms. They were testing the limits more readily now and this meant that facilitators needed to be clear about structure. We began to intervene when the women were becoming frustrated with their children. We would model ways to ground their children, such as a hand on the shoulder or a hug from the side. We would acknowledge children's feelings such as disappointment, embarrassment, or anger by giving their feelings a word. Sometimes we would re-direct the child by changing the activity or giving him a task to do, or by using humour. At other times we needed to be very clear about rules and expectations, reminding the boys in a firm manner what the rules were. We were also very clear about the "stick together" rule during group opening and closing and there was often a power battle with the boys about wanting to sit on the couch instead of with the group on the floor.

We usually were able to have them join us with some prompting, but on one occasion we physically moved a child into the group. Gillian commented that this was fine in the large group where there is a lot of support, but that it was more difficult when she was alone at home. This was another example of needing to remember the reality of parents who are parenting alone and who have numerous children (Bilinkoff, 1995; Kiernan, 1994; Wagar & Rodway, 1995). Some of these issues were further addressed in later stages of the group as we began to talk with the women about what the boys were trying to express when they were displaying certain behaviors.

Hughs and Marshall (1995) point out that it is necessary to be aware that many of the women had likely been told by their abusers that they were incompetent parents. We needed to be conscious that we were respectful in

our approach to dealing with parenting issues. The value of a multi-family group is that it allows for a simulated community where true feelings and behaviors can be dealt with in a safe environment (McKay, Gonzales, Stone, Ryland, & Kohner, 1995; O'Shea & Phelps, 1985; Rhodes & Zelman, 1984). This was the beginning of discussion with the women about what their children were trying to tell us through their behaviors, as well as the discomfort associated with parenting in a large group, and how we could work together to support the children.

We presented the parenting concerns from a team approach to problem solving so that the facilitators did not take on the role of expert. For example, we would ask the women why the boys seemed to act silly or why they became aggressive with their mothers in the group at times. We would brainstorm ideas such as they may be carrying uncomfortable feelings from the children's group, they may need to feel in control because they often have felt unsafe, or their scared and hurt feelings can get misdirected as anger towards their mother in a safer environment such as group. This led Linda to say that she often felt she rushed Grant, that she didn't take time to understand or talk with him about feelings. This caused other women in the group to talk about feelings of guilt for what their children have been exposed to. These discussions often came full circle with the women discussing their own childhood and how nobody took the time to listen to them as children.

Following this we had to plan for how to intervene with the behaviors. For example, Gillian suggested using a masking tape line to represent the difference between group singing or discussion area and the play area. We all agreed to introduce this boundary to the children and it seemed to work fairly well. Strategies as listed above were suggested and we decided to try to support each other as needed with the children - an agreement was made not to be

offended by the suggestions of other members or if interventions were modelled by the facilitators. This is referred to by Lowey (1973) as facilitating the decision making process. This discussion continued throughout the remainder of the group sessions.

Theme Stage 3: We're Taking You On

By the sixth week of the group two of the women were no longer attending. Mary's children had been apprehended and Maya had decided to no longer attend based on her schedule and the fact that her son was doing better at home and school. Whether this was a silent way of giving the feedback that the group did not meet Maya's needs is not clear. This was a difficult time for the other women as we could not give any confidential information to them and they were left wondering what had happened to these two women. We simply told the women that Mary and Maya would not be able to continue in the group with us. There were virtually no question as to why this was, as the women seemed to understand we could not share the reason with them. However, Gillian commented that she would miss Mary and that she hoped she was doing well. Linda also expressed her sadness that Mary and Maya had left the group. Mary had been one of the members that the other women seemed to look to for wisdom and experience, as she was older than some of the women. Mary also had a quiet way of responding to discussions with a gentleness and a willingness to share thoughts and feelings. This was greatly missed in the group, and every so often the women would wonder out loud how Mary or Maya was doing.

The facilitators were challenged from time to time about not having children and not truly understanding what it was like to have to parent alone full-time with numerous children and few resources. Glassman and Kates warn against this personalizing of the natural group process. Hunter, Bailey,

and Taylor (1995) tell facilitators, "If you don't know, say so!" (p. 43). The best way for me to handle this was to admit that the women were absolutely right. At the end of the day I get to go home, alone, to peace and quiet. I could never truly understand their reality, I could only try to empathize with them. These challenges occurred about mid way through the group and may have indicated that the women trusted the facilitators enough to take the risk to challenge us a bit. It was a healthy challenge, and the women seemed to respect an honest response and the limitations of my personal experience.

There was one incident where all the women challenged us. We were role-playing examples of engaging with our children, such as making eye contact, getting down to their level, being present with them. Gillian challenged that the reality for her is that her children are extremely difficult to settle - they are always challenging her with their anger or tantrums. She then demonstrated what it was like when her son came home from school. This was a humorous way to put me in my place. However, the role-plays did lead to some feelings of shame or inadequacy with the women. I needed to back track and talk about role-plays being a way to demonstrate an "ideal". If I was to re-do this component of the group, I would be cognizant of the dynamics of role plays that demonstrate a "right" and a "wrong" way.

Stage Theme Four: Sanctuary

The feeling of sanctuary came early on in the group - almost immediately. The women seemed ready to talk and to deal with the issues related to themselves and their families. I believe that inconsistent attendance meant that it was somewhat difficult to open up for the women who missed a number of sessions. Thus, while early in the group trust seemed to form, safety was threatened by people missing more intimate

group discussions, and having to re-define the rationale for certain agenda topics.

Gillian, in particular, helped the other women to feel relaxed and comfortable. Sometimes Gillian's role as leader in the group took over the role of the facilitator in this regard. This was sometimes appropriate and sometimes, I think, a need to reduce her own anxiety about the changing dynamics of the group. Glassman and Kates (1990) report that intimacy leads some group members to fear losing control.

One of the women began to ask for telephone numbers of other members and to suggest getting together. Although this was occurring in later weeks of the group development, issues the women were facing were very critical, and it seemed important to remain as a cohesive group. I addressed this in the following group, reminding people about the risks involved in forming friendships outside of the group before the group was completed. The risks discussed involved confidentiality of the group discussions, cliques forming, and conflicts occurring outside of the group which affected the safety of the group therapy process. The women discussed these concerns fairly openly and were able to decide to postpone outside group contact. Though Glassman and Kates (1990) warn against the facilitator taking on a parent or protective role at this stage, there was definitely some influence by the facilitators toward this decision.

As I had become more comfortable as a facilitator, I became more aware of the individual needs of the group members. Group members needed to pace themselves according to their own needs (Glassman & Kates, 1990). Samantha, who presented as quite shy, was very willing to talk during the check-in, but found it difficult to interrupt others or to offer her thoughts without some encouragement. I believed she was more comfortable within

the group as the weeks went on and I began to address questions to her more directly. This seemed to work well, as she took time to gather her thoughts and to share her experiences and her feelings about the topic at hand.

As we were getting closer to the multi-family group, I tried more and more to integrate the reality for children who had been exposed to family violence. The women began to remember some of what their children had witnessed, and had memories of children being caught between physical fights, children gathering up a baseball bat to protect their moms, and children having to call the police. These memories were very intense for the women and they talked about their feelings of guilt and sadness about what their children had to endure. While I would have liked to have begun this process earlier in the sessions, the women's personal crises and childhood memories meant that we needed to deal with other issues first. It was very difficult for the women to face their children's experiences of the violence and many of the women in the group had never had long term counselling for their own issues related to partner abuse.

Gibson and Gutierrez (1991) describe how difficult it is for these women to actually focus on their children's experiences while meeting their own needs for counselling and dealing with issues related to poverty and housing. Women will often minimize their children's experience of the violence (Henderson, 1993; Stephens, 1999) and the women in the group did need to be challenged occasionally about the impact of exposure to violence and their children's need to feel safe.

We were working with the women on the impact of violence on their children, yet in many ways their children remained unsafe. Gillian's ex-partner was now having regular visits with the children, and Linda's new partner was drinking and having outbursts of anger in front of her children.

Thus, while the women could have been utilizing the group to discuss how to re-establish a safe, structured, and nurturing family environment following exposure to violence, the children continued to have their safety threatened. The goals we had developed for the group in terms of living violence free and developing new family rituals was not possible within this context and did stifle the development of the group.

Kates and Glassman (1990) state that facilitators sometimes become vulnerable to the closeness at this stage and may become passive in terms of re-voicing the group goals and activities. I did not find this to be the case. Conversely, I began to be more comfortable voicing concerns and challenging the women. Perhaps I was getting anxious about group time ending and felt I needed to deal directly with issues such as new abusive partners, children's visits with ex-partners, ongoing safety concerns, external resource support for families, and the reasons for children's ensuing behaviors and feelings. Glassman and Kates (1999) refer to this as offering new perspectives and remind that confrontation should be used within the realm of respect for the participants' right to self-determination and with awareness of their strengths.

I was also spending a great deal of time outside of the group dealing with crises which were occurring within families in addition to the group time itself. Crisis can become a way that some families process past traumas as well as cope with current stresses (Boyd-Franklin & Bry, 2000). While Kates and Glassman (1990) discuss the necessity of a facilitator being comfortable with the closeness at this stage, I found I needed to begin to back away from the intensity of the involvement with the families in order to preserve my own energy and boundaries, to access other supports for the women, and to prepare the women for the final stages of the group.

Stage Theme Four: Sanctuary...

The Multi- Family Group

It was at the sanctuary stage of group development that the multi-family group began and the women had less time alone together. The mothers had only forty-five minutes before their children joined them. This forty-five minutes was spent doing a check-in with the women and then preparing them for the group themes that would be discussed with their children. We wanted to give the women an opportunity to deal with their own emotional reaction to the content in order that they would be able to support their children. Rabenstein and Lehman (2000) state that it is necessary to prepare mothers ahead of time for demonstrations such as videos and storytelling in order for the mothers to reflect on their own thoughts and feelings and prepare for their children's responses.

The children were accustomed to joining their mothers to play together, but were unaccustomed to dealing with the family violence issues within the larger group. The boys had dealt with family violence issues in their own group and there was trust already built with the children and the children's facilitators. However, one of the facilitators left after the second week of the multi-family group, and this was a loss for the children. This was a particular loss for Jeff, as he felt very comfortable with Christina and seemed to feel quite sad that she was leaving. He had a difficult time in her final group, often pushing limits, and not wanting to participate. Sarah, who co-facilitated the parent's group, was asked to participate in the children's group after Christina left, and this also affected the feeling of cohesion within the parents' group.

The women also had to give up much of their independent time with the facilitators in order to address the reality of what their children had

witnessed. The women in Kiernan's study (1994) also talked about wanting more time to speak with other parents about personal and parenting issues. All of these factors contributed to the unease of entering into this next stage of group. While in many ways the families were familiar and comfortable with one another, there were many changes that negatively affected the feeling of sanctuary in the group at this time.

During the multi-family group puppets were used to demonstrate a child's perspective of the family violence. The facilitators prepared a puppet show each week demonstrating a child's perspective of the violence. The children responded very well to the use of the puppet as a mediator of discussion about the feelings related to the violence they had witnessed. They demonstrated empathy for the boy puppet, "Max", told their own stories about the violence in their families, participated in protection planning, and discussed current worries and feelings related to their families. In these situations, according to Hunt and Renfro (1982), using a puppet becomes a buffer which often eliminates communication barriers between adults and children. For example, Alan, who was quite shy, responded to Max's questions even though he would not often respond to the facilitators or his mother. Even the women would address Max directly, which modelled "breaking the secret" for their children. The women were sometimes overwhelmed by what their children remembered about the violence and this was debriefed each week at the beginning of the multi-family group when the women were alone.

