NOTE TO USERS

The original manuscript received by UMI contains pages with slanted print. Pages were microfilmed as received.

This reproduction is the best copy available

UMI

THE USE OF STRUCTURAL FAMILY THERAPY AND ECOLOGICAL SYSTEMS THEORY WITH FAMILIES EXPERIENCING VIOLENCE

BY

VALERIE CHARLOTTE BIMM

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

MASTER OF SOCIAL WORK

Faculty of Social Work
University of Manitoba
Winnipeg, Manitoba

August, 1998

The author has granted a non-exclusive licence allowing the National Library of Canada to reproduce, loan, distribute or sell copies of this thesis in microform, paper or electronic formats.

The author retains ownership of the copyright in this thesis. Neither the thesis nor substantial extracts from it may be printed or otherwise reproduced without the author's permission.

L'auteur a accordé une licence non exclusive permettant à la Bibliothèque nationale du Canada de reproduire, prêter, distribuer ou vendre des copies de cette thèse sous la forme de microfiche/film, de reproduction sur papier ou sur format électronique.

L'auteur conserve la propriété du droit d'auteur qui protège cette thèse. Ni la thèse ni des extraits substantiels de celle-ci ne doivent être imprimés ou autrement reproduits sans son autorisation.

0-612-32057-X

Canadä

THE UNIVERSITY OF MANITOBA

FACULTY OF GRADUATE STUDIES
****
COPYRIGHT PERMISSION PAGE

THE USE OF STRUCTURAL FAMILY THERAPY AND ECOLOGICAL

SYSTEMS THEORY WITH FAMILIES EXPERIENCING VIOLENCE

BY

VALERIE CHARLOTTE BIMM .

A Thesis/Practicum submitted to the Faculty of Graduate Studies of The University

of Manitoba in partial fulfillment of the requirements of the degree

of

MASTER OF SOCIAL WORK

Valerie Charlotte Bimm   ©1998

TABLE OF CONTENTS

TABLE OF CONTENTS (cont'd)

TABLE OF CONTENTS (cont'd)

LIST OF FIGURES

Abstract

This practicum consisted of the application of structural family therapy and ecological family systems theory to families who had been affected by violence in the form of child abuse or domestic violence. Structural family therapy as a model, places primary importance on the structure of relationships within a family, and between the family and its larger environment. The setting for the practicum was the Elizabeth Hill Counselling Center. A total of 12 families were seen during the practicum and in some cases family members were seen individually. During the intervention, primary consideration was given to the safety of family members. A thorough assessment occurred prior to the intervention to determine a family's suitability for therapy. Several themes emerged during the practicum experience which included the existence of alcohol and violence in families, and the unique issues of violence in multiproblem families. Resistance to therapy was another issue which emerged in various forms. Another theme which was addressed were the ethical issues present in working with families affected by violence.

ACKNOWLEDGEMENTS

Introduction

This practicum consisted of the application of ecological systems theory and structural family therapy to families where violence had been identified as a problem. The idea of considering the entire family as the focus of treatment for family violence is still a relatively new and controversial approach. Concerns of safety, as well as legal and ethical issues were given primary consideration in all aspects of the intervention. The practicum was both a challenging and rewarding experience.

Violence can take a variety of forms in families depending on the relationship between the members involved and the nature of the behaviour. This practicum focused primarily on child abuse and wife abuse and the underlying systems within the family and society which support these forms of family violence. Both ecological systems theory and structural family therapy were well suited to conceptualizing the etiology and the treatment of family violence in this manner.

An ecological perspective recognizes that human behaviour is influenced by multidimensional factors within the individual, family, immediate environment, and broader culture. It builds on family systems theory by incorporating the relevance of the social, political, and cultural contexts and their reciprocal relationship with the family. This theory was particularly effective in addressing family violence which is widely considered to be multi-causal in nature. One of the characteristics of the ecological model is its ability to accommodate a variety of interventions and techniques. For this practicum, structural family therapy was used to complement the ecological perspective.

Structural family therapy is a systemic approach which places primary importance on the structure of relationships within a family, and between the family and its larger environment. Problems in family functioning, and individual symptoms of family members are considered to be the result of structural problems within the family. The structural model is based on a framework of normal family functioning. The characteristics include a

structurally organized system with clearly defined boundaries around the marital and sibling subsystems and the family as a whole (Hoffman, 1981).

The literature contains some examples of structural family therapy as it has been applied to work with families affected by violence but this literature is still relatively sparse. Gelles and Maynard (1983) identify that the aim of structural family therapy when working with this population is to alter the structure of family relationships to eliminate the use of violence between members, to improve family members' relationships with other systems and to improve the level of functioning of the family as a whole.

It is difficult for any one theory to explain the existence of violence in families, and there is no one particular intervention that is proven effective. It is important for the clinician to be aware of the different theories as they relate to wife assault and child abuse and to consider that they all have contributed to our understanding of this complex and emotionally laden issue.

This report provides a review of the literature beginning with a look at families as a unit, and their relationship with society. A review of ecological systems theory and structural family therapy is presented as well as their application to families affected by violence. The literature on family violence, in particular theories of its etiology, and the treatment of family violence as it has evolved over the past few decades, is also reviewed.

Chapter two outlines the procedures and other practical aspects of the practicum including setting, clients, supervision, and evaluation. Chapter three provides a case summary of all the clients seen during the practicum. Their names have been changed to ensure confidentiality. Chapter four provides an in-depth analysis of three of the clients seen during the practicum and details the application of structural family therapy and ecological theory.

Chapter five explores clinical themes which emerged during the practicum which included dealing with resistance, ethical issues unique to the area of family violence, the

relationship between alcohol and violence, and the challenges of multiproblem families and family violence.

The final chapter provides a summary of the evaluation of the practicum. As well, this chapter includes a critique of the approaches used, a discussion of the applicability of the selected models of treatment and a final commentary on the achievement of learning goals.

SECTION ONE: LITERATURE REVIEW

The Family and Society

The family is the primary unit which makes up society. The definition of family

varies both culturally and historically. For the purpose of this report, family will be

defined as a group of individuals related by biological ties or a long-term commitment and

an expectation of loyalty and trust, who generally inhabit one household, who share

activities and who may share responsibility for child rearing. Families are expected to

perform tasks which include the socialization and protection of children as well as to

provide companionship and love for the adult members. Throughout recorded history, the

family has been a core element in human groupings. The family has ensured the survival of

these segments of humankind by carrying out procreating, socializing, nurturing, material,

maintenance, and various social control functions (Wood & Geismar, 1989).

It is important in understanding the relationship between families and society to

note that the relationship is a reciprocal one. Society has certain expectations of the

family as described above and the family expects "legitimization, physical and social

security, order and continuity from society" (Wood & Geismar, 1989, p. 2). The

reciprocal relationship includes mutual dependency as well as adaptation. The family is

expected to accommodate to a culture and to transmit that culture and its values to its

members (Minuchin, 1974). The family accommodates to society, and is therefore

changing with it. The nature of this relationship results in the family reflecting societal

beliefs and values. The relationship between the family and society is crucial in

considering the values and beliefs that contribute to domestic violence and other abuses

within the family.

Like society, the family is a social unit made up of smaller units. The relationship

between the family and the individual is also reciprocal. Nurturance, protection, and

socialization are considered a family's internal functions. (Although they may also meet

the expectations of the larger society, they meet the needs of the child within the family.) In the early process of socialization, families mold and program the child's behavior and sense of identity. These individuals spend a great deal of time together (Bolton & Bolton, 1987). Straus (1979) for example has noted that the intensity of involvement between family members is unparalleled in any other relationship. The sense of belonging comes with an accommodation on the child's part to the family group and with his/her engagement in transactional patterns in the family structure that are consistent throughout different life events (Minuchin, 1974).

We know that when a family functions well the health and well-being of its members is promoted and maintained. Similarly, family dysfunction can contribute to personal and/or social problems. In the broadest sense, a family is seen as being a societal concern when it fails to carry out its expected functions. Such a family tends to be labeled as dysfunctional, or malfunctioning, meaning that some of these functions are not performed at all or are performed so badly as to bring about negative consequences both for the family itself and for those who are associated with it (Wood & Geismer, 1989).

Based on a cursory review of the literature it would appear that we know more about dysfunctional families than functional ones. Perhaps it's easy to identify family problems or weaknesses but harder to identify family strengths. Minuchin (1974) suggests that a well functioning family is identified not by the absence of problems, but rather by the family's ability to cope with them. Garbarino and Abramowits (1992) identify the following characteristics of strong families:

1. Clear, open, and frequent communication among family members.

2. A sense of belonging to a warm, cohesive, social unit, while at the same time nurturing the development of individual strengths and interests

3. Mutual support, recognition, and respect, and a willingness to make sacrifices if necessary to preserve the well-being of the family.

4. A religious or spiritual orientation.

5. The ability to adapt to and cope with stressful and potentially damaging events, as well as predictable lifecycle changes.

6. The existence of social connectedness and availability of friends, extended family, neighbors, and community organizations .

7. Clear well defined roles, and responsibilities and an enjoyment from spending time together (p. 80).

Although this does not amount to a comprehensive list of characteristics it provides a general sense of what a well functioning family might look like, and how the members might relate to one another. This discussion provides a foundation upon which a review of family violence will be conducted. It is important to understand that violence, like other social problems must be considered in context and that the contexts include the individual, the family, and society. Understanding the problem involves understanding the inter-relatedness between the contexts in which it occurs.

Violence in Families

When family members hurt each other emotionally, physically, or sexually, they are not functioning in a way that is promoting the health and well-being of the members. Many theories exist which attempt to explain why family violence occurs. In reviewing these theories it is important to recognize that our understanding and recognition of family violence has varied depending on the political climate and historical context.

Family violence has been in existence long before it was publicly acknowledged, and its incidence has not changed so much as its visibility. Society's response to the problem has been influenced by what was considered the cause of the problem and by the nature of the social control agencies which responded to it (Gordon, 1988). Thus family violence must be considered in its historical context to appreciate the political forces which have influenced the public perception and response to the problem.

Theories of the origin of child abuse and domestic violence will be explored separately but it is important to understand that there are common features to all violence in families and its origins. Finkelhor (1983) notes that all violence which occurs in families is an abuse of power. Whether the violence is by the husband against the wife or the parent against the child, a power differential exists. The abuse itself is often a response to perceived powerlessness (Finkelhor, 1983). In addition to these features, violence which occurs in families has an impact on family members which does not occur to the same extent outside the family. Finkelhor (1983) notes that abusing families share similar characteristics such as social isolation, and patriarchal structure.

There were also commonalities in the social response to different forms of family violence (Finkelhor, 1983). As noted above family violence has gone through an evolution depending on the historical context. Finkelhor (1983) notes that in each of the kinds of abuse, a social movement arose which drew attention to the abuse that was occurring. But in each case some ambiguity remained about how to define the normative boundaries of the abuse (Finkelhor, 1983). The area of family violence, therefore is complicated by problems around defining what constitutes abuse.

Etiology of Child Abuse

A plethora of theories exist to explain the occurrence of child abuse in families. They can be grouped into five main approaches: medical/individual; sociological; social learning; family systems; and multidimensional and feminist approaches. The medical/individual model was perhaps the first recognized model developed to explain the existence of child abuse. It evolved from the work of Hefler and Kempe (1962) with the discovery of the Battered Child Syndrome. The emphasis was on the medical model of explaining the accidental injury in the child victim as well as "mental illness" in the abusive parent. This gave rise to the psycho-pathological model of child abuse which focused almost exclusively on the parent who was thought to be suffering from a psychological

pathology or sickness that accounted for abusing or battering a child. Thus, factors were looked for within the person that may differentiate abusive individuals from non-abusive individuals (Murphy-Berman, 1994). Psychological characteristics of abusive parents were thought to include impulsivity, immaturity, and depression (Gelles, 1979). The parent's "sickness" manifested itself in the parent-child relationship. The model further suggested that the parents' psychopathology was a result of their early childhood experiences which included abuse and abandonment (Gelles, 1979). Early proponents of this model suggested that child abuse cases made up a cross-section of socio-economic status, ethnicity, age and education. These factors were not considered relevant to understanding abuse.

Clearly there were a lot of weaknesses to this model. Gelles (1979) identifies that the model failed to pin point which psychological characteristics characterized the pathology. In other words, there was no consistency as to which personality traits were associated with child abuse. There was a lack of adequate research and most studies were conducted after the abuse had occurred. "These types of after the fact explanations offered little predictive power in the study of child abuse" (Gelles, 1979, p. 32). The primary limitation to the theory was that it was linear in nature. It was believed that "Early childhood experience characterized by abuse creates psychological stress that produces certain psychopathic states. These psychopathic conditions in turn cause abuse acts towards the child" (Gelles, 1979, p. 30).