However, we were beginning to see the women become more demonstrative with their children and the children becoming more open to the nurturing. As the children became more comfortable, they were more likely to act out in the group - moving their bodies more physically, refusing

to join the circle after play time, and being more overtly angry with their parents. This was confusing to the women as they had hoped that their children's challenging behaviors would diminish, but in fact they seemed to be escalating. In a study of children exposed to partner assault and their mothers many of the women stated that their children became more "badly" behaved while in the group program (Kiernan, 1994). Further discussion about the children's current realities of ongoing safety concerns at home as well as the intensive topics that were being discussed helped the women to understand their children's responses somewhat. Putting their children's behavior in context was crucial to the women beginning to interact in a new way with their children. (Kiernan, 1994; Peled & Edleson, 1995; Suderman & Jaffe, 1999).

Nurture activities were less comfortable for the women, and these activities were introduced slowly and carefully as the group's comfort level progressed (Rubin, 2000). Families in our group really enjoyed the nurturing food related activities such as Licorice races, Jello through a Straw, and the Donut Munch. We always needed to balance these nurturing activities with an opportunity to move physically.

We also played a number of structure games such as Simon Says and Mother May I. There was one group where the use of challenge through a Tug o' War worked well to build cohesion among parent and child dyads. This, as well as activities such as the Paper Punch and Blow Me Over were cathartic and fun. We tried to give families an opportunity to play in dyads as well as in the larger group. The theraplay activities became more intimate as the group comfort level improved (Sherman, 2000).

In another of our multi-family groups we ran out of time to play. This was difficult for everyone. The children were angry and the women were

overwhelmed dealing with the disappointment their children felt. Ownership of this blunder needed to be taken by the facilitators. It was obvious how important the play time had become for both the adults and the children. Play was helpful in maintaining the interest of both the adults and the children who were attending the multi-family group. Dennison (1999) discusses the importance of meeting the various attention spans and various developmental levels within the group and suggests utilizing multiple interventions in order to keep the participants interested.

Theraplay activities, while encouraged and written down for the women to take home were not utilized as homework as was originally intended. An in-home component of service delivery would have helped to facilitate the transfer of play opportunities to the home setting (Boyd - Franklin & Bry, 2000). However, the ongoing crises in the homes of the families meant that they had difficulty transferring the theraplay to the home context.

Early in the multi-family group Gillian made a disclosure in the group to Jeff that she had been assaulted recently by her current partner. This did not seem to be an appropriate time for such a disclosure - she seemed to need to do this more for herself than for her son. Glassman and Kates (1990) warn against disclosure for its own sake as detrimental, particularly when some of the group members may be overwhelmed by intimate feelings and details. The other group members were silent, waiting for the facilitators to respond. We had talked about the importance of speaking openly about the violence in a safe place such as group. As the facilitator, I tried to relate feelings that her son may be having as he was hiding under the couch within the group room and seemed very anxious. One of the other facilitators tried to comfort Jeff by rubbing his back as he lay under the couch. He said "but you told me you fell."

Gillian was trying to be honest and open, but the content of this adult style disclosure in front of the group was very distressing for Jeff. We closed by acknowledging Jeff's sad and scared feelings as a natural reaction to his mom's story. I commented that it was important to discuss this later in private in order to give Jeff a chance to absorb the information. I did not address this disclosure the next week in the women's check-in time, and perhaps if I had prepared Gillian ahead of time we could have discussed this further as a group.

In speaking privately with Gillian and Jeff I attempted to assist Gillian to re-establish the family boundaries, and to deal directly with Jeff's feelings of fear and disrupted sense of safety. I also needed to talk with Gillian alone about being aware of her role as the adult in Jeff's life, and that while we need to be honest with our children it is important not to burden them with the feeling that they need to provide support to the adults in their lives.

The sanctuary of the group was improving in terms of the children being receptive to nurturing and the parents being open to having their children share about the violence they had witnessed in their families. However, ongoing family crises and sporadic group attendance impacted on the growth and development of the group.

Stage Theme 5: This isn't Good Anymore

Towards the middle/end of the mutli-family group Gillian and Jeff had two weeks where they were the only members in the group. While it was positive for this family to have the attention of the facilitators, it was particularly difficult for Jeff not to have other children as peers and buffers against being the centre of attention. However, Gillian was able to nurture her son by holding him on her lap or cradling him. Perhaps Jeff allowed this

because he did not need to be concerned about the impression his peers would have of him.

Despite his willingness to be nurtured, Jeff was letting his mom know he was angry with her about their current situation at home. He would tell the facilitators about things his mom had done in the past, and that she often got angry with him, or embarrassed him in front of others. Gillian was defensive with him at times, and we needed to acknowledge Jeff's feelings to model this for Gillian. We also talked about sharing this information in a respectful way that did not hurt feelings, to try to distinguish between being mad and being mean.

With many absences from the group, there was a bit of the momentum lost toward the end. This made the termination process difficult. When Linda and Grant, who had missed the group for two weeks came back, they also experienced the group alone. We needed to reverse the group topics again to ensure that they had an opportunity to do a protection plan together. Current safety issues arose out of this discussion as well. We were nearing the end of the group and there were ongoing emotional and physical safety needs within each of the families.

Samantha was also overwhelmed with her new relationship and the ongoing struggle she had with depression. She felt her children were suffering because she was now giving in to her new partner's demands for time and money. She had missed four of the multi-family group sessions and it was difficult to help her and Alan re-establish their place in the group. The goal of the group at this time was to be planning for a violence free lifestyle with their children. There were many barriers that prevented the women from being able to engage in these kinds of conversations and activities with their children. These included ongoing safety issues, visits with abusive

partners and new invasive relationships. Glassman and Kates (1990) refer to this as having difficulty conquering defensive barriers in order to work on the goals of the group.

As the facilitator it would have been helpful to discuss these closing issues related to cohesion and negative experiences with their children in the group at this time, but we were preparing to terminate and needed to deal with that loss as well. Glassman and Kates (1990) talk about the necessity of identifying negative reactions and exploring them in order for the group members to feel competent enough to move forward. The facilitator is to trust that the group will have the necessary strengths and skills to do this (Hunter, et. al., 1995).

There were, however, other supports in place for these families by this time and other social service agencies would continue to be involved with them. Consultation with and referrals to the appropriate services that would provide ongoing support for the families was integral to this stage of the group life (Gibson & Gutierrez, 1991; Glassman & Kates, 1995; Hughs & Marshall, 1995).

Stage Theme Six: We're O.K. and Able

Even with all that went on in their lives, the women continued to be as committed as possible - to themselves, to their children, and to the group. They have survived poverty, racism, family violence, and abuse. Profitt (1996) refers to the resilience of women who have experienced partner abuse and states that rather than viewing the women as victims we must acknowledge their tremendous strengths and coping mechanisms in surviving the violence. Stephens (1999) found that the women who had been

abused by their partners had a "strong internal mental model of care giving that predated their involvement with their respective partners" (p. 727).

Within this group the women also experienced what it felt like to play, to enjoy their children, and to be their child's support. Almost immediately within the multi- family group the children had spoken about the violence. When the children asked "Mom, can I tell about the time..." all of the women gave their children permission to speak openly about the violence. This openness continued until the end of the group, even though the group themes seemed to be disorganized given the inconsistent attendance and the varied needs of the families.

For Alan, who was shy and reluctant to speak in the group, his mother commented that she had asked him after the group in the thirteenth week what he remembered about the violence. While his memories were different from hers she accepted his perception and his memory and was able to support him. Grant was the leader in talking about the violence he had witnessed and this allowed Jeff to feel comfortable to share as well. There was a definite change as group was ending as to the level of comfort when speaking about family violence and personal experiences. The puppets likely added to this cathartic experience as they allowed the boys to feel less threatened about sharing their experiences.

The women commented on the enjoyment they had playing as adults and playing with their children. Many had never had this opportunity before. The theraplay activities enhanced both the group cohesion and the parent-child cohesion. Towards the end of the group the boys were more open to nurturing and the women were better able to structure activities with their children.

Some of the women commented they would have liked to have had more time to talk with each other alone. They also were feeling like their children's behaviors were an ongoing challenge.

The women and children continued to need community support to deal with the ongoing fallout related to current abusive partners, ex-partners who continue to be in their lives and the lives of their children, unsafe communities, and the emotional and physical demands of being a single parent (Boyd-Franklin & Bry, 2000; Levendosky & Graham-Berman, 2000).

Stage Theme 7: Just a Little Longer

The women were struggling with letting go and saying good-bye. This process of dealing with loss and grief was discussed two sessions before the final group, both with the women and the children. We read a story to both the women and the children about saying good-bye and tried to help the women prepare for their children's feelings, as well as their own. We spoke with the women about the necessity of ending group in order to have some time to absorb information and experiences. We also talked about how attendance had been sporadic these last weeks and it seemed as though families needed time to get ready for spring and summer activities. The women were expressing that they wanted more time to spend with the other parents and that parenting was continuing to be very stressful for them.

The women also asked if we would keep in touch with them. I needed to say that this was not possible, following the final post-group meeting. One family remained open to me following group, but this was because the children attended school within the catchment area in which I worked. Another family had support now from an intensive community program, from the school, and from external agencies dealing with issues specific to her

child's needs. The third family was also involved with external parent and respite supports.

While there were other agencies involved with the families the issues they faced remained intensive. Ongoing concerns included new partners with abusive behaviors, partners returning for visits with the children, and drinking within a family. The women were needing more individualized service and the group setting was no longer the place to deal with current crises.

Our final puppet show helped to open discussion about ways to say good-bye, and ways to keep in touch. The families participated in planning for the final group. At this stage in the group the women exchanged phone numbers and talked about getting together. This is also a part of the grieving process. It is uncertain if the women actually met following the group.

The group members did seem able to connect to the process of termination, share their fears, sadness or anger about the group ending, and celebrate the changes in themselves and their family (Glassman & Kates, 1990; Lacoursiere, 1993; Northern, 1969; Tuckman, 1965). One woman brought a thank-you-note for the group facilitators. As we were closing the women were still needing to discuss the ongoing challenges of parenting alone. They seemed frustrated and overwhelmed. This is common with endings as the members have anxiety about surviving without the group's support (Glassman & Kates, 1990).

The women did say they understood better what their children had been through as a result of the violence. They also commented that they enjoyed having time to play with their children. Finding this time at home remained difficult.

The certificate which was given to the families at the end of the group seemed to be an important part of the feeling of accomplishment, particularly for the women. Theraplay 'kits' were also given as gifts as a means of encouraging play at home. One thought was that perhaps these kits should have been given out earlier in the group process. Again, an in-home theraplay component would have facilitated the use of the kits earlier on in the group stages.

We also made t-shirts together that the women and children created with one another. This gave them a keep-sake from the group. As a facilitator I struggled with the idea of an imperfect ending (Glassman & Kates, 1990). I was rushed while preparing for the last night, one family could not come due to yet another crisis and we seemed to run out of time to do all we wanted to do in this group.

There was some follow-up with the families during the administration of the post-test measures following this final group. I visited Linda and Grant as they couldn't come to the last group and I gave them their gift and certificate. We made t-shirts together at their home and this termination ritual was important to them in spite of not ending with the rest of the group.

The Outreach Component

As the weeks progressed, there were issues raised within the group that required external contact with the families. One of the reasons for this may have been that most of the families in the group were living independently in the community. In previous groups many of the families that attended the family violence group had lived in a residence that provided ongoing service and support to families outside of the group.

One parent shared in the group that her child had disclosed abuse. This required home visits to deal with the need for external services, to de-brief the incident with the parent, and to assure there were ongoing community supports available to the parent and child. This included attending inter-agency meetings and follow-up appointments with the family to ensure that referrals were acted upon and that the family had a safety plan in place. I also attended a community agency for a tour and review of the support program with this parent.

Another family had an incident of violence in their home during the group experience. There were issues raised from a group meeting that required follow-up during the week with this parent and with the children. Safety was now an issue, and the children needed an opportunity to de-brief their thoughts and feelings about the incident. I met individually with the parent to reinforce the seriousness of the situation and to facilitate further protection planning. I spent time reviewing her child's behavior in the group and and discussed with her how these behaviors seemed to indicate that he was experiencing great anxiety.

Within another family the children's father had become re-involved. Meetings outside of group were necessary to ascertain the degree of contact with their Dad and the children's feelings about this contact, and to assess the parent's rationale for allowing visits. Concerns about the impact that contact with the father would have on the children were voiced strongly with this parent, but the visits continued to occur. Referrals were also made to respite support services for this family.

One family had to leave the group because her children were apprehended. There were follow-up calls made to this family to offer support. Towards the end of the group time this parent made a request for a letter of

information as to how many groups she had attended. While I attempted to address this issue further with this parent, no further contact occurred, as her phone was disconnected and she had moved.

Another parent was experiencing extreme distress because her new partner was taking financial advantage of her and she was concerned about bills, food, and rent. I provided a few counseling sessions by phone for this concern and reviewed the various types of emotional abuse and control that she was experiencing with this new partner.

Further to this, many family crises were occurring throughout the group which included family death and illness, as well as personal health issues.

Thus, while it was originally thought that the contact with families would be group based, it was necessary to provide counselling to the women and children outside of group through home visits and phone contact. Further to this, referral to outside agencies and meetings with these agencies also became part of my responsibility.

The Findings of Pre-, Mid -,and Post Measures

A summary of the results of the findings for the CBCL is found in Table 1. A summary of the results of the Parenting Stress Index is found in Table 2. There were some difficulties in administering the measure. Some of the women took the CBCL home to complete and did not bring it back. I did attempt to call about the measures and made a trip to their homes, but they could not find them and the group had already begun. Thus, Samantha and Mary did not fill out a CBCL at pre-test. As Mary and Maya dropped out of the group, there is only a CBCL pre-test from Maya and only one Parenting Stress Index from Maya and Mary.

Table 1

T Scores for the CBCL at Pre-, Mid -and Post -Test

		Internal	External	Total Problem
Jeff	Pre Test	66	69	**61**
	Mid Test	57	58	53
	Post Test	55	58	53
Grant	Pre Test	75	68	**65**
	Mid Test	66	54	55
	Post Test	69	55	**64**
Alan	Pre Test	n/a	n/a	n/a
	Mid Test	59	56	51
	Post Test	59	53	50
Luke	Pre Test	73	70	**65**
	Mid Test	n/a	n/a	n/a
	Post Test	n/a	n/a	n/a
Josh	Pre Test	n/a	n/a	n/a
	Mid Test	n/a	n/a	n/a
	Post Test	n/a	n/a	n/a

Note: Scores in bold indicate a borderline or clinically significant score on the total problem scale

Table 2

Percentile Scores for the Parenting Stress Index at Pre,- Mid -and Post -Test

		Child Domain	Parent Domain	Total Stress	Life Stress
Gillian	Pre Test	99+	95-99	99+	95-99
	Mid Test	95-99	90-95	90-95	99+
	Post Test	90-95	90-95	90-95	99+
Linda	Pre Test	85-90	70-75	80-85	99+
	Mid Test	60-65	35-40	45	35
	Post Test	50	10-15	20-25	35
Samantha	Pre Test	95-99	90-95	95-99	85-90
	Mid Test	90-95	80-85	90-95	70
	Post Test	80-85	75-80	80-85	80
Maya	Pre Test	95-99	75	90-95	75
	Mid Test	n/a	n/a	n/a	n/a
	Post Test	n/a	n/a	n/a	n/a
Mary	Pre Test	60-65	35-40	45-50	95-99
	Mid Test	n/a	n/a	n/a	n/a
	Post Test	n/a	n/a	n/a	n/a

As noted earlier, within the CBCL, T scores for the total internalizing, total externalizing, and total problem score between 60 and 63 are considered to be in the borderline range and T scores 64 and above are considered to be in the clinical range. The Parenting Stress Index (PSI) measures the level of stress a parent experiences as a result of their perception of their children's behaviors (Child Domain) and their own experiences as parents (Parent Domain). Total Stress scores and Life Stress scores are also calculated. Any score above the 85th percentile is considered clinically significant. It should be noted that the scores for the Parent Domain were consistently skewed by the number of spouse scale questions that the women did not respond to as their partners were not involved in their families.

Gillian and Jeff

Gillian had commented in the initial interviews that she was often frustrated with Jeff's refusal to follow instructions and was concerned with the angry way he interacted with her. She also said that Jeff fought with his younger brother constantly. There was a great deal of tension in the house and Gillian said that she felt she yelled too much. Gillian was very proud of the fact, however, that Jeff did well at school, his grades were high, and the teacher indicated that he interacted well with peers and adults. Gillian also spoke about wishing she had more time for herself and that she wanted to "make something out of her life". That is, Gillian planned to return to school and find work. She was overwhelmed by the energy it took to care for four children by herself and she had few supports.

Gillian's score at the PSI pre-test indicated she had a score for the Child Domain (CD) that fell above the 99th percentile. Distractibility/ Hyperactivity was the only subscale not within the clinical range. This fit well with the information that Jeff was able to attend to tasks both at home

and school and was not overly motor active. Gillian's Life Stress and Parent Domain scores were also clinically significant and fell within the 95-99th percentile. The subscale for Role Restriction was the only subscale within the Parent Domain not within the clinical range. Given Gillian's ongoing frustration with having her life plans on hold, this lower score was surprising.

The CBCL indicated that Jeff's total T score for total externalizing problems was in the clinical range. The Delinquent Behavior subscale was within the clinically significant range. Subscales items such as lying and cheating were particularly prevalent as were feelings of guilt and stealing from home. The score in the subscale of Aggressive Behavior was within the borderline range and the problem areas identified included "argues", "brags" and "is stubborn". This fit well with the clinical impression that Gillian found Jeff to be argumentative and unwilling to follow her directives.

Jeff's total internalizing T score was also in the borderline range. Items on the Anxious/Depressed subscore that seemed to be problematic included had to be "perfect", and is "self conscious". Thus, while Jeff may have been coping with his experiences by displaying externalized behaviors, he may also have been struggling with feelings of depression and low self concept.

Gillian presented as quite anxious during the initial interview and pre-test, talking throughout about how overwhelming her life felt. Gillian's expression of her concerns about Jeff's anger and aggression were also well represented in the CBCL. However, Gillian may not have recognized the significance of Jeff's internalized behaviors. Jeff's level of depression and anxiety were likely related to his need for safety and security. The clinically significant scores on the CBCL and the PSI certainly indicated that this was a family living in a state of extreme stress.

Gillian's score at the PSI mid-test indicated the score for the Child Domain (CD), had been reduced to the 95-99th percentile, as had every one of the subscales. Gillian's Parent Domain (PD) score had been reduced to the 90-95th percentile. This is likely due to the fact that there were three items missing on the Spouse subscale which had been filled out in the pre-test. While there were some reductions in Parent and Child Domain Scores, it should be noted that the score on the Role Restriction subscale had been increased and Attachment scores remained unchanged.

It was at this time that Gillian was considering returning to school and was feeling resentful about the restrictions her children presented. Gillian's Life Stress was consistently falling above the 99th percentile. It is interesting, that while her life stress had increased, all of her Child Domain scores had decreased, although most remained clinically significant. This fit with Jeff's reduced scores on the CBCL for the mid-point measures.

At the mid-test, Jeff was no longer in the borderline range for any of his scores. His total externalization T score had dropped to within normal range as had his total internalization T score. These reduced scores were a surprise, given an abusive incident that had occurred between Gillian and her current partner and the anxious behaviors which Jeff demonstrated within the group. Jeff also appeared to be quite angry with his mom at times, although there were some weeks where Jeff seemed comfortable within the group and he and his mom appeared to be enjoying each other's company.

Gillian's score on the PSI post-test indicated the score for the Child Domain (CD), had been reduced again to the 90-95th percentile as had every one of the subscales. Distractibility/Hyperactivity and Adaptability were now within the normal range.

Gillian's Life Stress remained clinically significant within the 99th percentile. While Gillian's Parent Domain (PD) score had been reduced, Isolation had increased and Attachment scores had increased to the 99th percentile. This was disappointing given that one of the goals of the intervention was to enhance the parent/child sense of attachment.

At post-test for the CBCL Jeff's total internalization and externalization T scores were again reduced. None of his subscale scores were clinically significant and all of them had been reduced, including the Aggressive Behavior and Delinquent scores and the Anxious/Depressed scores. This fit well with the information from the PSI that the Child Domain scores were reduced. We may be able to assume that the children's group and multi-family group had a positive effect on Jeff's feelings and behavior. However, these scores did not entirely fit with the clinical impression of the family's wellness.

By the time the group was ending Jeff's father was having visits with him again. Gillian was attempting to arrange child care for her children for the summer so that she could attend school. All of these events were extremely stressful for the family. It appeared that Jeff and Gillian's relationship, while Jeff had shared feelings and experiences with his mother, remained strained. Jeff would become openly angry with his Mom in the group and was often anxious and unsettled throughout the group as it was ending. This could have been partially due to changes in group format and membership, but given their dad's re-entry into their lives and their mom's plans to attend school, it is likely Jeff continued to feel unsettled and somewhat unsafe.

Linda and Grant

During our initial interview Linda stated that she felt that Grant was doing fairly well and that she did not find his behavior at home difficult to manage. However, Grant was in a low enrollment behavioral program due to his difficulties coping in the regular classroom. Linda shared that Grant was better able to discuss his feelings than were his brother and sister. Grant was very open in the initial interview about the violence he had witnessed in his family. Linda said she enjoyed being a parent, and had always taken care of younger children when she was growing up.

The pre-test PSI indicated Linda's score within the Child Domain (CD) fell within the 85-90th percentile. All of the subscales in the CD fell between the 75th-90th percentile. The subscales in the Child Domain that were clinically significant included Reinforces Parent and Acceptability. While Linda was saying that she found Grant's behavior easy to manage, it appeared that she did not feel his behavior reinforced her as a parent and that somehow Grant had not met Linda's expectations in terms of acceptability. Linda's Parent Domain (PD) score was within the 70-75th percentile, but it should be noted that there were 3 items missing in the spouse subscale. Linda's Life Stress was also clinically significant at above the 99th percentile. It was interesting that while Linda's life stress score was so high, her other scores did not go above the 90th percentile. It is possible that given the life stress indicated by Linda that she had under-reported and was de-sensitized to the crises that continued to occur in her life.

Grant's total internalization score was within the clinical range with a T score of 75. His total externalization T score was in the clinical range. The subscale of Delinquent Behavior was of particular concern with reference to items such as "no guilt" and "swears". The internalization subscales of

Withdrawn and Anxious/Depressed were also in the clinical range. Items of concern included such as needed to be "perfect" and "fearful", and on the Withdrawn subscale included, "stares" and"sulks". We could surmise that Grant, while sometimes trying to control his environment through negative behaviors, was likely feeling scared and anxious.

Linda 's score on the PSI mid-test indicated she had a reduced score for the Child Domain (CD) in the 60-65th percentile. The same subscales that were clinically significant in the pre-test in the Child Domain were consistent. These included Reinforces Parent and Acceptability. These are areas of influence for parent-child attachment and it is concerning that they increased at mid-point in the intervention. However, many family stresses were continuing to occur and Grant had made a disclosure to Linda that required immediate intervention. I was spending a great deal of time with the family outside of group and advocating/making referrals to support agencies. At this time Linda indicated that her Life Stress had decreased to the 35th percentile.