There is a significant amount of criticism of the medical model in the literature, and it is rarely used solely to explain child abuse today. The model needs to be taken in its historical and political context. Society's social institutions had not experienced the impact of the women's movement and the profession of social work was not highly recognized at the time (Bolton & Bolton, 1987). Is it possible that the illness-as-cause hypothesis was accepted readily because it soothed society's conscience, as well as the conscience of individual parents who may be subject to abusive impulses. Society was

absolved from guilt by this interpretation, for if child abuse was the result of the emotional illness of the perpetrators, social conditions need not be blamed, society was justified in the self-righteous prosecution of individual perpetrators, and it need not examine social circumstances and cultural trends which may be major factors in abuse (Gil, 1980).

The second major school of thought is the sociological model which attributes the problem primarily to social stress factors such as poverty, unemployment, drinking and isolation (Gordon, 1988). Murphy-Berman (1994) notes that sociological and cultural systems approaches place risk factors not only within the individual him or herself, but also within the individual's environment and culture. For instance, low family income, poor housing and unemployment have all been identified as contributing stress that may exacerbate family strain and abuse (Murphy-Berman, 1994). The leading proponents of the sociological model of family violence are Murray Straus and Richard Gelles. They found in their research that there were patterns of sociological and contextual variables that were associated with child abuse (Gelles, 1979). Sources of stress such as unemployment, and unplanned or unwanted pregnancy were thought to contribute to psychological stress in the parent to and lead to child abuse. Social diagnosis of this sort implies social action and demands resources. Gordon (1988) notes that social explanations of family violence dominate when progressive attitudes and social reform movements are stronger, as was the case during the 1970's when this theory was popular.

Sociological theories also explain why a certain amount of violence is considered acceptable in families. It recognizes that violent behavior exists in a sociological context and is subject to the values and norms of society. For example what was considered spanking a century ago might be considered abuse today (Gordon, 1988). Thus, there is a dilemma as to whether social control is exerted to maintain a certain level of violence in families, or whether social control is designed to keep violence from occurring (Gelles, 1983)

Social learning theory has had a major impact on how family violence is understood. Gelles (1983) explains that experience with, and exposure to violence serves as a learning experience which teaches that violence can and should be used toward family members. The family provides examples for imitation and role models which can be adopted in later life as the individual draws from childhood experiences (Gelles & Straus, 1979). Social learning theory therefore, explains the intergenerational transmission of violence.

Family systems theory has contributed to our knowledge of family violence. Straus's (1973) general systems model of violence between family members was the first theoretical application of a systems perspective to family violence. He proposed that violence, rather than being viewed as an aberration or product of the psychopathology of an individual member, was viewed as a system product or output (Maynard & Gelles, 1987). Systems theorists are interested in transactional sequences, especially positive feedback loops, which are the immediate cause of the escalations that lead to violence.

Masson and O'Byrne (1990) looked at family systems theory as an explanation for both child physical and child sexual abuse. Family systems theory emphasizes dysfunctional interactional patterns within families, supra-systems that may both create and maintain stress, and societal systems that paint unrealistic pictures of child rearing and the ease of parenting (Masson & O'Byrne, 1990). Even though parents are responsible for the abuse, there are factors in the interaction between family members, and the systems surrounding the family which help to explain the other predisposing factors which may increase the likelihood of abuse occurring. Parents who are physically abusive are often isolated and mistrustful of the outside world, and have a symbiotic relationship with each other (each seeking to be taken care of by the other) and/or with a child (expecting the child to take care of the parent), which leads to unrealistic demands and inevitable disappointment and frustration (Masson & O'Byrne, 1990). These transactional patterns can give rise to and perpetuate abusive behaviour.

In reviewing the various theories proposed to explain child abuse, it is clear that no one particular theory can adequately in explain the existence of child abuse. "Twenty years of research and theory construction have moved thinking about the nature and causes of family violence from an individual/psychological model to a multidimensional model which examines the individual, the family system, and the society" (Gelles & Maynard, 1987, p. 271). Gil was viewed to be one of the first to consider the multidimensional view of family violence. He concluded that the phenomenon of physical abuse of children should be viewed as multi-dimensional rather than uniform with one set of causal factors. He identified the following set of causal forces: (a) environmental chance factors; (b) environmental stress factors; (c) deviance or pathology in areas of physical, social, intellectual, and emotional functioning on the part of caretakers, and\or abused children themselves; (d) disturbed intrafamily relationships involving conflicts between spouses and or rejection of individual children; and (e) a combination between these sets of forces (Gil, 1970). He added that these forces are superimposed on the culturally permissive attitude that the use of a measure of physical force in caretaker/child interaction is acceptable, and related clear-cut legal prohibitions and sanctions against this particular form of interpersonal violence are absent (Gil, 1970). Gil (1970) was perhaps the first to develop a multi-dimensional theory and such models have become more sophisticated over time and perhaps more popular. Murphy-Berman (1994) explains that ecological models are the most comprehensive and define in terms of the degree of adequacy with which the individual is able to cope within the context of complex interactive family, community, and sociocultural constellations.

Child sexual abuse has undergone a similar evolution from individual based theories to multi-causal theories. Family systems theory is helpful in contributing to our understanding of sexual abuse in families. Certain family patterns in particular, seem predisposed to abuse such as high secrecy, avoidance of conflict between marital partners, and intense fears of separation so that the child is called upon/sacrificed to maintain

togetherness at the expense of the child's needs (Masson & O'Byrne, 1990). Family systems theory on its own is not an adequate explanation for child sexual abuse, and multi-causal theories have been proposed to provide an explanation for sexually abusive behaviour.

For example, Finkelhor (1984) developed a Four Preconditions Model of Sexual Abuse which is multi-causal in nature. It was an effort to address the shortcomings of previous theories which focused solely on the individual, or the family and neglected sociological factors. The model identifies four conditions which need to be met before sexual abuse can occur:

(a) A potential offender needs to have some motivation to abuse a child sexually.

(b) The potential offender has to overcome internal inhibitions against acting on that motivation.

(c) The potential offender has to overcome external impediments to committing sexual abuse.

(d) The potential offender or some other factor has to undermine or overcome a child's possible resistance to the sexual abuse (Finkelhor, 1984, p. 54).

This model explains, from a multidimensional perspective, how factors within the individual, the family and society interact resulting in the occurrence of sexual abuse. Masson and O'Byrne (1990) provide the following example of how the model is applied:

A father, himself abused as a child and seeking to be powerful in sexual relationships, fantasizes about his daughter; alcohol may have lowered his internal inhibitions or he may rationalize that it is an expression of love for his daughter; external inhibitors are low because mother is not present or able to prevent it or mother and daughter are not close and daughter is unable to confide; and finally father, by using force or fear, exploiting trust, or making daughter feel guilty about holding the family together, overcomes the child's resistance (p. 188).

Systems theory is not without criticism. "The major problem with the proposed systems theory is that it is so extensive and multidimensional that it cannot be tested" (Pagelow, 1984, p. 108). Any phenomena which is multicausal in nature is difficult to study, and to base conclusions on. There are no direct cause-effect results when dealing with child abuse, but rather there are many factors which affect the outcome of an individual's behaviour. Although multidimensional theories may be difficult to test through traditional research methods, it has been proven through research that no one theory can be used to explain the existence of child abuse.

The feminist movement has had an impact on the issue of child abuse, the theories used to explain it and the public awareness it has obtained. The movement helped to bring light to the fact that families reflect the values and beliefs of society. A patriarchal society, that is one which is dominated by men, is reflected in traditional families which results in limited power for women and limited choice of role. Feminist analysis recognizes abuse as rooted in unequal power relationships in the family and speaks to how women and children are victims of those relationships (Washburne, 1983). Thus women's power in society and the family is a factor in understanding abuse in families.

Women are also the perpetrators of violence against children, and Washburne (1983) states that feminists have glossed over this issue perhaps because of the discomfort of the idea of women as victimizers. Using a feminist analysis, she offers the following explanation for why women abuse children:

> Women's abuse of children stems directly from their own oppression in society and within the family. Women are expected to be the major caretakers of children, yet have few supports for accomplishing this since they have primary responsibility for maintaining the family. Women have fewer options than men for self-fulfillment and self-definition outside the family. It is not surprising, then, that some women displace their frustration and anger on their children, the family members who are less powerful than they (p. 291).

This is an important perspective to incorporate in the analysis of child abuse. It is helpful in understanding how agencies intervene with families in cases of child abuse. Often times the intervention is focused on improving the mother's parenting, rather than the father's. Even when the father is the perpetrator the mother is seen to have failed in some way because she was not able to prevent his violence.

The feminist movement was influential in the area of child sexual abuse. It can be credited for bringing the issue into public awareness and perhaps even for the mobilization of resources which occurred during the 1980's in response to the problem. Finkelhor (1984) notes that feminist thinkers stress that most abuse is committed by men against girls and therefore sexual abuse is a function of the inferior status of women and children. This perspective suggests that the source of the problem exists in the larger society, and therefore interventions and efforts to address the problem should be targeted at that level.

The feminist movement has been critical of family systems approaches to child sexual abuse because it negates the larger issues and places responsibility on a system which is not responsible for the abuse. In challenging the family systems approach, which fails to take into account power structures reinforced by society, feminists point out that families don't assault children sexually, men do (Masson & O'Byrne, 1990). A systems approach has been criticized for leading to blaming the mother for her partner's sexual abuse of her child. This criticism has been valuable to family systems therapists who have been forced to rethink their underlying assumptions about sexual abuse and the role of mothers. A new feminist-informed approach to family therapy has evolved which takes into account the issues of larger society, and their influence on families.

Etiology of Violence Against Women

For the most part theories explaining the existence of violence against women have mirrored those explaining child abuse. Gelles (1983) notes that the early writings on both child abuse and wife abuse portrayed the causes of domestic violence as arising from

offenders' psychological problems. . Unlike child abuse however, theories have also developed which point to psychological problems in the victim, in this case the battered women, as the cause of the violence. Walker (1979) states however, that no scientific data exits to support this, and if battered women behave strangely, it is probably as a consequence (not a cause) of being battered.

Social learning theory is also applied to domestic violence in considering the manner in which behaviour is transmitted intergenerational. Social learning considers the role of early socialization of girls and boys into gendered positions in relationships and how this can contribute to violence (Goldner et al., 1990). The cycle of violence is also explained with this theory. Walker (1979) describes the cycle of violence consisting of three stages: the tension building phase, the violent episode, and the reconciliation period. This cycle maintains the relationship and allows the abuse to be perpetuated. It appears that both partners may have learned this behaviour from their families of origin and may believe that it is the normal or usual way couple react, or they may feel trapped in a "hopeless" situation without knowing how to break the cycle (Geffner, Mantooth, Franks & Roa, 1989).

Another group of theories considers how larger systems impact individuals thereby contributing to violence. Sociological theories recognize that violent behaviour exists in a sociological context and it is subject to the values and norms of society. Cultural approval of violence is also a factor. Pagelow (1984) states that our culture promotes, stimulates, and even encourages and rewards violent behaviour and that this cultural approval of violence is an important factor in family violence. Social political theories which include feminist theory are also included in this group in terms of how family violence is explained. This theory looks at the power structure of society as a whole and how it is represented in the family. Historical research shows that the hierarchical structure of the family vests power in men to dominate and control others, and to use whatever means required to maintain their authority. Further, the unequal relations between men and women are

supported by society's institutions (Pagelow, 1984). The feminist level of analysis

considers the external power differentials between men and women including men's

subjective sense of entitlement, privilege, and permission to rule women, and women's

subjective belief that they must serve men (Goldner et al., 1990).

Family systems theory has also been applied to explain domestic violence. Violence

is seen as a system's product or output rather than as a product of individual pathology

(Gelles, 1979). The manner in which family members relate to each other, and the

transactional patterns that develop create a system where violence is maintained. Goldner

et al. (1990) note that in their work, on a systemic level, they are interested in the

transactional sequences, especially positive feedback loops, which are the immediate

"cause" of the escalations that lead to violence, as well as all the double binding processes

between the couple, the extended families, and the treatment and social service contexts

that constitute the problem-maintaining system. Geffer et al. (1989) explain that in

viewing the family as a system, the violent behaviour is seen to maintain equilibrium or

homeostasis. Internal or external stressors unbalance the family system, which leads to

instability in the relationship, and this leads to the violence that then stabilizes the

system.

Family systems theories have been criticized by the feminist movement because of

the tendency to blame women for the violence. At best traditional family systems

approaches watered down the batterer's responsibility for the violence. In terms of a

public response more emphasis was placed on why women remained in abusive

relationships as opposed to why men were violent in the first place. Feminists can be

credited for challenging traditional family systems approaches and for the evolution of

feminist informed practice with families.

Currently, integrated multi-causal models of domestic violence are becoming

increasingly popular. Gelles (1983) notes that multi-causal models of child abuse were

developed long before models of domestic violence. Goldner et al. (1990) developed a

model which integrates psychoanalytic, social learning, systemic, and socio-political perspectives into its treatment program. This approach takes into account the multi-determined nature of domestic violence and develops it into a comprehensive treatment approach.

The Impact of Abuse on Children

Before proceeding to looking at the treatment of family violence it is important to look at the impact on family members. Views of the impact of violence on families vary according to which theory of the etiology of violence is subscribed to. For example, linear theories consider the impact to be isolated to the people involved whereas multidimensional theories interpret a ripple effect from violence. To streamline this discussion the impact of violence will be discussed using a multidimensional view of the etiology of violence.

The impact of abuse on children is difficult to identify specifically because "most research is retrospective and this limits our ability to detect causal relations" (Garbarino, 1987, p. 299). Clearly however, children do experience not just the physical harm from abuse but also psychological and emotional consequences. Clear conclusions are difficult to draw due to the miriad of factors at play. In a comprehensive review of the consequences of abuse and neglect. Martin (1980) identified three major forms of harm: medical problems (ranging from nutritional deficiencies to hearing loss to brain damage); developmental problems (from mental retardation to language deficiencies to impaired motor skills); and psychological problems (encompassing the extremes on most dimensions for example being either very shy and inhibited or very aggressive and provocative, as well as general unhappiness, poor attachment, and inadequate peer relations).

Garbarino (1987) proposed applying an ecological framework towards organizing the knowledge about child maltreatment. This perspective allows us to look at how the child and the systems surrounding him or her are affected and the interactive relationships

both within and between those environments. It also incorporates bio-social aspects of each individual child and explains the inter-relationship between the two. Child development is incorporated in this framework because of the interplay between biological factors and the child's environment and primary relationships. "Our evolved biology sets an agenda for environmental influences on the organism's growth and development" (Garbarino, 1987, p. 302).

Garbarino (1987) also discusses the importance of attachment as a cornerstone to healthy child development as well as a potential mediating factor against the harmful effects of abuse and neglect. Because the human organism is primed to make extreme investments to establish and maintain attachment, the consequences to the child of a parent who impedes this process are likely to be grave. If we view child maltreatment as a threat or impediment to attachment then we should expect that maltreated children will suffer developmentally for their efforts to fulfill the biological script for attachment (Garbarino, 1987).

Garbarino (1987) looked at mediating factors of child maltreatment in different systems. These factors are important in understanding the impact of abuse and the interplay and multidimensional nature of violence. He discusses five levels: (a) organism, (b) microsystem, (c) mesosystem, (d) exosystem, and (e) macrosystem. Of particular interest is the role of microsystems in terms of what else is going on in the family that may affect the damage done by maltreatment, and what other microsystems the child participates in. For example, a study conducted by Hunter and Kilstrom (1979) suggests that the efforts of non-abusive parents within a family can be very significant in reducing the damage done to the child by an abusive parent. In looking at the mesosystem level, the family's interconnectedness with other social systems (families, peer groups, religious organizations, recreational groups, etc.) may have a mediating affect. Not only do these systems offer support to families they can also make up for parenting deficits and share in the rearing and socialization of children.

Exosystem factors are at play in terms of institutional policy and practice which affect victims of child maltreatment. Macrosystemic factors indicate the components of political ideology, for example the laws and values which protect family privacy. Risk factors and mediating factors combine in a multidimensional way at all of the different system levels.

As with physical abuse, the psychological and emotional trauma caused by sexual abuse is often of greater concern than physical trauma. The same factors considered in Garbarino's framework are also relevant to child sexual abuse. Further complexity is added to the issue due to the inherent secrecy of the act, the social and legal consequences for the abuser and the family and the fact that it cannot occur in the process of "normal child rearing" as can physical abuse.

Because of these complexities, the impact of sexual abuse is experienced differently that physical abuse. Browne and Finkelhor (1986) note that research on the initial effects of child sexual abuse identify anxiety, reactions of fear, depression, anger, hostility and inappropriate sexual behaviour to be commonly associated with sexual abuse. Long-term effects include depression, self-destructive behaviour, anxiety, feelings of isolation and stigma, poor self-esteem, a tendency toward revictimization, and substance abuse (Browne & Finkelhor, 1986). The emotional impact is a result of the damaging interaction which occurs with sexual abuse. Browne and Finkelhor (1986) explain that the sexual abuse creates trauma by distorting the child's self-concept, world view, and affective capacities.

The final section in looking at the impact of violence on children is the impact of domestic violence. This area is relatively new. Research exists to suggest that children are affected by their parents' violence and manifest certain symptoms. It is difficult to know conclusively whether the symptoms exhibited by children are a result of the traumatic reaction or by dysfunctional family characteristics which coexist with the violence. Silvern and Kaersvang (1989) posit that witnessing violence has costs, independent of the other

adverse influences often present in violent homes. They suggest that the impact of trauma is exacerbated by the fact that it is a result of intentional human action which shatters trust in relationships and that there is an element of self-blame for the child particularly when the conflict is related to child rearing which is often the case. They state that witnessing parental spousal abuse entails the fear, helplessness, and over stimulation that are at the crux of trauma (Silvern & Kaersvang, 1989).

In addition to what the child experiences directly there can be a backdrop of family dysfunction which compounds the problem. Elbow (1982) suggests that the dysfunctional patterns of the violent marriage impair the ability of the parents to meet the developmental needs of their children. Children learn that violence is an acceptable way to resolve conflict, and they experience anxiety around self-control issues. Elbow (1982) also suggests that family violence contributes to dysfunctional structure:

> The parents' poor self-image and excessive stereo-typical role expectations place a burden upon the children, because they feel a need to help their parents feel better about themselves. The symbiotic and ambivalent nature of their relationship contributes to the tendency to form parent-child alliances as opposed to the establishment of a firm parental coalition. Together these factors tend to contribute to confused generational boundaries and role reversal patterns. (p. 467)

David Wolfe and Peter Jaffe are credited for their research in the area of the effects of witnessing domestic violence on children. In their research they concluded that children who were exposed to domestic violence suffered behaviour problems in the clinical range at a rate of 2.5 times that of children from non-violent homes (Wolfe et al., 1985). Wilson, Cameron, Jaffe, and Wolfe (1989) note that children learn six lessons from violent parents:

> (a) violence is an appropriate form of conflict resolution; (b) violence has a place within the family interaction; (c) if violence is reported to others in the community, including mental health and criminal justice professionals, there are few, if any

consequences; (d) sexism, as defined by an inequality of power, decision-making ability, and roles within the family, is to be encouraged; (e) violence is an appropriate means of stress management; and (f) victims of violence are, at best to tolerate this behaviour and at worst, to examine their responsibility in bringing on the violence (p. 180).

Impact of Violence on Women

A full review of the impact of wife abuse is beyond the scope of this section however, an exploration of the specific effects of violence on women will be explored. This is highly relevant in terms of understanding treatment implications as well as in understanding how this violence, because it is so devastating, has far reaching consequences for the woman, the couple, and the family.

Women who suffer severe abuse have four times the rate of depression, psychosomatic complaints, and suicide attempts than do women who are not victims of violence (Stets & Straus, 1990 cited in Trute, 1997). Clearly violence has an emotional impact on women and as a result their ability to make decisions around their own safety may be affected. Harway (1993) notes that the diminished decision-making and problem-solving abilities that some researchers describe in battered women could well be the result of repeated exposure to trauma. For women who have experienced abusive relationships in childhood, the impact of wife abuse may be exacerbated. Harway (1993) notes that therapists need to assess not only for current battering, but also for concurrent sexual abuse, past adult sexual abuse, and childhood sexual abuse.

From a multi-dimensional perspective there are multiple layers of factors which result in violence occurring in a relationship as previously discussed and also factors which perpetuate the violence and ensure the woman will remain in the abusive relationship. Goldner et al. (1990) argue that abusive relationships exemplify, in extremis, the stereotypical gender arrangements that structure intimacy between men and women generally. Their work with violent couples involves looking at how men and women are

socialized into their gendered positions in their relationships. When violence occurs in a relationship, both the abuser and victim are affected often in ways that perpetuate the violence. It is important to note however that "there are no specific personality traits which would suggest a victim prone personality" (Walker, 1984, p.7). Some factors make a woman susceptible (Walker, 1984) however, "male violence is both willful and impulse-ridden, and it represents a conscious strategy of control, and frightening, disorienting loss of control" (Goldner et al, 1990, p. 346).

The theory of learned helplessness explains how violence can keep women connected to their partners. It was hypothesized by Walker (1979) that early social influences on women facilitate a psychological condition called "learned helplessness" which causes women to feel powerless to effect positive control over their lives. It was suggested that learned helplessness is responsible for the apparent emotional, cognitive, and behavioral deficits observed in the battered woman, which negatively influence her leaving a relationship after the battering occurs (Walker, 1979). She explained further that childhood socialization practices that encourage passivity and dependency may increase a women's vulnerability to developing learned helplessness in a battering relationship (Walker, 1984.)

The second major theory that has implications for the battered woman and her relationship with the batterer is the cycle of violence itself. Walker (1984) describes it as follows:

The theory tested was that battering is neither random or constant, but rather occurs in repeated cycles. each having three phases. The first is a period of tension-building, which leads to phase two, or the acute battering incident. The third phase consists of kind, loving, contrite behavior displayed by the batterer toward the woman, which provides the reinforcement for the cycle" (p. 2).

The cycle of violence is connected to the pattern of learned helplessness. During the first phase of tension building, the woman will often try to placate the batterer and

may avoid responding to his hostile outbursts. "Often she succeeds for a little while which reinforces her unrealistic belief that she can control his behavior. It also becomes part of the unpredictable non-contingency/response/outcome pattern which creates the "learned helplessness" (Walker, 1984, p. 95). These theories help explain the impact of violence on women and on the relationship and helps to answer the question about why women choose to stay in the relationship.

Violent Men in Relationships

Men need to be held accountable for their actions but they also need to be understood. Less is known about abusers because "they tend to deny their violent acts, minimize their intentions or results, project blame onto victims, or simply refuse to cooperate" (Pagelow, 1984, p. 324). What we know however, is that as with women, males are influenced by the values of patriarchal society and their socialization results in certain entitlement, power, and privilege. This belief system can lead to conflict with relationships between men and women and conflict can lead to violence. Despite these universal influences most men do not abuse their wives. Walker (1984) states that violence does not come from the interaction of the partners in the relationships, but rather the violence comes from the batterer's learned behavioral responses. Pagelow (1984) identifies eleven common features of men who abuse their wives: low self-esteem, traditionalists, emotionally inexpressive, lack of assertiveness, social isolation, employment problems, alcohol dependency, violence in the home of orientation, authoritarian personalities, moody, and wall punchers.

Walker (1984) notes that the best predictor of future violence is past violence. This includes witnessing receiving and committing violent acts in their childhood home, violent acts towards pets, inanimate objects, or other people, previous criminal record, longer time in military service, and previous expression of violent behavior toward women. If these items are added to a history of temper tantrums, insecurity, need to

keep the environment stable, easily threatened by minor upsets, jealousy, possessiveness, and the ability to be charming, manipulative, and seductive to get what he wants. and hostile, nasty and mean when he doesn't succeed - then the risk for battering becomes very high. If alcohol problems are included, the pattern becomes classic (p. 11).

Walker (1984) also points to additional factors in the relationship which may increase the risk of a man abusing his wife. Socio-economic differences, in particular when the woman has a higher socio-economic status than her husband may place her at greater risk. This suggests an inability on the part of the male to tolerate disparity in status and reveals fundamentally sexist thinking. Men who are much more traditional than women in their attitudes towards women's roles are also at high risk (Walker, 1984). Men who are insecure often need a great deal of nurturance and are very possessive of women's time. Sexual intimacy early in relationships is another factor which has a negative impact on relationships and increases the risk of violence. Finally, abuse of alcohol and drugs is connected to violence but this relationship is unclear and warrants further study.

It is important to note that men are impacted by the cycle of violence and are "rewarded" by the impact of their violent behavior and therefore receive reinforcement. They are caught in this cycle as are women, they feel shame and guilt for their behavior and this, together with their deep insecurities, is often what contributes to their denial and minimization (Walker, 1984).

In addition to being victims of violence themselves, women may be in the position of a non-offending parent if their child/children are abused by their partner. In cases of child sexual abuse, mothers may not be aware that abuse is occurring, or they may be powerless to do anything about it. Many factors will come into play in a mother's response to the sexual victimization of one or more of her children. Often non-offending mothers are dealing with many other personal and social difficulties, such as low

self-esteem and isolation from social networks, which impede their ability to help the victimized child (Trute, et al., 1993). Sgroi and Dana (1982) noted that women often tended to be "psychologically absent" in their relationships with both their husbands and their children. This pattern was the end result of multiple unsuccessful attempts at psychological investment that were either rebuffed or ignored by their mates (Sgroi & Dana, 1982). This psychological absence may then reduce the external inhibitions for an offender.