At mid-test Linda's Parent Domain (PD) score was reduced to the 35-40th percentile and none of the subscales were now in the clinical range. Total stress was also in the normal range at the 45th percentile.

At mid-test, Grant remained in the clinical range for total internalizing T scores. Grant's total externalization T score had dropped into the normal range. The subscale of Delinquent Behavior remained at the borderline range and Aggressive Behavior had dropped to the 50th percentile. The Anxious and Depressed subscale scores continued to be within the borderline range. In group we noticed that Grant needed to be in control of most situations and that it was difficult for him to attend to tasks for long periods. Linda would try to deal with Grant's need to gain attention, but would often resort to

becoming verbally frustrated with him. At home it was apparent that Linda was reverting to yelling and that this was distressing to everyone in the house.

It is possible that given the life stress indicated by Linda that she had under-reported, possibly based upon the fact that crises in her life occurred regularly and she had adapted her coping mechanisms until extreme life stress had become normalized.

At post-test Linda 's score indicated that she had a reduced Child Domain (CD) score at the 50 percentile. The same subscales that were clinically significant in the pre-test in the Child Domain had reduced to within normal range including Reinforces Parent and Acceptability. Linda's Life Stress remained at the 35th percentile. Linda's Parent Domain (PD) score was reduced and every one of the of the subscales had been further reduced. Total Stress was also reduced to the 20-25th percentile.

At post-test, Grant's total internalization T score was within the clinical range. His total externalizing T score was within normal range. The total internalization and externalization T score was within the normal range. It seems that Grant's scores again indicated that he was experiencing some anxiety and depression, with the Anxious/Depressed subscale in the clinical range. While his internalization scores had increased since the mid-test, they remained lower that the pre-test. Throughout the group experience, Grant's family continued to cope with many crises. In the last weeks of the group Grant disclosed his fears about his mother's current partner and his concerns about the safety in the community. These experiences may explain why his internalization T score increased.

I would like to believe that the group intervention helped to reduce Linda's feelings that Grant did not meet her expectations and that she did

begin to enjoy her time with him, as indicated by the reduction of the Reinforces Parent and Acceptability subscales. I would also like to attribute the reduction on aggressive behaviors and lower scores in the internalization T-scores as an indication that group had taught Grant some new coping skills. Boyd-Franklin and Bry (2000) state that "...any family experiencing a crisis may feel acute grief; families that operate in continuous crisis mode, however, have become inured to loss and block the further pain" (p. 59). Given the amount of time I spent dealing with crises in this family, I must assume that some form of post-traumatic coping is occurring here, as Linda's responses seem too low given her circumstances and the behaviors and interactions seen in group and at home.

Samantha and Alan

Samantha commented in the initial interviews that she had been out of her relationship for only a short time and that it had been extremely physically abusive. Samantha said that due to counselling for herself she had become more assertive with others and better able to participate openly in contexts such as sharing circles. Samantha said that she had numerous children at home and was sometimes overwhelmed by their needs, but she did have supports from some external agencies. Samantha felt that Alan had great difficulty expressing his feelings or accepting nurturing from her. She said Alan had talked very little about the abusive incidents he had witnessed at home. Alan was also taking medication as he had been diagnosed with Attention Deficit Disorder. Alan spoke very little throughout the interview, appearing quite shy.

Samantha's score on the PSI pre-test indicated she had a clinical high score for the Child Domain (CD) that falls within the 95-99th percentile. All of the subscales in the CD fell between the 85th and 99th percentile, thus they

were all clinically significant. Samantha's Life Stress was also clinically significant. Her Parent Domain (PD) score was in the 90-95th percentile, but it should be noted that there were 3 items missing in the spouse subscale. The subscales for Isolation was well within the clinical range. Samantha had indicated that her support network was limited and consisted mostly of formal supports. Other areas of concern included the subscales for Depression, and in particular the subscale for Attachment. Samantha had also indicated that she felt depressed at times, given the enormity of the parenting responsibilities she had. Participating in a group that sought to improve the parent-child relationships fit the needs of this family. It is evident that Samantha would require a great deal of emotional support given her sense of isolation and depression. Total Stress was also in the clinical range. There are no pre-test scores for the CBCL to measure Samantha's perception of Alan's behavior.

At mid-test Samantha's subscales within the Child Domain were reduced in the areas of Distractibility/Hyperactivity, Mood and Acceptability. The Child Domain score was reduced to the 90-95th percentile and the Parent Domain Score was reduced to the 80-85th percentile. Within the Parent Domain, while her Isolation percentile increased, her Attachment score decreased to the 85th percentile. The Total Stress score was also slightly reduced.

The CBCL mid-test score indicated that Alan's total T scores for internalizing behaviors were within normal range. His total externalizing T scores were also within normal range. All subscales fell below borderline or clinical ranges. Clinical impression would have been that Alan was somewhat withdrawn from others in the group, but perhaps this was not an indication of internalization of feelings. While Alan rarely spoke in the

group, he did seem to enjoy the activities with his mom and revealed some affect when playing with his peers in the group.

At post-test Samantha's subscales within the Child Domain were increased in the area of Distractibility/Hyperactivity, but decreased in the areas of Mood and Acceptability. The Child Domain score was reduced as was the Parent Domain Score. Within the Parent Domain, while Samantha's Isolation percentile had decreased, the subscale of Attachment increased to the 90th percentile. However, the Depression scores had been reduced to the 80th percentile. Depression continued to be a concern, given Samantha's information that she struggled with feelings of sadness each day. The Total Stress was now reduced to the 80th percentile. Samantha's life stress at the time had increased since the mid-test. This certainly fit with the clinical impression that Samantha was more distracted in the group and had missed attending a few weeks. She had indicated to the group that she was in an emotionally abusive relationship and that she was concerned about finances. Samantha's attachment to Alan remained an issue for he and Samantha, although this subscale score had been reduced since the pre-test.

Alan's post-test scores indicate that his total internalization T scores remained the same and his is total externalizing T scores decreased slightly. The total T score for internalizing and externalizing scores was at the 50th percentile. All subscales remained within the normal range. Thus, there was little change from mid-test to post- test with Alan. Towards the end of group Alan did seem a bit more connected to the other boys in the group, enjoyed the play activities with his Mom and had shared somewhat in the family violence discussions. It certainly would have been interesting to compare these scores to the pre-test score.

Maya and Luke

In the initial interview Maya said she struggled with Luke's behaviors at home. She felt he did not follow directions and would sometimes become extremely angry and have tantrums. Maya indicated that Luke had not witnessed her being hurt because she had left her abusive partner while she was still pregnant with Luke. However, it was believed that exposure to the impact of family violence was prevalent given that Luke continued to have visits with his father and conflict persisted between his father and Maya.

At pre-test Maya had a clinically significant score for the Child Domain (CD) that fell within the 95th percentile. All of the subscales in the CD fell between the 90 and 99th percentile, thus they were all clinically significant. This fit with Luke's CBCL where both internalized and externalized behaviors were a concern. His total internalization T score was within the clinical range of 73. His total externalization T score was within the clinical range at 70. His total internalization and externalization T score was within the clinical range. Within the subscales particular areas of concern were Somatic Complaints and Delinquent Behavior. Sub-scale items such as "no guilt", "lying" and "swearing" were indicated as areas of concern.

Maya's Life Stress was within normal range. Her Parent Domain (PD) score was below the 80th percentile, but it should be noted that there were 4 items missing in the spouse subscale. The subscale for Isolation was well within the clinical range and seemed to be the greatest area of concern. Maya indicated that she preferred to keep to herself and had only her sister and one other friend that she spent time with. The other parent subscale that was well within the clinical range was Depression. This, coupled with the extremely high scores in the Child Domain likely mean that Maya felt very overwhelmed. In spite of this, scores indicated that she felt fairly competent

as a parent and felt attached to Luke. These strengths seemed evident in the group as they played together with warmth and enthusiasm. It is unfortunate that this family did not complete the group, as Maya's relatively low scores in the Parent Domain indicate that she may have been able to use the group information to intervene with Luke's difficult behaviors as the relationship itself seemed to be strong.

Mary and Josh

In the initial interview Mary indicated that she and Josh were quite close, although there had been periods of time where they had lived apart. She said she felt that Josh could share his thoughts and feelings with her. She indicated that Josh had been witness to physical abuse against her by more than one partner. Josh was quiet in the interview, adding bits of information as requested. All of the subscales in the CD fell below the 85th percentile, except for Reinforces Parent, which was in the 90th percentile. The parent who scores high on this subscale does not see her child as a source of positive reinforcement. This information did not coincide with Mary's comments that she felt she and Josh were very close.

Mary's Life Stress was within the 94 percentile range. Her Parent Domain (PD) score was below the 85th percentile. The subscales were all within the normal range. While there was no defensive responding indicated, Mary may have grown used to the crises in her life as her Parent and Child domain scores and total scores were low compared to her Life Stress.

There is no CBCL for this family. However, clinical impressions indicated that Mary seemed to rely on Josh as an adult support to her. Josh was a little shy, but usually very willing to participate in group activities.

Mary's life continued to be stressful and there were many losses in their life. Josh appeared to become more withdrawn as the weeks passed.

The Mother's /Caretaker Evaluation

The women commented that they thought the group had helped their children to "express themselves" and talk about "home issues". Perceived improvements in children's behaviors include "listening better" and "cooperating". One woman felt her son was not as shy as before the group. It was suggested that the group should provide more information about what went on in the children's group. Another consistent comment made was that the women enjoyed having individual time with one child. All the women said they would like to attend the group with one of their other children.

The Mother's Group Evaluation

The women said they really enjoyed their time with the other women and would have liked more time with only the women. One woman, who was quite shy, commented that she found it helpful that the other women were so friendly. Another woman commented that she did not feel judged in the group and found it easy to talk. Other feedback included that they wished we could have played more. The women were also glad that the children had an opportunity to talk about the violence they had been exposed to and that they seemed to be coping better.

PRACTICE AND LEARNING THEMES

There were many layers to the theoretical foundation of both the group intervention and the group process. The practice considerations involved facilitating a parent and child group that utilized play for both children and adults as a means to heal from family violence and to enhance their parent-child relationships. As well, the intervention occurred within the structure of a circle and attempted to integrate Aboriginal culture as the foundation to the group practice. The multi-generational impact of colonization on play, development, and family relationships was examined. Finally, the impact of exposure to family violence as it relates to a child's experience was explored. The following themes emerged as a result of the implementation of this group.

Families in Ongoing Crisis

One of the criteria for the group was that the women and children needed to be as safe as possible. This meant that the women had to have left their abusive relationships and that the families needed to be safe from exposure to ongoing family violence. There were many issues that persisted for all of the families we worked with that did not allow for feelings of safety and security in their lives. I spent a great deal of time between groups supporting families while they dealt with the ongoing crisis within their communities and within their families. According to Fisher, Fagot, and Leave (1998), and Lindsay (1998), financial limitations and high stress levels are the two major factors that interfere with family therapy. The families in the group continued to be under an enormous amount of stress and this impacted both on their ability to attend group and to participate within the group.

The women and children who attended group were living independently in the community. In previous parent-child groups that had been facilitated at the Elizabeth Hill Counselling Centre, the families had been living in residence at a second stage housing facility. They were provided with shelter, a safe environment, and emotional and practical support for concerns or crises that arose during and following group. This year, however, none of the women who participated lived in a residential agency. The women were referred from other external social service agencies such as Child and Family Services. While one of these women did have a parent aid from a support agency and saw a counsellor on occasion, many of the women were isolated and living in unsafe communities without many supports. Two of the women had only recently moved to the city and had fewer supports. We know that isolation is common for women who have recently left violent relationships (Bruce, 1998; Bilinkoff, 1995; Gibson & Gutierrez, 1991; Suderman & Jaffe, 1999).