Finkelhor has noted (1984) that there is growing evidence that when mothers are incapacitated in some way, children are more vulnerable to abuse. Thus a woman's relationship with her child plays a critical role in preventing abuse. This relationship may be impacted by the woman's relationship to the offender. Finkelhor (1984) explains that mothers may be unable to protect children because they themselves are abused and intimidated by tyrannical and domineering men. Even large power imbalances that may stem from differences in education may undercut a woman's ability to be an ally for her children (Finkelhor, 1984).

Treating Child Abuse

Treatment approaches to child abuse vary depending on the theoretical focus. Murphy-Berman (1994) notes that each causal model carries with it certain assumptions about the likely reasons for the development of the initial abuse and neglect problem, and certain notions of what "successful" treatment would look like. When an ecological approach is used, multidimensional factors within the individual, the family, the immediate environment, and the broader culture are examined as interactive systems in the assessment process. Interventions are geared both at helping the individual build his/her personal strengths more effectively, and on altering structures in these individual, family, community, or sociocultural systems to provide a more supportive context in which to live (Murphy-Berman, 1994).

Initial intervention in cases of child abuse is primarily the responsibility of mandated agencies such as Child and Family Services. It has been noted that traditional interventions in child abuse work have resulted in protecting the child from his parents by physically removing the child and placing him/her in foster care (Asen, George, Piper & Stevens, 1989). Although apprehension is still necessary in some cases of child abuse, it is considered only as a last resort after all other options are explored. Social workers have become more informed over the years about the impact of separating children from their parents. Depending on the level of risk, other options exist in terms of intervention beyond simple apprehension.

When an ecological approach is applied, the multiple layers of systems surrounding the family and its relationships with those systems need to be assessed. It is imperative that multiple agencies, as well as informal supports are involved in the process. A thorough assessment of the family's various systems, the potential strengths, and sources of stress need to be identified. Often times, different types of assistance are required such as practical necessities such as food and housing, education may be required around parenting, and therapeutic intervention may be necessary in order to address underlying problems for individuals within the family or for the family as a whole.

Perhaps one of the most challenging aspects of applying an ecological framework to child abuse cases is the conflict that occurs between the various professionals involved with the family. Asen et al. (1989) note that the degree of anxiety among the professionals is frequently far greater than that of the family itself. They add that the management in such cases is frequently marked by successions of case conferences involving large numbers of professional helpers who typically take different views regarding appropriate intervention (Asen et al., 1989). Although the involvement of different systems is necessary to ensure an ecological approach it is nonetheless, challenging.

Intervention models have been developed which are helpful in coordinating work with families where children are at risk of abuse and neglect. For example, the

HOMEBUILDERS program developed out of Washington state targets children who are at risk of entering agency care (Bath & Haapala, 1993). The program has been duplicated in many cities across North America. The program is designed to be short term (between 4 and 8 weeks) and intensive. The service is multidimensional and includes crisis intervention, family therapy, advocacy, home-management, life skills training, and the provision of concrete assistance, with the specific mix of services being tailored to the family's needs (Bath & Haapala, 1993).

This program was developed in an effort to place services to families at the "front end" with the stated objective of reducing the number of children in agency care. The program is appealing from a financial point of view because it is thought to reduce costs by preventing placement in the first place. In most cases the costs of intense, multidimensional treatment is still less than that of placement. The program also recognizes that special training is required of social workers to provide the service. Bath and Haapala (1993) note that HOMEBUILDERS' therapists are trained in a wide variety of therapeutic techniques to have as many options available as possible to work with families. Another identified strength of the program is its use of evaluation to determine its effectiveness.

As the program is still relatively new, the long-term effects of intervention have yet to be determined. An obvious criticism can be directed toward the short-term nature of the intervention, particularly given the often chronic, multiproblem families that are referred to the program. Bath and Haapala (1993) found in their research that although the majority of all children avoided placement, children from neglectful families were almost twice as likely to be placed than children from abusive ones, with those from multiple maltreatment families being at highest risk. Given the existing research the model may need to be modified to allow for longer interventions with families experiencing chronic problems.

Special attention needs to be paid to intervention in cases of child sexual abuse. From an ecological perspective, sexual abuse is a problem which originates in the systems that surround and make up the family. Intervention, in order to be effective, must address the individual and family's relationship with those systems. Tierney and Corwin (1983) explain sexual abuse from a systemic perspective as follows:

> Molestation cannot be explained or predicted on the basis of the personality traits of those involved, or through the identification of pathological family patterns. Rather, it should be seen as occurring in a context consisting of family living patterns that offer an opportunity for such behaviour, a family history which does not rule out the sexual objectification of children, and an absence of outside contacts which encourage role-appropriate behaviour (p. 110).

The multidimensional nature of sexual abuse needs to be considered during the investigation, assessment, and treatment of sexual abuse.

Child sexual abuse is a legal, moral, and mental health problem. For that reason a child's disclosure of sexual abuse will result in the involvement of multiple systems which will include police, child welfare, medical and mental health services. The different mandates of these agencies can create a powerful intrusion in the lives of children and their families with different professionals inquiring in a repetitive, yet seemingly uncoordinated manner (Trute, Adkins, MacDonald, Vaughan-Jones & Fedoruk, 1989). For many families the stress of the intrusion of these multiple systems may outweigh the stress of the sexual abuse itself.

Special attention needs to be paid to the victim and the non-offending parent, or parents to assist them in coping with the initial disclosure and its impact on the family as well as in dealing with the different agencies that will become involved. Trute et al. (1989) note that mothers often hold the key position in the recovery process both for the victim and for the family as a whole. Mothers respond in a variety of ways to their children's disclosure depending on a variety of issues including their own previous sexual

victimization. Many need assistance in order to respond in a way that is protective and supportive to their child. Trute et al. (1989) suggest that when short-term crisis services are available to non-offending parents immediately following a disclosure, it can protect victims from long-term deleterious effects of sexual abuse, as well as stress from the involvement of multiple agencies such as police, the legal system, and child protection services.

This approach is ecological in that it recognizes the need for intervention with systems within the family beginning with individual work with the mother and child. Individual therapy with mothers of incest victims is a necessary precursor to involvement in other modalities of therapy (Trute et al., 1989). Where possible conjoint work with the mother and child should begin. This can serve to join more closely the victim and the non-offending parent in a shared understanding of the circumstances of the abuse, and enhance their positive mutual connectedness to each other through this time of stress and insecurity (Trute, et al., 1989). In considering treating child sexual abuse from an ecological perspective, intervention must focus on the systems that surround the child and their ability to restructure in a way that meets the child's needs.

Treating Domestic Violence

Just as the theory of etiology of domestic violence has changed over the years so too has the professional response to the problem. Society responds on a multitude of levels as previously discussed; legal, political, social, individual, and familial. Counselling is one of the ways the problem can be addressed on an individual and familial level. Today there are a variety of treatment options available to families who are experiencing domestic violence. Four types of intervention will be discussed; women's shelters, men's groups, intervention for children, and family therapy. Depending on the nature of the violence, and who is involved it is possible that different therapy modalities may be used with the members of one family. For example a woman who is experiencing violence from

her partner may leave the relationship, and attend a women's shelter. Her partner may attend a men's group and receive counselling in anger management, then the couple may reconcile through a process of family or couple therapy.

The primary issue when intervening in cases of domestic violence is the victim's safety. For that reason certain interventions are considered more appropriate at different times depending on the safety of the victim, and the risk of violence. Trute (1997) proposes that intervention in cases of domestic violence be conceptualized into two phases. Phase I involves gender-specific (i.e., separate for men and women) group and individual therapies (Trute, 1997). Phase II treatment involves couple and family therapy and can only begin when the battering has stopped, when the woman believes she is safe and when both partners express a commitment to their relationship (Trute, 1997). It should also be noted that regardless of the type of intervention, or the stage of treatment it cannot be assumed that the battered woman wants to leave the relationship or wants to stay. Therapists should be cautious not to counsel women to leave and should not make efforts to maintain the relationship at all costs. The choice belongs to the members of the couple.

Treatment for Battered Women

Women's shelters are one of the ways that women seek assistance and safety from abusive relationships. Although women's shelters are not therapy in and of themselves, their development and evolution are important in understanding society's professional response to family violence. Women's shelters grew out of the feminist movement of the '60s and '70s. Women who were living with violent partners were turning more and more to women's centers for crisis assistance as they lacked other housing alternatives and had few resources to help them escape from the violence (Gilman, 1988). Until this time, sheltering for homeless women had been most often provided by religious or other philanthropic organizations. The philosophy of the shelter was to provide the woman with the physical and psychological space apart from her batterer that could allow her to

reflect upon her situation and her future and achieve a more balanced perspective (Gilman, 1988).

Different shelter ideologies have developed over time. Diversity in perspectives has led to considerable debate about appropriate shelter goals and functions. Particularly contentious has been the dispute about whether professional counselling is a necessary service or whether battered women simply need an opportunity for respite, self-healing and life planning (Russell, 1990). In one study conducted by Russell (1990) with four shelters across Canada, residents themselves placed a high value on individual counselling. In most instances counselling was perceived as increasing self-esteem and the ability to function independently. Russell (1990) also noted that group programs were not widely supported by women attending shelters. She writes "the lack of wholehearted endorsement of groups may reflect the absence of a common perspective among women using shelters, a diversity of life experiences that precludes the development of a communal ethos, or simply the inability to perceive larger issues in the face of critical personal problems" (p. 26). Although the role of shelters was initially to provide a safe place for women, in most cases it has evolved to also include the provision of counselling in order that women have an opportunity to receive emotional support and information.

Gender specific treatment has an important role in the intervention of domestic violence. Women's shelters, as well as other counselling agencies who see battered women, must place the emphasis on the women's safety and potential strengths. Trute (1997) emphasizes that at this stage the services should assist victims to protect themselves and their children, strengthen their self-esteem, and facilitate choice in relationships. Individual work with battered women needs to extend beyond the treatment of the psychological effects of the violence. Battered women possess certain strengths as a result of having to cope in an abusive environment. Harway (1993) notes that battered women possess strength, persistence, and survival skills, in contrast to their widely portrayed weakness and passivity.

Treatment for Men Who Batter

Batterer programs were founded in the late seventies largely in collaboration with the battered women's movement to complement the work of nearly 1,000 women's shelters (in the United States). With more recent prompting from the criminal justice system and the advent of family service efforts, some 200 batterer programs have been established, and many more are being developed. The great diversity of approaches and techniques has, however, brought controversy as well as confusion to the field (Caesar & Hamberger, 1989). In the overall history of the movement, the establishment of programs for batterers has not paralleled the proliferation of shelters and services for women (Caesar & Hamberger, 1989). Emphasis was placed on helping the woman leave her abusive partner, therefore the batterer was not included in counselling. Caesar and Hamberger (1989) note that many men's programs developed only after programs were developed to provide safety, support, and empowerment to battered women.

The lag in resources for men has been connected to the lack of demand for counselling from the men themselves. Since most men who batter believe their battering behavior is either justified or a normal male prerogative, they do not see that their behavior is a problem for themselves let alone for others (Pressman, 1984). Since they tend to minimize the behaviours and are not empathic regarding the feelings of their victims, they do not see how the behavior is detrimental to their relationship, to intimacy, to trust and is consequently harmful to themselves as well as their partners (Pressman, 1984). Thus their denial runs deep and they are unlikely to request help unless ordered to by the court, or they are in such crisis as a result of their partner leaving that they are prompted to seek help. Because battering partners generally are very dependent upon their partners and believe they cannot function without them, the woman's departure is enormously frightening, stressful, and even devastating (Pressman, 1984).

Perhaps a shift in societal attitudes contributed to the increased availability of counselling for men who batter. Given the shame and stigma associated with the act it is

difficult for men to be open about their violence in light of the social and legal consequences. Although men need to be held accountable for their behavior, they can also be given the opportunity to change. Counselling for violent men is becoming established as an appropriate intervention to stop the violence (Gilman, 1988). Gender-specific treatment for men is an important first step to ending violence. Trute (1997) notes that during this stage batterers should address individual belief systems (challenging patriarchal and oppressive views) and be assisted with individual behavioural control (identifying and regulating angry affect).