Most of the women had experienced physical, emotional, and sexual abuse in their own childhood and adult lives. Due to the impact of colonization, the child welfare system, and the generational impact of the residential schools, the women were without many healthy family supports. Their extended families were often in crisis or seriously ill and coming to the women for support at a time when the women already had limited resources. Kiernan (1994) found that the woman who had experienced partner assault described their experience of isolation as related to not being able to rely on extended family members and in some cases having been completely cut off from them. According to Werner (1989) resiliency in high risk children is associated with factors which include affectionate family ties and external

support. These two resiliency factors were only minimally available to the families in this group.

Due to the losses and abuse that the women experienced in their childhood and adult lives, many had had their own children apprehended. Within some of the families, the children had only recently been returned to their mother's care. Now the women were expected to reacquaint themselves with their children while parenting alone. They had to cope with the ensuing feelings and behaviors of their children that were the result of exposure to family violence (Holden & Banez, 1996), deal with attachment issues related to being separated from their children (Solomon & George, 1996), and confront their own feelings of grief and loss which were constantly being triggered by their children's experience (Boyd-Franklin & Bry, 2000; Rubin, 2000). Meeting once a week did not seem to provide enough time for the women to adequately deal with all these issues.

Some of the children themselves had been left with caregivers who were actively abusing alcohol, and they had been direct victims of physical, emotional, and sexual abuse within their families, their foster homes, and their community. The children in the group continued to be at-risk. During the course of the group one child disclosed to his mother that he had been sexually abused. Our findings about the prevalence of child abuse among the children is consistent with the literature. Lazer, Goodson, and DeLang (1986) found that 86% of the children in women's shelters were also victims of direct abuse or neglect. Sudermann and Jaffe (1999) report that in 30% to 40% of families where abuse occurs against the mother the children may also be physically or sexually abused.

Many of the women were in new relationships. While these were not the abusive relationships that were identified in the intake, these new

relationships were often abusive or were putting families at risk. One woman came to the group with a bruise and disclosed she had been hit by her common-law partner. Another child disclosed that his mother's partner was drinking and this scared him. One woman told the group that her new partner was constantly asking for money and making her feel bad for not giving him help. One study that looked at the effects of witnessing family violence on children (Fantuzzo & Lindquist, 1989) revealed that children's difficulties were directly related to the number of family stresses. Thus, while the women were out of their original abusive relationships, their current relationships were also unhealthy and causing feelings of fear, anger, and sadness for the children within the group.

Custody and access issues as well as safety issues continue to be threats long after the woman has left the abusive relationship (Hoffman, Sinclair, Currie, & Jaffe, 1990; Suderman & Jaffe, 1999; Zorza, 1995). The birth fathers of some of the children wished to have contact with them. One partner had returned from out of town and had moved into the vicinity of the family's home. Another partner had been released from jail and was now a safety risk to the family. The women would often minimize the father's abuse and its impact upon the children by saying things like "... their father may have hurt me but he would not hurt the children". This is common for women leaving abusive relationships as they feel confused by their children's own ambivalent feelings about their father (Jaffe et al., 1990; Stephens, 1999). Protection plans, ongoing discussions about the negative impact of the abuser having visitation rights, and de-briefing incidents that occurred with their ex-partners were additional stressors for the women and many of these incidents were dealt with outside of the group time.

The families continued to live in poverty. According to Ehrenreich (1995) some battered women's shelters report that 60% to 95% of the women in the United States who leave abusive relationships apply for welfare. Sometimes the women were struggling to meet the basic needs of their family. This is an enormous stress that at times must supersede dealing with the ongoing emotional needs of yourself or your children. Gibson and Gutierrez (1991) point out that women who have left abusive relationships must focus on their realistic concrete needs. Women leaving abusive relationships need assistance to access additional services that help to reduce their isolation and provide various supports for themselves and their children (Bilinkoff, 1995; Hughs & Marshall, 1995; Purvis, 1995; Suderman & Jaffe, 1999). These findings are consistent with my experience in this practicum. Referrals to other social service agencies for the families in this group included The Child Guidance Clinic, Child and Family Services, Family Centre, Families Affected by Sexual Assault (FASA), and Wahbung Abinoonjiiag.

In conclusion, meeting once a week was not a comprehensive enough intervention for the families with whom we were working. Multiple long- and short-term issues continued to interfere with the day to day emotional and physical safety of the women and children. This meant that I also spent a great deal of time in the families' homes or interacting with other systems related to the families' needs throughout the week. While this was a necessary part of the group process, in the future an outreach component should be formally structured as part of the expectations of the group facilitator. This would include an acknowledgment of time and resources necessary to provide such outreach services. Programs such as the service home for safe-home children (Gibson & Gutierrez, 1991) recognizes the need

for intensive supports and places families with host families who will offer them ongoing social and emotional support for three months after leaving the abusive relationship. Other sources such as Glassman and Kates (1990) and Boyd-Franklin and Bry (2000) advocate for home based support for families with multiple stresses.

The Adult Play Intervention

When we began to plan the groups we knew we wanted to incorporate play as an integral intervention strategy for working with both the women and the children. Terr (1999) emphasizes the necessity of providing an opportunity for parents to revisit play in their adult lives, before they are able to meet the play needs of their own children. Frank (1978) discusses the very passive, non-interactive forms of recreation in which many adults (and even children) engage. These passive activities include t.v. watching and playing video games. Gil (1994) concurs with Frank when she discusses the reluctance of adults (including clinicians) to utilize their own spontaneity and imagination. Play that is fun and spontaneous is considered to be for kids and becomes devalued in adulthood (Tietel, 1998).

However, we had concerns that the women would not be comfortable with play, and that they would likely be reluctant to take risks in the group to play. I was expecting comments often found in the adult play literature such as, "That's silly", "I'm not doing that" or "What has this got to do with anything ?" (Rhodes & Zelman, 1984; Rubin, 2000). This was not the reaction we received at all. We had prepared the women that we would be playing in the group and had given a rationale for that in the intake process. We had discussed that playing was the way that children explored their world and that children needed their parents to encourage and participate in play in order to learn and to form relationships.

There were no questions from the women about why we, as adults, would be playing in the group. Even in the intake process the women began to discuss their memories of childhood play. Lieberman (1978) discusses the loss that occurs in adults when their play needs as children are not met. They began sharing that they had moved around so much from family to family that they didn't feel comfortable enough to play. One woman said she remembered any attempt at games ending up in screaming or fighting matches among family members.

One of the strategies which was useful was trying to make certain the activities were initially group games, rather than games which highlighted individual participation. This allowed the women to get "lost in the crowd" and hopefully to feel less vulnerable. According to Blatner and Blatner (1997) many adults who have been scrutinized and judged in their play as children carry these experiences and inhibitions into adult life and spontaneity can be very threatening to some as it creates overwhelming feelings of vulnerability. However, on the first night of the parents group the women became involved immediately. There were a few women who were somewhat extroverted, but even the two women who were somewhat shy immediately participated.

Perhaps one of the reasons that the women felt this comfortable with one another and with the play activities was that there had been some preparation for the idea of play in the intake process and in the initial group. The room was also conducive to separating the circle/sharing area from the play area beside it. This allowed for a transition to take place as the women had to move from the discussion group area in order to physically enter the play area. One of the helpful pieces for facilitating this process was that the facilitators were ready to be silly, to take risks, and to give energy to the group

games. Kiernan (1994), found that the women and children said they needed a facilitator who was energetic and open in their family violence groups in order to create a relaxed and fun environment. There was always playdough, bubbles and markers in the centre of the sharing circle which allowed the women to play even as we were talking. It also seemed that the women were simply ready for some fun in their lives.

We discovered immediately that if the play time did not occur until later in the group, or if we tried to play within the sharing circle itself, the effect was not the same. Due to the fact that many topics were intensive for the women and the facilitators, we found that the physical movement within the play allowed for a catharsis of feelings and a release of the intensity of the group discussion. Through play adults can resolve some of what seems unknown to us and can clarify and express hidden feelings (Frank, 1976).

As we began to ask the women to play Feeling Charades or to lead Simon Says, they were more reluctant to take risks. It was difficult for Linda, who was quite shy, to lead games. But, there were surprises as she demonstrated "excited" within her Feeling Charade or got the giggles unexpectedly. Play was an opportunity for the women to take the risk to express themselves in ways they may not have been able to in the "real world". It allowed for challenges to the way they saw themselves day to day (Haight & Miller, 1993).

We also had to be aware of physical difficulties and we planned or adapted games accordingly. One of the women was pregnant and her physical needs changed as the weeks went by. A few of the women also suffered from arthritis.

The adult play also initiated a more in-depth discussion about their own childhood experiences. The women had memories of being responsible

for many younger siblings and being worried that the children they were responsible for would hurt themselves. They remembered adults drinking and fighting and that they felt helpless and afraid. This was not a safe atmosphere conducive to playing. Some of the women who had lived in foster homes also felt as though they were there to clean and cook, not to play. Another of the women had a medical condition as a child that made it difficult for her to participate in physical play. When we had a guest speaker describe traditional ways of nurturing, the women shared that they had not experienced this kind of nurturing as children.

Lieberman (1978) suggests that parents will give up their defenses caused by traumas and loss when they can recall and spontaneously feel their own deprivations. Play within the group also helped to provide opportunity for spontaneous actions and emotions. These memories allowed for the facilitator to make the link to their own children's experiences of the violence. The women were then able to discuss how the violence had impacted on their children's wellness and on their ability to feel safe to play or to have play relationships.

Throughout the weeks we attempted to link the principal elements of a healthy parent-child relationship as outlined in the theraplay model (ie. nurture, structure, engagement, and challenge) with the play process. Rubin (2000) states that in the multi-family theraplay group for homeless women and children, there was little effort made to relate the information from the parent group to the rationale for theraplay. While the women in our group certainly enjoyed the play and benefited from the play experience, it is uncertain whether they connected that experience to the theory. The experience itself is likely the most crucial part of having the women understand the importance of engaging with their children in a playful way.

However, there needs to be some understanding of the theory behind the practice in order for the women to fully appreciate the benefit of these play experiences and to sustain the play as an important part of family life.

Theraplay with the Women and their Children

We attempted to utilize the four components of theraplay to enhance the parent-child relationship with the women and their sons. In the parents' group we had each component represented as a weekly theme as a means to understand the theory and practice of theraplay. The following is an overview of each of the theraplay components and how they were utilized and received by the families within the group.

Nurture

Boyd - Franklin and Bry (2000) suggest that parents are better able to parent their children and have more influence over their children's behavior if the relationship is warm, nurturing, and non-conflicted. Nurture activities use touch, cuddling, and feeding as an attempt to enhance the parent - child relationship. Some of the children were initially uncomfortable with the nurture activities. The women said that their children seemed to stiffen when given a hug or to pull away when touched.

The nurture games in the early weeks of the group were less intrusive and included group activities such as the Slippery, Slippery Slip and the Handstack. Having a fun activity allowed the children to feel more comfortable with the nurturing that came from the lotioning of their hands by their moms. Moms too, seemed a bit uncomfortable with activities such as the M&M find and needed to be slowed down to feed their children the M&M's. Certainly this would affect their children's level of comfort with nurturing as children who have experienced family violence tend to be very tuned in to their parent's level of anxiety (Jaffe et al., 1990). As the weeks went

on parents became more demonstrative and the children were more relaxed with touch. There were moments in the circles where the boys were lying in their mothers' laps or holding their hands while they talked.