Group work, using a gender specific approach, is a common treatment modality for men who batter. The group enables men to decrease their isolation and diminish dependency on their victims. Through sharing their feelings, the men begin to form ties with their peers and learn to trust other men. Groups are thought to be more successful in confronting denial and giving support when changes in behavior begin (Pressman, 1984). Pressman (1984) identifies the following treatment issues for battering men:

1. Denial and minimization of violent behavior.

2. Externalizing blame.

3. Developing ability to control expressions of anger.

4. Making connections between early experienced learning and current behavior.

5. Developing motivation to seek help other than fear of imprisonment or loss.

6. Overcoming impulsive behavior: developing ability to make decisions with critical thought and awareness of consequences.

7. Identifying and expressing feelings other than anger.

8. Expressing needs in non-demanding ways (assertiveness training).

9. Developing a broader view of male-female roles, interaction and characteristics.

10. Developing trust in others.

11. Building support networks.

12. Self-esteem.

13. Tendency to be suicidal (p. 60).

These are some of the issues addressed in group therapy for men who batter. In some instances group therapy is not indicated: the presence of psychotic symptoms, substance abuse unless a man is in concurrent treatment for substance abuse, brain injury, psychopathic disturbance, and extreme resistance (Pressman, 1984). Individual treatment can be considered in instances where group work is not considered appropriate.

Treatment For Children

The effects of domestic violence on children has been considered more recently, and consequently treatment of children who have witnessed family violence is receiving more attention. Elbow (1982) posits that with a few exceptions, mental health professionals have overlooked the needs of such children unless they become victims of physical or sexual abuse. One indication of this oversight is the paucity of articles devoted to the impact of conjugal violence on children. Secondly, emphasis on social learning theory as an explanation of the perpetuation of family violence obscures the intensity of the anxiety, fear, conflict, and guilt children experience as they witness parental conflict or are drawn into it (Elbow, 1982).

Henderson (1990) found in reviewing the literature that there is clear evidence that witnessing violence has long-term effects on children. She also states that there are a number of studies that have looked at both the abuser and the abused in terms of their exposure to violence in their families of origin. The connection between experiences of violence in childhood and an increased likelihood of subsequent behavior is generally agreed upon. This clearly underlines the importance of intervening with the children in order to break the cycle of abuse as it moves through the generations at a devastating social cost (Henderson, 1990).

Children are affected by witnessing violence in a variety of ways depending on the family structure. developmental stage of the child, presence of siblings, degree and nature of violence. Treatment can occur with children while they are at the shelter with their mother. or congruently while the parents are receiving counselling. Pressman (1984) identifies the following treatment issues for children.

1. Learning norms of behaviour regarding violence.

2. Dealing with ambivalence about the abuser.

3. Loss and mourning when mother separates from father.

4. Dealing with the denigrating words of fathers regarding mothers when children have visits with him.

5. Helping mother be open with the children regarding her decision to leave and reasons for leaving.

6. Role-modeling of male-female relationships and non-violent males.

7. Appropriate expression of feelings rather than withdrawal and aggression.

8. Individuation when children are fused with mother.

9. Support networks for stability (school, Big Brothers, YMCA, Program).

10. Appropriate child role as opposed to parentified child and support for mother.

11. Self-esteem

12. Trust (p. 43).

These issues can be addressed during group therapy, or individual therapy with children.

Elbow (1982) discusses the impact that family violence has on the parent-child relationship and that these effects have a potentially damaging impact on children. Several practice recommendations are made for social workers to address the issues that are present in the parent-child relationship when domestic violence occurs. The first is assessment which also includes assessing the parents' perceptions of the children's

involvement in and reactions to parental conflict. She writes: "Included in this assessment should be the parents' sensitivity of denial of the impact of their violence on the children, parent-child coalitions, the expectation of the children, and the presence or absence of behavioral or emotional disorders" (Elbow, 1982, p. 470). She identifies the need for social workers to help parents, individually or as a couple break the pattern of drawing the children into the arena of conflict. The third area of recommendations pertains to parental leadership. This addresses the tendency toward forming parent-child alliances. Clarification of generational boundaries can be improved as the parents develop skills in setting limits and following through with consequences (Elbow, 1982).

Elbow (1982) identifies communication as another area that requires intervention. She cautions that the concept of allowing verbal expression of feelings and needs is often resisted, because feelings are often equated with inadequacy and loss of control. She concludes that in addition to individual, marital, or family counselling, group work or individual casework with the children may also be indicated, especially if the parents have difficulty establishing their leadership role.

Family Therapy as Treatment for Domestic Violence

Providing family therapy to families where violence has occurred is relatively new. The premise of family therapy is that the family is a functioning organism with no single member as the identified patient. This premise protects individual family members from being labeled as 'the problem'(Pressman, 1984). When applied to families experiencing violence this can be problematic as batterers may feel they are not fully responsible for their behavior. Bograd (1992) suggests that systems formulations still either implicate battered women or diffuse responsibility for male violence in spite of ample evidence that the abuser produces his own behavior through self-talk and self-created arousal patterns independent of the women's current behavior, interpersonal style, belief systems, or family history. Feminist writers have gone so far as to question the appropriateness of family therapy for treatment of couples involved in domestic violence because its focus on the

couple defuses the batterer's responsibility for his actions (Hansen & Harway, 1993).
Many family systems theory concepts such as reciprocity, enmeshment, hierarchy and
boundaries. negate female experience, are patriarchal, and ignore the social reality of
women by failing to take gender into account. For example Walters, Carter, Papp and
Silverstien (1988) suggest that systems therapy discriminates against women by seeking
balance and equilibrium through role complementarity for the family system as a unit,
without addressing the unequal access of each individual to choice of role. Other concepts
such as circular causality are of particular concern as it connotes that the responsibility
for abusive behavior is shared by all members. This concept has contributed to
mother-blaming in family violence situations.

Feminist theorists and practitioners can be credited with encouraging family
therapists to rethink their traditional theories and make modifications to them. Masson
and O'Byrne (1990) posit that systemic ideas can be used to integrate feminist principles
with family therapy and thereby improve it. For example, women can be encouraged to
draw a "boundary" around themselves rather than seeing themselves in terms of their
relationships with others. Thus family systems theory need not be rejected outright on the
basis of valid criticism from feminist theorists, but rather the perspectives can be
integrated to create a feminist informed, family systems approach.

There is growing support from clinicians to combine feminist and family systems
perspectives (Breunlin, Schwartz, & Kune-Karrer, 1992; Goldner, Penn, Shienberg, &
Walker, 1990; Hansen & Harway, 1993; Trute, 1997; Walters, Carter, Papp, &
Silverstien, 1988). Goldner et al.(1990) identified 3 basic assumptions in their clinical
work which are necessary to effectively combine systems and feminist perspectives:

(1) Gender inequality is a social reality and women who are beaten by men are their
victims. At the same time, reciprocities and complementary patterns in the couple's
relationship are implicated in the cycle of violence.

(2) At an ethical level. the batterer is held responsible for the violence and intimidation,

and the woman is held responsible for protecting herself, to the extent that it is possible.

(3) Social control is sometimes necessary to stop the violence, and violence is a criminal act for which legal sanctions are appropriate. (p. 345).

When therapists recognize how gender shapes the roles of family members they are closer to feminist informed practice.

In reviewing how family violence is treated by the helping professions all approaches described above are treatment options for individuals and families. It is the responsibility of the practitioner, however, to ensure the appropriate treatment is provided regardless of what family members request. Many abusers consider family therapy to be the treatment of choice because of the illusion of shared responsibility for the problem. Consideration should be given by the clinician as to what means of intervention is appropriate at what time.

As previously discussed, Trute (1998) proposed that intervention in cases of domestic violence can be conceptualized into two phases. The first is gender-specific, and aimed primarily at stopping the violence, and helping the victim to keep herself safe. Family therapy is considered a second phase intervention which can begin only after the violence has stopped. Trute (1998) identifies six clinical criteria which should be considered before couple or family therapy can begin. First, the therapist must determine whether the victim is safe from physical violence during therapy. For most couples this will mean that the perpetrator has "graduated" from a group treatment program, he understands he is responsible for is own use of violence, and he has demonstrated that he is capable of self-control (Trute, 1998). Secondly, the severity of past abuse needs to be assessed, and consideration should be given to whether to involve men who have been extremely violent, in conjoint therapy. Gelles and Maynard (1987) also note that in cases of severe and life-threatening violence it is clearly inappropriate and extremely dangerous to use conjoint or systems interventions. Another consideration for conjoint therapy is

whether fear pervades the relationship. A battered woman may remain fearful even after the violence has ended. Trute (1998) notes that these fears should not be taken lightly or ignored. and need to be directly addressed prior to the initiation of any relationship therapy. The perpetrator's motivation for violence needs to be explored, in particular whether there is mutual violence in the relationship. Trute (1998) also states that it is important to determine whether the couple is emotionally connected in any way, or whether they are just two people living together. And finally, it is important to ascertain the existence of psychosis or major personality disorder, or addiction by either, or both partners. Trute (1998) states that couple counselling is not appropriate for men suffering from psychosis or major personality disorder, and in cases of addiction, these problems should be addressed individually before couple counselling begins.

In conclusion, there are a variety of treatment approaches aimed at addressing domestic violence. Safety of the victim of violence is the primary consideration, and should guide therapists' thinking in terms of implementing, or referring to a specific approach. Systems approaches such as family therapy and conjoint therapy can be used in the treatment of domestic violence, but only once the violence has stopped. Careful assessment needs to occur in order to determine whether a couple is appropriate for conjoint therapy. Without proper screening, women may be put at greater risk as a direct result of the intervention.

This review of the family violence literature has highlighted the key aspects of child abuse and domestic violence. Of particular relevance were the underlying systems within the family, and society which support the existance of these problems, and contribute to their perpetuation. This provides a framework upon which to proceed with further examination of the literature as it relates more specifically to conducting family therapy in cases of family violence.

Structural Family Therapy

Historical Background

The practice of "therapy" has been around for centuries. Family therapy however, is a relatively new way of looking at and dealing with problems. Family therapy began essentially as a reform movement pitted against orthodox psychiatry and psychotherapy. Whereas some psychiatrists and psychotherapists insisted on locating problems within the identified patient, seminal thinkers such as Don Jackson, Virginia Satir, and Nathan Ackerman pointed to the roles families play in supporting problem behaviour and led the field in developing ways to treat patients by working within the context of the family (Fishman, 1993).

Different approaches to family therapy emerged during its infancy and each contributed to its present day theory and practice. Analytic, transgenerational, communications, humanistic, and cybernetic theories were its greatest influences. In the 1960's no one technique predominated, although the dominant implicit theoretical stance adopted by most therapists was that dysfunctional behaviour was to be viewed as the product of dysfunctional relationships rather than individual pathology (McCown & Johnson, 1993). The patient's context became as important as his or her personality characteristics, and general systems theory was adopted as a means of conceptualizing the context and the interventions within it (Fishman, 1993).

Systems theorists flourished during the period of the late 1960's, when there was money for community programs and for treating the psychosocial problems of the poor (Hoffman, 1981). In 1962, Salvador Minuchin, together with E. H. Auerswald and Charles King, got a research project funded to study and work with families of delinquent boys at Wiltwyck School (Hoffman, 1981). The school served primarily Black and Puerto Rican youngsters from New York city ghettos. Minuchin and his coworkers were attempting an experiment in the application of the budding theory of family therapy to low socioeconomic families (Aponte & Van Deusen, 1981).

McCown and Johnson (1993) note that attempts at serious scientific inquiry by family therapists were rare during the 1960's with the exception of Minuchin and his group, and their work represents some of the first outcome literature in family therapy. Furthermore their work with high risk families allowed them time to refine both theory and technique (McCown & Johnson, 1993). Minuchin and his coworkers developed a therapeutic approach that was founded on the immediacy of the present reality, was oriented to solving problems, and was above all contextual, referring to the social environment that is both a part of and the setting for an event (Aponte & VanDeusen, 1981). Minuchin went on and became the director of the Philadelphia Child Guidance Clinic in 1965 where he collaborated with Jay Haley. There, Minuchin and Haley pioneered what is now known as structural family therapy (McCown & Johnson, 1993).

Basic Concepts

Minuchin (1974) states that family therapy is based on three main assumptions: that context affects inner process, that changes in context produce changes in the individual, and that the therapist's behaviour is significant in change. Structural family therapy emphasizes the importance of the structure of those contexts in which the individual is embedded. The psychological structure of the individual is viewed as interdependent with the person's social structure, and that social structure is treated as the medium through which the individual functions and expresses him/herself (Aponte & VanDeusen, 1981). With respect to the first assumption, Minuchin (1974) explains that an individual's psychic life is not entirely an internal process. The individual influences his/her context and is influenced by it in constantly recurring sequences of interaction. The individual who lives within a family is a member of a social system to which he/she must adapt. His/her actions are governed by the characteristics of the system, and these characteristics include the effects of his own past actions. The individual responds to stresses in other parts of the system, to which he adapts, and he/she may contribute

significantly to stressing other members of the system. The individual can be approached as a subsystem, or part of the system, but the whole must be taken into account (Minuchin, 1974).

The second assumption is that changes in a family structure contribute to changes in the behaviour and the inner psychic process of the members of that system (Minuchin, 1974). People develop their sense of self as a result of interacting with people in their environment. Certain aspects of one's self are expressed in certain environments. Fishman (1993) states that some facets of one's self are problematic. Thus when we want to bring about change in our clients, we must transform their contemporary context such that their more functional facets will be brought out.

The third assumption is when a therapist works with a client or a client's family, his/her behaviour becomes part of the context. The therapist and family join to form a new, therapeutic system, and that system then governs the behavior of its members (Minuchin, 1974). Hoffman (1981) suggests that Minuchin's inclusion of the therapist as an active intruder, changing the family field by his/her very presence is of major therapeutic importance. Hoffman (1981) explains:

> To whom does he speak? Who is allowed to speak? Whom does he elevate? Whom does he challenge? Which persons does he bring together? Which does he push apart? It is by such moves that the therapist begins to restructure the relationship system in the family and to alter the context that supposedly nourishes the symptom (Hoffman, 1981, p. 264).

These basic assumptions form a foundation for structural family therapy. Fishman (1993) states that what distinguishes structural family therapy is that it offers a clear and useful way to assess and treat organizations in which interactions are embedded. The structural aspects of the organizations, and the interactions within it are of key importance. The structure of the social system in relation to its functions provides the parameters by which the therapist will measure the family's adjustment (Aponte &

VanDeusen. 1981). Structural family therapy flows from how a family's organization is conceptualized. and the meaning attributed to the interaction between family members.

The structural organization of families refers to relational patterns common to all families. colored by the personal idiosyncrasies of each family with its traditions, culture and socioeconomic situation, and adapted to its functional requirements (Aponte & VanDeusen. 1981). Minuchin (1974) describes these two systems of constraint which maintain the transactional patterns within a family. The first is a generic system involving the universal rules governing family organization. For example there must be a power hierarchy in which parents and children have different levels of authority. There must also be a complementarity of function with the husband and wife accepting interdependency and operating as a team (Minuchin, 1974). These generic transactional patterns are present in every family system and are based on the necessary functions required of the system. The members of the system structure their relationships in accordance with the requirements of each transaction.

The second system of constraint is idiosyncratic, involving the mutual expectations of particular family members. The origin of these expectations is buried in years of explicit and implicit negotiations among family members, often around small daily events (Minuchin, 1974). What is important about these transactions is that they were functional at one time. and may still be for the family. The repertoire of structures that the family develops to carry out its ongoing functions through their recurring operations takes on a character as unique to each family as the personality structure is to the individual (Aponte & VanDeusen. 1981).

It is these two systems of constraint that enable the system to maintain itself and to complete its necessary functions. It offers resistance to change beyond a certain range, and maintains preferred patterns as long as possible. Alternative patterns are available within the system. But any deviation that goes beyond the system's threshold of tolerance elicits mechanisms which reestablish the accustomed range (Minuchin, 1974). The term

homeostatic maintainer has been used to describe the process by which families regulate themselves and maintain a state of equilibrium. Fishman (1993) explains that homeostasis does not mean a totally static state. lacking in growth and development, but rather a consistent steady state that all living things mush have in order to exist. In the family that is functioning well, the process is fluid and dynamic and by its nature incorporates developmental change even as it lends stability.

Although a family needs to maintain stability in order to function, it must also be flexible. The continued existence of the family as a system depends on a sufficient range of patterns. the availability of alternative transactional patterns, and the flexibility to mobilize them when necessary. Since the family must respond to internal and external changes, it must be able to transform itself in ways that meet new circumstances without losing the continuity that provides a frame of reference for its members (Minuchin, 1974). Fishman (1993) explains that while some forces within the family are striving to adapt to developmental pressures or other stress, one or more other forces are operating to keep it stuck, unable to make the appropriate developmental changes. During therapy with a family in crisis. discovering who or what is functioning to maintain the status quo is key to efficient therapeutic change.

Central to structural family therapy are the concepts of subsystems, boundaries, power. and alignment. The family system differentiates and carries out its functions through subsystems. Individuals are subsystems, within a family. Dyads such has husband-wife or mother-child can be subsystems. Subsystems can be formed by generation. by gender. by interest, or by function (Minuchin, 1974). The boundaries of a subsystem are the rules defining who participates and how. These "rules" dictate who is in and who is out of an operation, and define the roles those who are in will have vis-à-vis each other and the world outside in carrying out that activity (Aponte & VanDeusen, 1981). The function of boundaries is to protect the differentiation of the system. Every family subsystem has specific functions and makes specific demands on its members. The

development of interpersonal skills achieved in these subsystems is predicated on the subsystem's freedom from interference by other subsystem (Minuchin, 1974). For example the skills learned within a sibling group cannot be achieved if there is overinvolvement from parents. The marital subsystem will have closed boundaries to protect the privacy of the spouses. The parental subsystem will have clear boundaries between it and the children, not so impenetrable as to limit the access necessary for good parenting. The sibling subsystem will have its own boundaries and will be organized hierarchically, so that children are given tasks and privileges consonant with sex and age as determined by the family's culture (Hoffman, 1981).

Minuchin (1974) states that the clarity of boundaries within a family is a useful parameter for the evaluation of family functioning. Boundaries can be conceptualized as falling along a continuum, with one extreme being disengaged, and the other enmeshed. In describing a family along this axis, one is addressing questions of differentiation, permeability, and rigidity of boundaries among and between individuals and subgroups in a family, and between the family with its subsystems and its social environment (Aponte & VanDeusen, 1981).

In some families boundaries may become blurred and the emotional distance between family members decreases. Minuchin refers to this pattern of boundary functioning as enmeshed. Members of enmeshed subsystems or families may be handicapped in that the heightened sense of belonging requires a major yielding of autonomy. The lack of subsystem differentiation discourages autonomous exploration and mastery of problems (Minuchin, 1974). Further, the boundaries among some or all of the family members are relatively undifferentiated, permeable and fluid. These family members function as if they are part of each other (Aponte & VanDeusen, 1981).

On the other end of the continuum some families develop overly rigid boundaries. Communication across subsystems is difficult, and the protective functions of the family are handicapped (Minuchin, 1974). This extreme type of boundary functioning is called

disengagement. Family members behave as if they have little to do with one another because within their families their boundaries are so firmly delineated, impermeable, and rigid that the family members tend to go their own ways with little overt dependence on one another for their functioning (Aponte & VanDeusen, 1981). In other words, a system toward the extreme disengaged end of the continuum tolerates a wide range of individual variations in its members. Stresses in one family member do not cross over its inappropriately rigid boundaries (Minuchin, 1974).

It is important when considering the concept of boundary to acknowledge that there is a wide normal range of functioning that most families fall into. Secondly, the level of disengagement or enmeshment may vary depending on the function of the subsystem. Minuchin (1974) states that in human terms, enmeshment and disengagement refer to a transactional style, or preference for a type of interaction, not to a qualitative difference between functional and dysfunctional. Most families have enmeshed and disengaged systems. For example, a parent-child subsystem can tend toward disengagement as the children grow and finally begin to separate from the family. Aponte and VanDeusen (1981) state that it is not the structures themselves that communicate whether they are functional or dysfunctional. It is whether the boundary functioning, be it enmeshed or disengaged, supports the family's symptomatic behaviour.

When the concepts of boundary and subsystems are applied to assessing family functioning a picture begins to emerge from which the intervention will flow. Structural family therapy is based on a model of normative family functioning. Therapy, from a structural point of view, consists of redesigning family organization so that it will approximate this normative model more closely (Hoffman, 1981).

Minuchin (1974) looks at the structure and function of three important subsystems in families: the spousal subsystem, the parental subsystem, and the sibling subsystem. He states that the main skills required of the spousal subsystem to function and perform its tasks are complementarity and mutual accommodation. Both husband and wife must yield

part of their separateness to gain belonging (Minuchin, 1974). The individuals within the spouse subsystem need each other for support in order to cope with the stress they are experiencing from the multiple demands of life.

Families with children also have a parental subsystem. The spouse subsystem in an intact family must now differentiate to perform the tasks of socializing a child without losing the mutual support that should characterize the spouse subsystem (Minuchin, 1974). As the child grows, his/her developmental demand for both autonomy and guidance impose demands on the parental subsystem, which must be modified to meet them. The parenting process differs depending on the children's age. When the children are very young, nurturing functions predominate. Control and guidance assume more importance later. As the child matures, especially during adolescence, the demands made by parents begin to conflict with the children's demands for age-appropriate autonomy (Minuchin, 1974). Functional families will adapt to their children's changing developmental needs at the same time maintaining the integrity of the spousal and parental subsystems. Structural family therapy recognizes the normal difficulties of negotiation inherent in the family life cycle (Masson & O'Byrne, 1990).

Finally, the sibling subsystem is where children learn to relate to one another, and develop skills that will assist them in developing peer relationships and dealing with the outside world. They also bring experience of the outside world into the sibling subsystem. The boundaries of the sibling subsystem should protect the children from adult interference, so that they can exercise their right to privacy, have their own areas of interest, and be free to fumble as they explore (Minuchin, 1974).

Alignment is another concept along with subsystems and boundaries which helps to conceptualize family structure. Alignment is described as the joining or opposition of one member of a system to another in carrying out an operation (Aponte & VanDeusen, 1981). For example, if a father agrees on the mother's discipline of the children he is aligned with her. In well functioning families, members can shift alignments flexibly

depending on the issue. The term stable coalition is used to describe the joining together of family members against another so that the pattern becomes a dominant, inflexible characteristic of their relationship (Aponte & VanDeusen, 1981). This structure can be a source of internal stress and lead to symptoms in one or more family members.

Another form of problematic structure related to alignment includes the detouring coalition. This is a form of stable coalition which is distinguished by its intent to diffuse the stress between the members of a coalition by designating another party as the source of their problem and assuming an attacking or solicitous attitude toward this person (Aponte & VanDeusen, 1981). For example spouses who are experiencing marital breakdown and stress may enter a coalition with their child who becomes the symptom bearer thereby supporting the system. Triangulation refers to two opposing parties seeking to join with the same person against the other, with the third party finding it necessary, for whatever reason, to cooperate now with one and then with another of these opposing parties (Aponte & VanDeusen, 1981). For example if conflict exists between the mother and father the conflict may be triangulated through a child. One parent may align with the child against the other parent, forcing the child to cooperate, while the other parent also attempts to align with the child.

Power is the third structural dimension of transactions most often identified with structural family therapy along with boundary and alignment. It is described as the relative influence of each member on the outcome of an activity (Aponte & VanDeusen, 1981). Power, as defined by structural therapy, refers to a characteristic of the social interaction, not of the individual. Aponte and VanDeusen (1981) state that the basic structural problem with power is the lack of functional power in the system. It is the generic problem for individuals or groups who are not able and/or allowed to exercise the force necessary to carry out functions appropriate to them in the system in which they are operating. An example is parents who do not have the leverage to direct and discipline their children.

Assessing Family Structure

The key concepts described above provide a framework for assessing family functioning. This section will provide further conceptualization of family structure as it relates to the development of problems in families. Families are constantly adapting to changes and stressors from a variety of sources including individuals within the family, subgroups, and pressures that are external to the family unit. The family structure must be adequate to, and harmonious with, functions of its members, its subgroups and the social environment. If it is not, the family has the capacity to generate new structures (Aponte & VanDeusen, 1981). It is through the process of developing new structures and by adapting to change that families grow and develop in a way that promotes the well-being of its members.

Adapting to new situations can be stressful, and families may experience anxiety and resistance in the face of change. This is to be expected and Minuchin (1974) cautions that practitioners need to be careful not to label a family as pathological because it is experiencing a transition. This process is better conceptualized as families in transitional situations, suffering the pains of accommodation to new circumstances. The label of pathology is reserved for families who in the face of stress increase the rigidity of their transactional patterns and boundaries and avoid or resist any exploration of alternatives (Minuchin, 1974).

Families respond in a variety of ways to new situations. Fishman (1993) explains that some systems respond by transforming the rules under which they operate, thereby allowing new behaviours, functionally more appropriate to the new structure, to be expressed. In other systems, the stress on the family is prolonged and the result is the emergence of medical or psychological symptoms. In average families, the therapist relies on the mobilization of the family resources as a pathway to transformation. In pathological families, the therapist needs to become an actor in the family drama, entering

into transitional coalitions in order to skew the system and develop a different level of homeostasis (Minuchin, 1974).