The group activities that involved hand holding or passing a ball to one another were the beginning of touch or nurturing activities within the group community. Nurturing activities help the group to build relationships and to enhance connections to one another (Rubin & Tregay, 1989; Steffans & Gorin, 1997). Activities such as placing your head on each other's belly and laughing came later in the group. This allowed for a graduated level of comfort. The comfort with touch within the group did improve.

Structure

One of the premises of theraplay is that the adult needs to be in charge in order to give his/her child a sense of safety and security. Bilinkoff (1995) reports that many survivors of domestic violence are reluctant to take control of their children's behaviors because they associate control with abuse. Behavior challenges with children exposed to family violence are also associated with inconsistent parenting caused by the dynamics of the cycle of violence (Wolfe, Cameron, Jaffe, & Wolfe, 1989).

We, as facilitators, tried to balance being in charge of the play, while encouraging the mothers to be in charge of their children (Rubin, 2000). It was very important to balance structure activities with nurture and engagement activities in order to ensure that behavior management was not the primary focus of these sessions. We also tried to be flexible in allowing moms and children to lead certain activities in order for them to experience taking this risk and to build further community relationship skills.

Both the women and the children struggled with letting go of control within the play time. There were a few children who were often trying to

redirect or introduce a new game. Sometimes the women would also try to take the play time in a different direction. We needed to be cognizant that exposure to family violence has meant that the women and children needed to be hyper-vigilant to their environment and to be in control of their surroundings. As Purvis (1995) states, they expend a lot of energy avoiding problems. However, we also wanted to demonstrate for the women the value of providing structure and safety for their children.

Discussions and role modeling about alternatives to yelling or spanking came out of the play experience. The women were able to watch us redirect the children and they were able to express their ideas to one another about how to handle difficult behaviors in the group. Parent sharing time is one of the positive outcomes of facilitating a multi-family group (Dennison, 1999; Leichter & Schulman, 1968; 1996; Rhodes & Zelman, 1986).

Engagement

The women did seem to enjoy their play time with their children. When the women and children were involved in theraplay activities such as Mirrors, Hi and Thank You Ball, Zoom-Erk, or Funny Bones they were encouraged to be making eye contact, to be enjoying one another and to be "noticing" things about one another. There is nothing like knowing that your parent loves to be with you, will laugh with you, and be silly with you. Bailey (2000) writes about the importance of touch, eye contact and the demonstration of pure enjoyment of your child. If these sensory, cognitive, and affective experiences are not occurring between a child and his/her caregiver, the brain may actually maladapt (Perry, 1997).

We tried to incorporate engagement games that allowed for child/parent time in dyads to encourage this enjoyment of one another. We also tried to help the women understand their children's behavior as a way to

recognize their children's feelings. Hughs et al. (1989) described women who have left abusive relationships as being in an emotional turmoil that sometimes interferes with their ability to empathize with their children's experiences. Hopefully, if parents and children play together they will connect emotionally. Stephens (1999) promotes experiential activities that foster empathy. These activities may help women understand their children's behaviors and feelings about the violence.

Sometimes the boys' behavior during play was challenging. There was some refusal to participate, a need to be in control, and some anger directed at their parents. These engagement games often led to a discussion with the women about how to interpret different behaviors. Why did children need to control the group? Why did some of the children move from one activity to another so quickly? Why did my child become angry with me during the play time? Spacarelli et al. (1994) recommend that treatment strategies for working with women and children exposed to family violence should reflect an awareness of stressors with which the children are trying to cope. These were important discussions as we tried to strategize with the women how to cope with their children's feelings and behaviors each week. Sometimes the facilitators were not sure how to intervene either and we tried to balance role modeling with empowering the women to intervene themselves.

Challenge

The children loved the animation of a challenge. Licorice Races, Donut Munches, and Jello Slurps were excellent ways to build cohesion between the mothers and children when they were in pairs. The boys responded with laughter and enthusiasm to the challenges of Blow Me Over or the Cotton Ball Race. These were all activities where the boys could experience success. Structure helped to make these challenge games safe and predictable.

The physical games such as Newspaper Punch helped to reduce the children's stress and provided a physical outlet. We had to be very careful to structure these challenge games to avoid anyone getting hurt. The boys would quickly become very animated and physical and this allowed for an opportunity to define structure, and to place limits. There were times when we should have intervened sooner in order to defuse conflict that was the result of over-activity.

The Tug of War was also an excellent challenge game that allowed for the boys to have fun competing together with their mothers and to deal perhaps with angry or frustrated feelings that came up in the group. This was a cathartic activity for the women and the facilitators as well. They could take the risk to challenge one another with fun and enthusiasm. It was important, however, to be conscious of the impact of competition between group members, between mothers and sons, and even between facilitators and group members. Competition that struggles with the elements of life that challenge us all, such as space, time, and gravity create more opportunity for cohesion (Steffens & Gorin, 1997). We tried to make sure that the boys and the women could be successful at the challenge games and that there was a lot of encouragement and celebration throughout these activities.

Some of these play components from the group transferred to the home, but overall the women did not seem to use the theraplay activities much outside of the group. A home-based theraplay intervention may have assisted the women in seeing the value of playing with their children throughout the week.

The Facilitator's Dual Role: Support and Challenge

It is difficult as a facilitator to balance the role of support with the role of challenge within the group. I think one of my strengths as a facilitator

comes from being able to make people feel comfortable while being empathic and demonstrating understanding. However, once people in the group are comfortable it becomes more difficult to have the courage to challenge them. This is a personal issue for me based on not wanting to confront conflict. My worst fear is that a group member would leave based on my having challenged them.

If challenge does not occur within the group, however, then the group members can become bored or restless as few changes occur in their family or in their individual lives. According to Glassman and Kates (1990) group members may find comfort in relating and belonging, but lack the motivation to make true changes. If there is a trusting relationship built within the initial group sessions, some challenge will likely not affect the women's ability to use the group as a place to accept varied feedback from the facilitator.

If challenges from the facilitator lead the women to feel as though they are being judged, then further discussion about the role of the facilitator and the goals of the group may need to be held. This process must remain respectful of the group member. Glassman and Kates (1990) warn that members should never be pushed against their will to change the form or content of their sharing. We did not discuss the discomfort of challenge within the group though this may have been helpful to the process, as a group can be an effective way to practice conflict resolution skills and to improve social skills.

One example of conflict within the group concerned issues related to attendance, including not calling in when missing the group and arriving late. We did not make the group expectations clear early enough in the intake process and therefore needed to back track on those issues. McNeil and Herschell (1998) advocate for attendance contracts when working with

families who have multi-stresses in their lives. These contracts outline specific dates and the importance of calling in advance when attendance is not possible. We did not address how sporadic attendance or being late affected the whole group. This would have been a helpful conversation in terms of allowing the women to talk about what it felt like when they or others did not attend regularly.

Some of the women were also making decisions to go back to school. This was a very delicate topic, as I wanted to empower the women to have a vision about what they wanted from their lives. However, the children in many of the families were still very vulnerable and needed to have their emotional needs addressed with ongoing support from their parent. In some situations decisions such as going back to school would add additional stress to the family where there were already multiple stressors. As a facilitator, I attempted to address these concerns openly, and to also balance this with support for whatever decision was made by the women.

Parenting was another area where challenges were sometimes necessary. It is very difficult to parent your children in front of others (Rhodes & Zelman, 1986; Rubin, 2000; Sherman 2000). Parents often view their children's behavior as a reflection on themselves. We were able to model other ways of coping with the children's behavior in the group without having to name what we were doing. This would include, for example, hugging a child in order to settle him, naming the feeling the child may be having, or using structure and humour to set limits and re-direct the activity. This was an area that we discussed in depth with the women and they often talked about feeling embarrassed when their children didn't "behave" within the group. Rabenstein and Lehman (2000) suggest working with the parents to re-establish parenting roles within the group. We brainstormed ways that

we could address the children's behaviors within the group together without yelling or using threats. This was a very helpful process that we utilized particularly in the family circles.

Finally, it was important to challenge the women to face what it was like for their children to be exposed to family violence. Thus when they discussed their children's behaviors we were able to relate that back to the violence their children had been exposed to. As discussed earlier, many women minimize the impact of the family violence on their children (Stephens, 1999). While most of the women were cognizant that the violence had affected their children, these discussions helped to break some of the women's denial that the children did not witness the violence directly or that they were not affected by it. One of the more difficult areas of challenge was the ongoing safety concerns within the families. Some of the women's ex-partners had visits with the children and some of their current partners were also displaying abusive tendencies. It was necessary to challenge the women about the behaviors of their partners and the impact this was having on their children. Stephens (1999) suggests that advocating for children exposed to family violence requires a clear and consistent stance regarding child safety. This was sometimes viewed as supportive by the women and sometimes viewed as intrusive. Stephens (1999) also promotes making the distinction between the women's feelings about the abuser (I feel guilty keeping the children from him; I'm scared of him) from their behaviors (I will take steps to have visits supervised; I will develop a protection plan). In some cases, the more the women were challenged, the less likely they were to share information.

It would have been helpful for the group if I had introduced the idea of challenge from the beginning as a natural part of the group process (Glassman

& Kates, 1990). This would have allowed for more natural disagreement and discussion that would likely not have been threatening to the group members or to the health of the group in general.

Puppetry as a means to 'Break the Secret' about Family Violence

Using puppets in the family circle was an additional component of the group that had an unexpected positive impact on the women and children. As we developed the themes of the week, the thoughts, feelings, and actions that a family dealing with family violence would experience were demonstrated by the puppets. During discussion periods we continued to use "Max", the boy puppet, as our group facilitator. Sweeney and Homeyer (1999) report that while the information puppets are presenting may be threatening, the puppets are still make-believe and this creates a feeling of safety for children.

The puppets worked well as a means to demonstrate and name feelings related to the family violence. The separate persona allows the children to express forbidden thoughts and feelings (Sweeney & Homeyer, 1999). As Max was experiencing his thoughts, feelings, and reactions to the violence, the boys would empathize with him. As Max was willing to share his feelings and his stories about the fighting that he had witnessed, the boys began to share their own stories. It was remarkable how they would confide in Max, console him, or give him ideas about how to cope.

Chiles (1992) discusses the use of puppets in the hospital setting as a therapeutic tool that allows children to safely explore their feelings and to gain some mastery over a difficult experience. "By entering the child's world of fantasy and imagination, a puppet can help to identify fears and misconceptions and teach children about what is happening to them" (Chiles, 1992, p. 2). Even the quietest of children responded to Max when he asked

them a question. Hunt and Renfro (1982) found that while the children may not have been willing to speak directly to the adults in the group they would talk through and to a puppet.

Max also allowed the women to view first hand the experience of children who are exposed to the violence. Stephens (1999) has discussed how difficult it is for abused women to accept the impact of the violence on their children. The women were prepared ahead of time about the puppet theme and were better able to support their children because they knew what was coming next. The women also interacted with Max, called him by name, asked him questions, and responded to his questions . It is not uncommon for adults to also feel more comfortable sharing their thoughts and feelings with a puppet (Herman & Smith, 1988).

Max's mother and grandmother characters empathized with the women's experiences. The puppets modeled how difficult it is to parent in the midst of family violence or even after the relationship has ended. The characters were also able to role model for the parents different ways to talk with their children or to intervene with difficult behaviors. We tried to be aware that Max's mom might get a little frustrated with him and that she didn't always know how to cope with the stress of parenting. However, it was important to stay focused on the children's experience and feelings as this was the primary purpose of the puppet shows.

While presenting the puppet show it was important to have a facilitator who was not involved in the show, as performing prevented the ability to focus on what was happening in the group with the families. A third eye for observing the response within the group is necessary (Glassman & Kates, 1990). The facilitator who was not using a puppet character should

be able to help direct the questions or respond to the participants' needs during the discussion.

Max also allowed for some humour within discussions, sometimes by being silly or sharing an embarrassing moment with the group. Schaefer and O'Conner (1989) found that puppets provided a safe, vicarious outlet for impulses and fantasies. Max became someone who the families welcomed as a part of the group. He had his own personality and his own place within the group.

The Integration of Aboriginal Culture within the Group

As part of the group process it was important to integrate Aboriginal culture with group practice. A culturally appropriate approach would imply that the core beliefs, values, and practices of the Aboriginal culture are integrated into the healing journey (Dumont- Smith, 1995; Maracle, 1993; McKenzie & Morrisette, 1993). We talked about all of us being equal in the circle and that what we share in the circle must remain confidential (Choquosh Auh - Ho - Oh, 1990). We utilized a sharing circle format and a grandfather rock was passed. Those holding the Grandfather talked and others in the group did not interrupt them. An adaptation to the sharing circle was that we introduced the topic of the day and then asked the women to comment on their experiences from last week in the circle. This provided a structure to the sharing.

Sunbear (1991) discusses the use of the medicines within the circle. The medicines of cedar, sage, sweet grass, and tobacco were also introduced in the first meetings and sage was used for a smudge each week following. We shared why we smudge and a smudge occurred each week before opening prayer. All but one of the women were comfortable with the smudge and we discussed that if people were not comfortable, they did not need to feel

obligated to participate. These teachings seemed to lead the group members to talk about the origin of their culture, which nation they were from and their experiences with learning about their own culture. There was one woman who was not Aboriginal and she too shared about her culture and her cultural practices.

The multi-family group approach worked well because the group was somewhat representative of the holistic approach to healing which includes individuals, family, and community. Absolon (1993) states that social work practice should support the role of Elders, the family, and the community. Nelson, Kelly, and McPherson (1985) agree that people should not be removed from the interpersonal network that gives their needs and behavior meaning.

The Medicine Wheel of health and wellness was utilized as a means to look at how family violence had impacted upon the emotional, physical, spiritual, and intellectual wellness of their children (Bopp, 1985; Bruce, 1998). There is much evidence that the Medicine Wheel is a legitimate helping tool for social work practice (Absolon, 1993; Longclaws, 1994; McKay, 1995; Morrisette et al., 1993). We also discussed the Four Nations Medicine Wheel and that many of the nations were represented in our group (Bopp, 1985).

We developed a play wheel that utilized the four directions of play and child development (curiosity, exploration, creativity, and mastery) and the four theraplay dimensions that coincided with these directions (structure, nurture, engagement and challenge). The Medicine Wheel is an excellent holistic paradigm for understanding ourselves in the world, and worked very well in helping the women understand the impact of family violence on their children. However, the teachings of the Medicine Wheel were minimal

and integration of knowledge about family violence and healing as it related to the Medicine Wheel teachings were not comprehensive.

Further to this, we discussed colonization and its impact on Aboriginal people. We did this in the context of loss of family, loss of opportunity to play, and the family violence and abuse that all had experienced. Bruce (1998) states that "To get to the root of the problem and find the causal links, one simply has to look at the issue from a historical and culturally appropriate perspective" (p. 1). Again, while I tried to integrate an understanding of the impact of colonization on Aboriginal people, these discussions may not have been as comprehensive as they could have been.

We did have a male speaker come to talk with us about traditional nurturing and the losses experienced through the colonization process. The women appreciated hearing these teachings from a male perspective and were touched by the way he understood the experience of being an Aboriginal child or parent.

In order to have a truly culturally integrated program we would have needed to have an Elder present in our circles to provide teachings (Bruce, 1998; Dumont-Smith, 1995). We also needed a more comprehensive approach to using the Medicine Wheel as a model of practice. Further to this, the integration of Aboriginal games would have added greatly to the play experiences of the families. Finally, an introductory session as to the impact of colonization on Aboriginal families would be helpful before the group starts.

CONCLUSIONS

Learning Goals

In past social work positions I facilitated groups for parents and children affected by family violence. I knew that there was something missing in the interventions we were utilizing. We had not addressed the women's own childhood experiences or taken into consideration how colonization impacted upon the prevalence of family violence and the disruption of the parent-child relationship. In previous parent groups we discussed the impact of family violence with parents and developed strategies for coping with their children's feelings and behaviors. However, we did not utilize an intervention that focused on the enhancement of the parent-child relationship itself. These experiences working as a social worker in various family violence programs led to the specific learning objectives for this practicum.

The first learning objective was to develop group facilitation skills as they related to an adult/parent play program. We began the group process with the parents by encouraging them to play. We were astounded at their enthusiasm for playing together. We were not adapting these childhood games for adults, we were asking adults to play childhood games.

As a facilitator I learned how to format the play in order to minimize feelings of vulnerability for the adults. We played group games where everyone participated together. As comfort levels grew we worked in pairs and then played more independent games such as Charades. We did need to work to keep the games moving fairly swiftly and to encourage the women to stay focused on the game as they were apt to begin to engage in a dialogue rather than to continue playing. Debriefing did occur following the play. The women disclosed some of their childhood experiences of play and were able

to connect these experiences to their own children's feelings about the violence to which they had been exposed.

The facilitators needed to be "in charge", but we also needed to be flexible with the various needs of the group members to control the group activities. I learned how to encourage those who were shy to eventually take risks by leading the group in a silly game, or by trying out new ways to express themselves in a safe environment. In contrast, we tried to create situations where those adults who needed to be in control were willing to follow others who were leading the play, even though they did not know what was coming next!

The second objective was to strengthen an understanding of the dynamics of family violence within the context of the parent and child relationship. We attempted to discuss with the women the ways that witnessing violence had impacted on their children. The use of puppets was also an excellent way to break the secret of the family violence and allowed the children to tell their mothers what they remembered and how they felt as a result of witnessing the violence at home.

As well, we discussed with the parents ways that the violence had affected the opportunity to provide consistent nurturing and structure to their children. We reviewed their children's reactions to the violence and their disrupted sense of security as a result of the violence. When we were introducing the four themes of theraplay, we did attempt to connect these play interventions with their own child's need for nurturing, structure, engagement, and challenge. Whether these attempts at making these connections for the women were successful is not clear. As attendance was an issues, some of the women missed these links of theory and practice. Further

to this, I'm not certain if we provided enough clarity in our articulation of these connections.

The third learning objective was to develop knowledge in the area of parent and child relationships and the use of therapeutic techniques that enhance that relationship. We learned to assess which theraplay component needed to be utilized in order that a certain family or the group as a whole could enhance their relationship. Many of our activities included structure and nurturing games, which seemed to meet the needs of this particular group of both women and children. Parents in families exposed to violence seem to need encouragement to provide structure and consistent limits for their children. There was also a discomfort with nurturing on behalf of the adults and the children. The women had not had their nurturing needs met as children or adults and their children were caught in this cycle of mistrust and loss.

We saw some definite improvements in the demonstration of nurturing between parents and children. There were also wonderful moments of engagement and challenge. The parents and children truly enjoyed one another and teamed up in games in a way that helped them feel pride for their family and build cohesion in their relationships. Through the theraplay experience we were able to demonstrate parenting strategies and discuss the feelings often hidden behind their children's behaviors.

The fourth objective was to develop group facilitation skills necessary for leading a multi-generational and multi-family group. Play was an excellent intervention that met the needs of both adults and children in a multi-generational group. Games and activities were initiated that helped the group as a whole become more connected to one another. Play also provided the dyadic activities between mothers and children which would enhance

their individual relationship. These play activities kept everyone's energy alive and allowed the interest of both adults and children to be captured.

Puppets are another example of integrating mediums that fit with a multi-generational group. Both the women and the children benefited from hearing Max's story about his family. The women were able to experience a child's viewpoint and support their children as they shared their memories of the violence. The children were able to confide their feelings to Max and also show empathy for his situation. They were empowered to offer Max suggestions on how to protect himself and how to take care of his feelings. Max's family was Aboriginal and his grandmother was Max's best support. This helped to develop pride in the children for who they are, where they come from, and who they have in their lives to turn to for help.

The fifth learning objective was to develop group facilitation skills which integrate the history and culture of Aboriginal people. Throughout the group I tried to integrate Aboriginal history and culture. I had wanted there to be an understanding that Aboriginal families have been greatly affected by colonization. While I did provide information about colonization I do not feel the information was integrated as well as it could have been. It would have been helpful to have at least one meeting before the start of the group to deal directly with the topic of colonization in order to develop a foundation for the group intent.

I believe the sharing circle format and the understanding of equality and confidentiality are integral to running a culturally appropriate group. The smudge and its medicines provided the families with a peacefulness and cleansing at the beginning of each group. I tried to utilize the teachings of the Medicine Wheel for understanding health and wellness as well as to demonstrate the value of play and healthy child development.

The final objective was to develop an understanding of group themes and stages and an ability to facilitate the group according to the needs of the group at each stage. I became more familiar with the group themes and stages as I facilitated this group and was able to be mindful of the group process as various challenges within the group arose. I was surprised at the immediacy of the cohesion within the group in the first weeks, but the reality of the women's lives meant that they were not always able to attend. As a facilitator it became necessary to change topics, backtrack for women who had missed a week, and sometimes amalgamate two weeks into one.

Plans for the group were also changed according to the outcomes of the group topics from week to week. Each topic presented issues that needed to be revisited the following week. These issues included parent's feelings of sadness about what their children had experienced, the challenges of playing with their children, understanding their children's thoughts and feelings related to the violence, and coping with parenting your child in front of the group.

Of course, challenging the women was another important learning experience. It was difficult for me to take the risk to challenge the women about their decision related to family safety, parenting and their children's experiences of the violence. These challenges were very important, however, as their children's need for emotional and physical safety was a priority in terms of group goals and expectations.

I often needed to re-focus the group, and bring members back on topic. In order to stay focused on the group goals each week it was necessary for me to provide individual counselling outside of the group and to make referrals to outside agencies. It would have been helpful if there was a formalized

outreach component to the group process. This would also provide an opportunity for families to utilize theraplay at home.

Recommendations

Given all that I have learned through this practicum experience the following are recommendations for future groups for Aboriginal women and children who have been exposed to family violence.

Develop an environment that is conducive to feelings of comfort and safety.

I believe the environment surrounding the group was very conducive to feelings of trust and safety. The room was large enough to allow for a sharing circle area and a play area. In the circle area the pillows, blanket, and play items all seemed to provide feelings of comfort. The use of the medicines and the smudge added to the soothing nature of the room. In the play space there were few supplies and a large empty floor with no chairs. The doors to the room were, of course, closed and the noise outside the room was minimal. These basic preparations set the tone of nurturing and care and could be utilized with a variety of groups.

Create a program that is more comprehensive in its approach to integrating Aboriginal culture into group practice with families exposed to family violence.

While there were many culturally appropriate interventions integrated into this group process, there are additions that would have improved the cultural component of this group. An initial group orientation meeting

specific to the impact of colonization on Aboriginal people would have allowed for further group themes to integrate this knowledge as it related to loss of childhood and family violence. Theraplay activities that utilized traditional Aboriginal games would have enhanced the mother-child play time. Finally, having an Elder in the group to provide teaching and healing would have been a great support to the facilitators and the group participants.

Increase the intake meetings to two sessions.

At least two intake sessions are necessary in order to describe the group goals and objectives, hear the women and children's stories, discuss roles and responsibilities of facilitators and group members and to complete the assessment and evaluation components of the group. It is not possible to have the children hear their mother break the secret of the violence, provide support, and attend to the task of completing the measures in one session. As well, another intake session would allow for further screening as to each family's appropriateness for the group. Given our time lines, it was not possible to begin the intake interviews any earlier, but in the future, it would be helpful to start the intake process at least one month before the start of the group.