Minuchin (1974) identifies four areas from where stress can originate: stressful contact of one member, or of the whole family, with extrafamilial forces; transitional points in the family's evolution; and idiosyncratic problems. When a family member is experiencing stress outside the family this may be felt by other family members. How this stress gets resolved reflects the functionality and the structure of the transactional patterns. Minuchin (1974) gives the example of a mother and father who are both stressed at work and come home and criticize each other but then detour their conflict by attacking a child. This reduces the danger to the spouse subsystem, but stresses the child. Through this analysis, the therapist identifies the source of the stress and its impact of the system.

Secondly, an entire family may come into contact with extrafamilial forces which stress the system. Family coping mechanisms for example are particularly threatened by poverty and discrimination (Minuchin, 1974). Careful attention should be paid to the family and its relationship with the larger environment. The eco-structural approach to therapy, which is a part of structural family therapy, is an effort to include, along with the family, other social systems as contributors to the structure of human behaviour and to work through all these systems to achieve change (Aponte & VanDeusen, 1981). In assessing stressful contact with extrafamilial forces the therapist must consider the impact on the family, and intervention may need to include altering the structure of those relationships. Fishman (1993) emphasizes that the social context that impinges on the nuclear family can and usually does, include people and forces well beyond the family's bounds. To address fully the needs of the modern family, one must work to transform these outside social forces as well as the forces within the family.

Stress encountered at transitional points in the family's life cycle may also be problematic. Families, like all living systems, have tendencies toward both equilibrium and evolution. During the course of a family's life, there are destabilizing developmental

pressures that disrupt equilibrium and challenge the family to evolve (Fishman, 1993).
During this process new subsystems must appear, and new lines of differentiation must be
drawn. Conflicts inevitably arise during this time which if resolved will lead to growth. If
they are not resolved. then transitional problems lead to further problems (Minuchin,
1974). A classic example is a family with a child who is becoming an adolescent. A
structural shift takes place as the child, through a normal developmental process, is more
exposed to the world outside the family. The relationship between the parent and child
changes and should reflect increased autonomy consistent with a parent-young adult
relationship. When this transition is blocked, conflict will occur which, depending on the
severity, may impact and involve the entire family. Families go through numerous
transitional points which can be a result of developmental changes in family members, as
well as absorbing a new member, or adapting to decreased membership through death,
separation or divorce.

Minuchin (1974) identifies the third source of stress on families to be around
idiosyncratic problems. Families may have unique difficulties that appear outside of what
most families would normally encounter. For example if a family member becomes
seriously ill. some of his or her functions and power must be allocated to other family
members. This redistribution requires adaptation in the family. When the sick member
recovers, a readaptation to include him/her in his/her old position or to help him/her take a
new position in the system becomes necessary (Minuchin, 1974).

It is important therefore to consider the source of stress for families and how
families are structuring themselves to cope with this stress. If the family is presenting for
therapy then more than likely it is having difficulty in negotiating a structure that fits with
its changing context. Fishman (1993) developed an assessment model which includes
assessing family structure, developmental pressures on the family, the history of the
system, and the assessment of process, and the homeostatic maintainer. Although there
is significant overlap with Minuchin's model, of note is the importance of history, process,

and the homeostatic maintainer. Fishman (1993) states that in addition to taking the general history of the family and its stressful life events, the therapy must learn the history of the problem presented, the steps the family has taken in attempting to resolve it, and the involvement of any other therapists and agencies, past and present. This allows for a tracking of the problem, and its evolution in the family system. The therapists are not concerned so much on what happened in the past, as they are with how the past has contributed to the present family structure. The assessment also may reveal untapped family strengths, or resources available in other social contexts.

Assessment of process in the final dimension of the assessment model. Fishman (1993) states that the therapist must be able to describe the various processes at work in the system, both those that can be observed among the family members in the treatment room and those of which the therapist becomes a part, acting and being acted upon. He emphasizes that for this reason the therapist must be aware of any of his/her own issues which may impact his/her reaction to families. Assessing process involves identifying the homeostatic maintainer. As previously stated the homeostatic maintainer is the person or force which keeps the system "stuck". Fishman (1993) notes that the system cannot heal and begin to operate in a more functional manner until the operation of the homeostatic maintainer has been identified and changed to permit the system to change. By disturbing the balance of the system, the therapist can observe who reacts to return the system to its status quo, and by what process. (Fishman, 1993). By challenging the system in this way the therapist can test his/her hypothesis around how the problem is being maintained, and formulate an intervention accordingly. Another aspect of addressing process is by identifying the transactional patterns. This will help determine what patterns are at work in the system that are contributing to dysfunction. Fishman notes that assessing how families deal with conflict and confrontation is helpful in tracking patterns as well as boundary problems.

Intervention

During structural therapy, assessment and intervention are interwoven. The assessment is not a linear process consisting of the client telling the therapist what the problem is but rather it is an interactive process in which the therapist becomes part of the system as a means of assessing its response to his/her involvement and using that feedback to formulate his/her hypothesis. Structural therapy incorporates both assessment and goal-setting into the therapeutic process so that they become integral facets of therapeutic intervention (Aponte & VanDeusen, 1981). Once the assessment is formulated then the intervention shifts toward restructuring the system. In the subsequent section a model for treatment will be reviewed, then specific intervention techniques will be discussed.

Fishman (1993) identifies a five step model of treatment which involves gathering the members of the system, generating goals and planning treatment, addressing the dysfunctional patterns, establishing and maintaining a new organization, and ending therapy. In gathering members of the system the therapist must consider who to include in therapy, and how to motivate family members to attend. Depending on the presenting problem it may be helpful to have people from the family's larger social network present during this meeting (for example extended family, school personnel, friends, etc.).

During the second stage of the treatment, goals and a treatment plan are generated. The assessment occurs during this stage, however it is also an intervention stage in the sense that the therapist connects to the family, engaging family members in the therapeutic process. Families come to therapy because they are hurting and they want support and nurturance. Fishman (1993) states that his rule in therapy is to confirm the individual and challenge the system. With this approach in mind the therapist can provide the support family members need to become engaged, but restructure the system as required. Techniques such as joining and accommodation are important during this stage. Minuchin (1974) emphasizes the need to provide support throughout the therapeutic process as a means to promote movement in therapy. The therapist must help family

members in such a way that they are not threatened by major dislocations (Minuchin, 1974). Supporting family members through change may also mean helping to create systems within the family which foster support between members.

During this stage of the process the therapist also begins to challenge the family's linear thinking of the problem and replace it with a circular view. Family members must learn a new way of experiencing themselves in relation to others in order to understand the part they are playing in the problem and how they must change so that the symptomatic member will improve (Fishman, 1993) This shift for families occurs most effectively if it is experienced rather than described. Therapy is not aimed at gaining insight and an understanding of the problem so much as emphasizing the problem in the process of change (Aponte & VanDeusen, 1981).

Fishman (1993) states that the goal of the third stage of treatment, addressing the dysfunctional patterns, is to destabilize the organization by creating discontinuous or intermittent change. Therapeutic crises are created to provoke the members of the system to different interactions; when the system is challenged it is not permitted to return to the status quo but is forced to reorganize (Fishman, 1993). Restructuring techniques are important during this stage and structural change will not occur without them.

When the therapist decides to create a therapeutic crisis, he/she looks for a natural opening. Both Minuchin (1974) and Fishman (1993) suggest that this opening may come in the form of incongruent verbal and non-verbal messages by a family member. Fishman (1993) gives the example of a father of a teenaged boy who described his son's out of control behaviour, but his face, instead of registering outrage or concern, displayed a big smile. Fishman (1993) explains that by using this technique a crisis was created in the session by rendering explicit the covert alliance of the father with the boy and he sided with the mother against them. Similarly Minuchin provides an example of a woman who complains that her husband is a silent person but she consistently interrupts and silences him when he starts to talk. In both cases the patterns are outside the family's awareness.

By making an observation in a non-blaming manner the therapist challenges the family's perception of the problem.

In the above example Fishman unbalances the system by siding with one family member over another. This is a helpful technique in creating a crisis and shifting people's realities. It is important however that the therapist not continually side with the same person, or against the same person as this would be counterproductive. Unbalancing is considered a short-term tactic (Fishman, 1993). Minuchin (1974) adds that this type of entrance into the family structure requires careful planning and an ability to disengage, so that the therapist is not pulled into the family war.

Fishman (1993) states that in the fourth stage of the treatment a new organization of the family is established and maintained. He states that the success of this stage depends on the family's relationship with systems outside of its immediate context. The idea of recontextualization is not new, of course. Alcoholics Anonymous and other such groups represent new contexts in which changes in the patterns of addictive behaviour are encouraged and supported (Fishman, 1993).

During the final stage of the treatment therapy is terminated. Ideally this occurs when the system has been restructured and the family is no longer experiencing problems. If there has been no change however, and no progress is being made, the family should be informed that therapy will end on a specific date (Fishman, 1993). This may motivate some families by creating a crisis which can be used therapeutically, otherwise it can be concluded that the family was not ready for change.

Structural Techniques

During this section, the structural techniques used during therapy will be discussed. Aponte and VanDeusen (1981) organize the techniques into three categories depending on what they are meant to accomplish. Some techniques are used to create the

transaction the therapist is to work with, some are for the therapist to join with the transaction and others are basically to restructure the transaction.

In creating a transaction the therapist can use three techniques: structuralization, enactment inducement, and task setting. Structuralization refers to the therapist's attempts to relate to family members in a way that will promote the desired response from the individual, structuring his/her own transactions that best fit the situation and will solicit the desired response. For example if a woman is withdrawn and passive in the session, the therapist may relate to her in a way that respects her views, and her authority in the family.

Another technique is to have the family enact a transaction in the session. The therapist may ask family members to discuss a particular topic to assess how they manage conflict. While such an enactment has obvious value as an assessment tool, it can be utilized therapeutically through the appropriate structuralization of the way the request is made, and in the timing of the enactment itself in therapy (Aponte & VanDeusen, 1981).

Assigning tasks is another means of creating a transaction. These can be done in the session at the request of the therapist. Tasks assigned within a session may simply indicate how and to whom family members should communicate. Tasks can be related to the manipulation of space. The therapist may say "I want you to sit next to your wife and take her hand whenever you think she is anxious."(Minuchin, 1974, p. 150). Tasks may also be given in the form of homework. Tasks whether in session or outside of session are particularly helpful because they can give families new alternative ways of relating to one another.

The second set of techniques are joining techniques which are used primarily to connect and engage with families. Through the use of tracking, the therapist adopts symbols of the family's life through which to communicate to the family and around which to build relationships (Aponte & VanDeusen, 1981). For example the therapist may wish to use themes from the members' culture which could challenge their thinking or stimulate discussion. Aponte and VanDeusen (1981) provide the example of a couple in therapy

who is experiencing difficulty around the husband's disproportionate spending on himself. This couple has a strong Eastern European cultural background, and the husband prides himself on being a good provider. In the example, the therapist asked the wife to give examples of how her husband provided for her and ways in which he failed to provide for her. The therapist uses tracking by connecting with the couple through the use of the theme of "providing". In this example tracking is also used as a restructuring technique as it is used to challenge the system.

Accommodation is the way in which a therapist joins by relating to the family in congruence with the family's transactional patterns (Aponte & VanDeusen, 1981). Minuchin (1974) states that accommodation refers to the adjustments the therapist makes of him/herself in order to join with the family. Empathizing with family members around their experiences within their context is crucial for joining to occur and for therapy to be successful. Minuchin (1974) gave the term maintenance to the planned use of support of specific family structures. If during assessment strengths are identified in specific structures, then techniques should be used which support them.

In the final grouping of structural techniques, methods are used to change the structure of the transaction of the family or other systems involved in the problem (Aponte & VanDeusen, 1981). These techniques are divided into two categories of structural problems, those stemming from system conflict and those stemming from structural insufficiency. Techniques that deal with system conflict fall more along the lines of those that break down or reorganize structures, while the techniques that are more appropriate to structural insufficiency tend to come under building new structures or reinforcing existing structures (Aponte & VanDeusen, 1981).

Structural Family Therapy With Violent Families

There continue to be relatively few examples available in the literature of structural family therapy being applied to families where violence has occurred either in the form of

wife assault or child abuse. Families need to be at a certain state of readiness in order for any form of family therapy to be considered safe and appropriate. Fishman (1993) states that in deciding who to include in therapy it is important that people whose involvement could be dangerous, be excluded, particularly in cases of sexual abuse and violence.

As previously discussed, family therapy is not an intervention used to stop violence from happening. Alternative forms of intervention need to take place before families are considered appropriate for therapy, regardless of the approach. In determining the family's state of readiness the person who has committed the violence needs to be assessed in order to determine his/her acceptance of responsibility, and motivation to change. Men who are violent with their wives, may find family therapy appealing because it gives the appearance of shared responsibility for violence.