Create an opportunity for the women to know what topics their children are discussing in the children's group.

Maintaining communication channels with the parents and keeping them well informed of their children's groups would have lessened some of the anxiety the women may have felt about their children attending the

group. This would also have given the women an opportunity to discuss feelings and thoughts related to the children's group content. Respect for the children's privacy with regard to disclosures in the children's group would need to be reinforced with the parents.

Create formalized individualized counselling opportunities to meet the needs of the women outside of the group time.

Most of the families we were working with had very chaotic and stressful lives. The women and children were living in poverty, were often unsafe, and had few emotional supports. There were many intensive issues related to physical and emotional safety that occurred regularly throughout the group time. Thus, it was necessary to provide outreach support to many of the families in the group. This outreach component should be formalized in recognition of the complex issues that families leaving violent relationships face. Having at least one other office day devoted to outreach through the duration of the group would have helped to alleviate some of the reactive quality of the group facilitation role and would also have provided the families with more comprehensive support. This home-based support could include in-home theraplay with families which would reinforce the value of regular playtime with their children.

Utilize puppets as a means to break the secret of the family violence with the children and the parents.

The puppets were an excellent addition to the family violence theme of "breaking the secret". Puppets are a valuable tool when working with multi-

family groups as they allow for children to remain engaged while the mothers begin to understand their children's experiences. Through the puppets the children were able to talk about the violence they had been exposed to, their feelings about the violence, and ways they had coped with their feelings. They would likely not have been able to express themselves this way in an adult and child discussion format. Puppets are an excellent addition to any multi-family or children's group.

Develop a strategy for resolving group conflict during the first group.

The facilitator should introduce the idea of conflict to the group in the first meeting. If conflict was viewed from the beginning as a natural part of any relationship, we could have used the group more readily to learn conflict resolution skills in a relatively safe environment. Further to this, it would have been helpful for the women to be prepared for some challenge from the facilitators in a way that was respectful of their experiences. Certainly, the women could also have been invited to challenge the facilitators as necessary. Some preparation about conflict conversation strategies such as 'I' statements may have helped facilitate this process.

Be aware of people's vulnerabilities related to adult play.

While this group seemed very ready to play, I believe this is the exception and not the rule. During the intake process we prepared the women for the fact that we would be playing in the group and this was very helpful. Other adults I have worked with in the group context are very reserved about playing in front of one another. This is mostly due to a vulnerability

associated with play from their own childhood. Introducing games that do not single people out is crucial in the first weeks. Slowly introducing more hand to hand contact, and more intimate games such as "Funny Bones" or "Belly Laughs" should occur as the weeks progress as people seem comfortable. If people are negative or seem angry about play, it's important to try and understand that this likely comes from a place of fear. Gently encourage them, but do not tease or put people on the spot.

Any facilitator should try to be aware of individual strengths and areas of vulnerabilities with the women as they play. Initially use the women's strengths and comfort with certain play to build their confidence about taking risks. As the weeks progress, give the women an opportunity to take on a role they would not normally have. This allows them to explore new ideas or ways of being through safe play. Play is an exciting new discovery for most adults and can truly enhance their physical and emotional life, as well as the group experience.

Continue to utilize theraplay as a means to enhance the parent -child relationship with mothers and their children who have been exposed to family violence.

There is no doubt that theraplay activities provided an opportunity for parents and children to make eye contact, laugh together, touch one another, and truly enjoy each others' company. The use of the play also provided the women with new ideas for setting limits and being consistent. This "in action" intervention facilitated an opportunity to view the children's behaviors and the parents strategies for coping. We could then de-brief with the women regarding the feelings their children may be having and discover

new ideas for intervening with nurturing and care. This opportunity would not have been present in a more psychoeducational group setting.

Summary

When I began the practicum process, I had surmised that developing play skills with the women and facilitating play between the women and children in a multi-family group setting would enhance the healing process for Aboriginal families who have been exposed to family violence. This practicum experience has provided me with an opportunity to develop an intervention which would test this hypothesis. The strategies utilized in the practicum were based on the literature review and my own experience in social work practice.

There were many stresses that the women and children experienced while in the group. Families were coping with custody and access issues, loss of family members, sexual abuse disclosures, and safety issues. The Parenting Stress Index indicated that at the end of group the women continued to be within the clinical range for parenting stress. It is difficult, therefore, to determine the impact of this particular group on the lives of the women and children. There were many other external events that likely made the group themes and experience difficult for the women and children to process and integrate.

That being said, it is clear that the women enjoyed having time with one another to discuss parenting concerns and to share thoughts and feelings related to the violence their children had experienced. They felt comfortable within the group. The women also reported that they enjoyed playing and appreciated an opportunity to share individual play time with one child. They certainly came to the group ready to have fun! Observations by

facilitators indicated that the women became more demonstrative with their children and that the children became more comfortable with their mother's engagement and nurturing attempts as the group progressed.

The families also had an opportunity to break the secret of the family violence. The women were well prepared to give their children permission to speak about the violence within the group. The group experience may have been the first time that many of the children had shared their thoughts and feelings about the violence together with their mothers.

I am uncertain if this group format fit with the needs of these families given the reality of the many crises in their lives. Even at the end of this group intervention, the women and children were living in unsafe circumstances. The women continued to feel overwhelmed. The referral criteria must be clear and the intake process must be comprehensive to determine readiness for the group. Referrals to external agencies became a necessary part of the closure with the group. I believe that in order for this group intervention to be effective the women must be safe, must have had an opportunity to heal from their abusive relationship, and perhaps have appropriate community supports in place. Within this context, the adult play format, the parent-child theraplay and the parent-child family violence themes are all very valid interventions when working with Aboriginal women and children exposed to family violence.

I am very grateful to the women and children who participated in this group. I am in awe of their strength and resiliency.

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Appendix A

Children Exposed to Family Violence

Intake

Family Members

Parent:

Address:

Phone #:

Children: **D.O.B:** **Address:**

1. How long have you been out of the abusive relationship ? When was the last abusive incident ?

2. Do you still have contact with the abusive partner ? Do you have a protection order of some kind ? Are there outstanding charges ? Any dual charges ?

3. What kind of abuse did you experience when in the relationship ?

Physical

Emotional

Sexual

Control and Isolation

4. What kinds of abuse was your child exposed to and how has the exposure to family violence affected your child ?

5. Was your child directly abused ?

Emotional

Physical

Sexual

6. How do you feel the family violence affected your relationship with your child?

7. Does your child have contact with the abusive partner ? How often and under what conditions ?

8. Does your child face any challenges in terms of :

a) behavior

b) relationships with peers

c) academic learning

9. What are your child's strengths ?

10. What do you enjoy most about your child ?

11. How comfortable are you with the idea of being in a group where you will be asked to play with other adults and with your children ?

12. What do you hope to get out of your experience in this group - both for you and your child ?

Appendix B

The Parent's Group

Phase One

Group Structure:

- Smudge and Prayer:

Each group began with a smudge. Teachings about the medicines were provided to the women. Sage was the medicine most often used as it is considered to be a woman's medicine. This gave the women in the circle an opportunity to ground themselves and remember their connection to the world around them. Opening prayer was a time where we acknowledged the creator in our lives and welcomed our grandmothers and grandfathers into the circle with us.

- Check -in/Sharing

The facilitator created a thought or question to consider during check-in that coincided with the theme of the day. The women had an opportunity in this time to share about their week, their concerns and feelings. A Grandfather rock was used to ensure that when one person is speaking the others in the circle listened without comment. The Grandfather rock is our connection to Mother Earth and a reminder of the connection we have to all our relations.

- Introduction to the Theme of the Day

The facilitator described the plan for the circle each week. A short introduction to the subject was presented at this time.

Themes included:

- Getting to know each other.
- Childhood memories of play.
- The impact of family violence on child development.
- Nurturing
- Structure
- Challenge
- Engagement
- Hearing the children's stories - Getting ready for stage two of group

- Warm -up game:

A warm up game was utilized to honor the necessity of play in our lives. Women were encouraged to be silly and move their bodies as they took risks to play together. This facilitated openings for feelings, understanding and processing of childhood or adult issues that may be difficult to express through talking. It also created an opportunity for women to feel more comfortable in "play mode" in order to re-connect through play with their children. Theraplay activities were chosen that encouraged the four components of nurture, challenge, engagement and structure. These activities occured in a designated play area, outside of the circle.

- Discussion Period

The women returned to the circle and the theme of the day was discussed. The first four weeks were spent understanding their own experiences related to play as children and adults. A discussion of the impact of that family violence has on the children's wellness was also discussed. The final four weeks included a discussionand interaction focused on the four components of theraplay and the rationale for utilizing these play activities with the children. This rationale was again related to the impact that family violence had had on their children,

- Break

A ten minute break for snack and conversation will occur each week.

- Theraplay Game

A game which is relevant to the play and relationship topic of the week was played by the group members. This game was utilized as an activity for both parents and children to participate with when the children joined the circle.

- Nurturing

A nurturing activity occured, such as lotioning, that tought the women the ways that they can care for themselves and demonstrate caring to their children. This was a way to prepare the women before their children join the group.

- Parent/Child Time

For the last 15 minutes of each group the children joined their mothers. There was a short circle time together to share what they learned in each of their groups. Following the sharing the women and children playerd together using a nurturing and a challenge or engagement activity. Usually the parents and children were familiar with the activity from their individual group time.

- Closing Prayer and Song

Parents and children returned to the circle to sing the closing song together and to say a closing prayer. The song remained the same throughout the weeks.

Appendix C
The Parent-Child Group
Phase Two

- Smudge and Prayer

Each group continued to open with a smudge and a prayer.

- Check-in/Sharing

Check-in with the parents continued as in the initial eight weeks

- Review of Family Group Content

The facilitator would prepare the women for the family violence theme each week. The puppet show was presented to the parents first, followed by a discussion about their children's possible reaction to topics and how they could support their children when they saw the puppet play with them. De-briefing about the previous weeks topic and their children's reactions also took place at this time.

Themes included:

- My Family Tree
- All kinds of Feelings
- Breaking the Secret
- The Violence is not my Fault
- Protection Planning
- Anger in Families

- Peaceful Plans for my family
- Saying good-bye
- Celebration

- Parent and Child Time

The children joined the parents and we shared a snack together as a transition time.

- Hello Song

A hello song welcomed everyone to the circle.

- Group Rules

- No hurts
- Stick together
- Listen when others are talking
- Have Fun

- Puppet Show

Facilitators presented a puppet show that included a boy their age whose mom got hurt by his Dad. The puppet shows followed the family through the transition of leaving their community in order to be safe, and trying to start their life again with just the mother and son. Following the puppet show a discussion with parents and children followed where the theme of the puppet

show was discussed and children could share feelings and experiences as they wished.

- Theraplay Time

Children and parents participated in theraplay activities within dyads and all together in the larger group.

- Closing Song and Prayer

Families returned to the circle for closing song and prayer

Appendix D

MOTHER'S GROUP EVALUATION

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

2. What did you like about the group ?

3. What did you dislike about the group ?

4. How much do you think the group helped your child ?

5. Have you noticed any changes in your child as a result of participation in the group ?

If yes, what changes did you notice ?

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

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

8. Would you tell a friend who has problems in her family to come to this kind of group ? Yes No

Appendix E

MOTHER'S/CARETAKER'S EVALUATION

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

2. how much do you think the group helped your child ?

A lot		A little		Not at all
5	4	3	2	1

3. Have you noticed any changes in your child as a result of participation in the group ?

Yes No

If yes, what changes did you notice ?

4. How much information did you receive about what your child was learning and doing in the group ?

A lot		A Little		Not at All
5	4	3	2	1

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

APPENDIX F
PARENT AND CHILD WELLNESS WHEEL