Similarly in cases of child abuse, parents may target the child as the source of the problem, and may avoid accepting any responsibility. When child abuse is suspected, the interventions required at that time, focus on the immediate safety needs of the child, and an investigation and assessment of the family situation needs to occur by the appropriate agency. Masson and O'Byrne (1990) state that once an investigation is concluded and a protection plan for the children formulated and agreed upon by those agencies involved, then treatment becomes a possibility and family systems ideas have an important role to play.

The family's wishes should also be taken into consideration in deciding who should attend and participate in treatment. When safety in not an issue then the therapist can be more insistent around who should and who should not attend. For example, Fishman (1993) notes that it is crucial to the therapeutic process that the homeostatic maintainer be present because without this person or force present the dysfunctional patterns cannot be addressed and changed. When violence exists in a family however, safety must be the therapist's primary concern.

If it is determined that the person who has been violent is not a candidate for family therapy, he/she should be directed toward a more appropriate intervention such as an anger management group, or individual counselling. In the case of violence by parents toward children, individual counselling for the parent may be indicated in combination with family therapy, instead of family therapy, or as a prerequisite for family therapy.

Given the difficulty many abusers have in taking responsibility for their behaviour, it is not surprising that it remains relatively rare that family therapy is used in treating family violence. Despite this however, it remains a helpful framework in assessing families, and in conceptualizing the etiology of violence. It is particularly helpful when combined with ecological theory in understanding the multidimensional nature of violence, the impact of societal values and their contribution to the power imbalances that exist in families, and the limitations of the legal and social response to the problem.

If it is determined that it is not appropriate to include the individual who is violent, structural family therapy can be applied to the remainder of the family, or parts of the family. For example it may include the mother and children, an individual family member or a sibling group. The following examples in the literature demonstrate how structural family therapy can be applied to understand the multidimensional nature of violence in families, and to treat the entire family in one example and to treat an individual family member in another.

Gelles and Maynard (1987) identify several aspects of structural family therapy which are particularly relevant to the violent family. Violence is structured into family systems over time through its rules, boundaries, roles and communication patterns. The structural therapist analyzes the rigid, repetitive sequences and habits by which the families organize themselves. The therapist challenges the family's pattern of interacting, forcing members to look beyond the symptom of family dysfunction and to examine the covert rules governing the family's transactional patterns (Gelles & Maynard, 1987). The structural model is helpful in providing a framework for understanding how violence

develops within a family system. When an eco-structural framework is applied, other systems and their inter-relationship are considered.

Structural family therapy is applied to a case example in the article. There are no modifications made to the model from what would be considered traditional structural family therapy and the authors summarize the goals of therapy as follows: (a) to change the interactional patterns so the family members perceive each other differently, (b) to establish boundaries between subsystems, (c) to support appropriate hierarchies, (d) to facilitate direct marital/parental interaction, and (e) to encourage more fitting sibling relationships (Gelles & Maynard, 1987). In the case described in the article, violence is occurring between the teenaged son and mother, as well as the mother and father. The strength of the model is demonstrated in cases like this in terms of the ability to track family patterns across various systems. Gelles and Maynard (1987) point out that the model is only appropriate in cases of mild to moderate violence. In cases of severe and life-threatening violence, it is clearly inappropriate and extremely dangerous to use conjoint or systems interventions (Gelles & Maynard, 1987). This presents a dilemma for the therapist however, as there is not a clear way of determining when the violence is moderate and when it is severe particularly given the fact that violence escalates over time, and that family members, even the victims themselves may not be capable of providing an accurate assessment of their own risk or the precise level of violence.

One of the ways that the therapist can attempt to assess the level of violence is to conduct a screening interview which is separate from the therapeutic process. Family members should be interviewed separately as well as together when appropriate, to determine an accurate assessment of risk and safety and therapeutic suitability. In the example provided by Gelles and Maynard (1987) this had not occurred and therefore, it cannot be determined with any certainty that the level of violence was at a level which would consider the family appropriate for treatment.

In another example contained in the literature, structural family therapy is applied to work with battered women. This model is applied to cases where a battered woman has left her partner and sought the support of her family of origin. It considers the dysfunctional transactional patterns that have been passed intergenerationally which may perpetuate the cycle of abuse (Leach, 1990). Leach (1990) explains that an abused woman becomes dependent on the actions of others over time as a means of coping with violence. Family members may contribute to the abused woman's powerless stance by resuming familiar, family roles created in her childhood or adolescence. In an attempt to help, the family may actually take over the life of its abused daughter and make decisions for her. For this reason, the approach proposes that the family of origin be involved in the battered women's counselling using the structural family therapy model. Leach (1990) states that it is important to begin family involvement as early as possible after the abused woman has returned to her family of origin. At that point, the family structure is in a period of transition and many dysfunctional transactional patterns are not yet solidified.

In bringing the family of origin into treatment the therapist can observe the hierarchical structure of the family, and the part various family members play in maintaining the transactional structure of the system. Leach (1990) states that the ultimate goal of therapy is to develop a functional family system that can support the abused woman while encouraging her to develop greater autonomy. Techniques of joining, deriving a family map, and restructuring are used to create a more functional family structure. This model can also be applied to cases where women are not necessarily living with their families of origin but have separated from their partners and require increased support from their family.

In conclusion, their are relatively few examples of structural family therapy applied in cases of family violence in the literature. As previously stated there are times when it is clearly unsafe and inappropriate to involve the entire family in therapy however, and careful consideration needs to occur around the when structural family therapy should be

used. Structural family therapy can be applied to parts of families or to individuals. More research is required to develop a framework for determining the suitability of family counselling in cases of family violence.

Ecological Theory

Basic Concepts

Ecological theory is used to describe the multidimensional relationship between various systems. Germain (1991) explains that ecology, the science that studies relations between organisms and their environments, is used as a metaphor. It facilitates taking a holistic view of people and environment as a unit in which neither can be fully understood except in the context of the other. The ecological model is one that grows directly out of social work's dual commitment to the person and to the environment (Bower, 1988). In this respect the approach is not new, in fact clinical practice in social work has traditionally involved interventions that are anchored in the social context (Rodway & Trute, 1993).

Mary Richmond, an early twentieth century pioneer in the field of social work, was among the first to articulate how the social environment plays a critical role in the psychological life of human beings (Pardeck, 1996). Ecological theory when combined with family therapy is a relatively new concept. The origins of the ecological approach in family therapy can be credited to Minuchin and his coworkers (Hoffman, 1991). Of all of Minuchin's collaborators, E.H. Auerswald took perhaps the most interest in using an ecological systems perspective. "Auerswald's 'ecological systems approach', as he called it, was directed at the total field of the problem, including other professionals, extended family, community figures, institutions like welfare, and all the overlapping influences and forces that a therapist working with poor families would have to contend with" (Hoffman, 1991, p. 257).

In working with families it is clear that they are greatly affected by the systems around them. Fishman (1993) states that to address fully the needs of the modern family one must work to transform the outside social forces as well as the forces within the family. Many problems which manifest themselves in the family can be traced to systems outside the family. or a relationship between the two. An ecological approach aims to enrich social support resources, as well as improve the internal coping patterns of families, so that a better match can be attained between a family's needs and the circumstances of its physical and social environments (Rodway & Trute, 1993).

In defining client problems, one must look at the transactional process between the client and his/her ecosystem. Pardeck (1996) states that this approach, for example, suggests that emotional disturbances are a result of a pattern of maladaptive transactions between the person and the environment. He cites one study where children who are viewed as highly disturbed are more likely, unfortunately, to arouse disturbed reactions in more than one social setting (Pardeck, 1996). Germain (1990) describes the transactional relationships within an ecosystem as a circular loop in which an event or process may be a cause at one point and an effect at another in the ongoing flow around the loop of social, cultural. emotional. psychological. and physiological process.

The behavioral setting offers the practitioner insight into assessing the client's problems. Germain emphasizes the importance of the "goodness of fit" between a person and her/her environment. A "misfit" between these factors may violate physical, psychological. or social needs, thus resulting in clients experiencing stress or disjunction between individual needs and "environmental nutriments".(Pardeck, 1988). The setting should be viewed not only in simple behavioral terms as stressed in learning theory, but as an inextricably interwoven relationship that includes physical settings, people, time and individual behavior (Pardeck, 1996).

The ecosystem and its relationship to the individual is important in understanding ecological theory. People function in more than one ecosystem simultaneously. For

example one's systems may include self, family, work, school, church, and neighborhood. We respond to these various systems and they respond to us. Pardeck (1988) explains that the environment contributes to the person's development and adjustment, the person's behaviour creates responses within the environment, and the changed environment therefore exerts a different effect on the person.

Assessment and Intervention

The concepts of behavioral setting, transaction, and ecosystem help to further define ecological theory, and how problems might manifest themselves in individuals and families. The theory provides a foundation for developing an assessment and then an intervention. Assessment should include information from the family itself, as well as significant others in the life of the family, and the observations of the therapist. Pardeck (1988) states that the assessment should identify sources of discord in the ecosystem as well as sources of strengths that can be used to improve the "goodness of fit" between the client and important people in the client's life. Rodway and Trute (1993) add that assessment should provide for the use of a wide range of intervention resources tied to multiple levels of the target ecosystem. Required services should be specified to enable the client to make reasonable progress toward the achievement of treatment goals (Pardeck, 1988).

Pardeck (1988) developed a seven stage model of intervention which put ecological theory into practice. The stages are as follows: entering the system, mapping the ecology, assessing the ecology, creating a vision of change, coordinating-communicating, reassessing, and evaluating. The first stage begins at the assessment point when the decision has been made to provide service to a client. The goals of this approach are to assess the relationships in the client's life and to identify the point of entry into the client's world. In the next stage the practitioner maps the ecology by identifying the various systems in the client's life and how they relate to one another.

Both events and people are considered relevant subsystems. Once the ecology is mapped it is then assessed and interpreted. Once the strengths, weaknesses, and influential relationships have been identified. the practitioner can interpret this information to the client and significant persons in the client's ecosystem (Pardeck, 1988). Next a vision of change is created by identifying areas that need to be changed, focusing on the total ecosystem, and on the strengths present in this ecology. It is during this stage that a method of intervention is agreed upon by the family and the practitioner. Because much of the change effort is in the hands of those significant persons in the family's ecosystem, the fifth stage. coordinating-communicating, involves offering support and sustaining the family's continuing change efforts (Rodway & Trute, 1993). Contact should occur with the various systems with which the family is involved. Re-assessment should occur with consideration for the need to re-map the ecosystem based on feedback from the family or other systems. If the intervention efforts are assessed to be successful, the practitioner can move toward the termination stage. Evaluation involves a look at the total treatment process. This can be done informally or by using a formal evaluation. It is important to assess whether the family's perceptions of improvement match the practitioner's and this information can be gained through evaluation.

SECTION TWO: PRACTICUM SETTING AND PROCEDURES

Setting

This practicum was carried out at the Elizabeth Hill Counselling Center (E.H.C.C.) (previously named the Community Resource Center) located on McDermott Avenue in Winnipeg. The E.H.C.C. provides counselling services to individuals, couples, and families who reside primarily in the core area of Winnipeg. There are no jurisdictional requirements, and clients are eligible to receive service regardless what part of the city they reside in. No fee is charged to clients. The E.H.C.C. and Psychological Services Center also exist to prepare students from a variety of disciplines to be competent and caring professionals. Thus the purpose of the E.H.C.C. is two-fold: to train students in their respective disciplines, while receiving supervision from qualified professionals, and to provide a valuable service to the community.

Clients

This practicum involved the application of structural family therapy within an ecological framework for work with families. Some form of family violence was identified by most of the clients who were seen during the practicum, however, more often several problems were identified by the client at the referral stage. While the family unit was the focus of the intervention, the entire family did not always participate in therapy. Initially it was proposed that six families would be involved in the practicum with the assumption that each would remain involved continuously from the beginning to the end of the practicum. This did not occur, in fact several clients did not return after one or two sessions. As a result, a total of 12 clients were seen in an effort to establish a group of clients who were committed to remaining involved. From the twelve clients seen approximately five attended 6 or more sessions. In the following chapter a brief summary

will be provided of each of the clients, followed by a more in-depth analysis of three of the families.

Procedures

The procedures that were followed during the practicum were consistent with those in existence at the E.H.C.C.. In general these involved developing a therapeutic relationship with the client, assessing the client's problem, developing treatment goals, implementing a treatment strategy, and evaluating the treatment strategy. To facilitate this process a therapeutic contract was established, explicitly or implicitly, which addressed with the client the frequency, length and duration of meetings, who would be present, confidentiality and its exceptions, expectations of the client, and expectations of the therapist (i.e., availability between scheduled sessions). How these procedures were operationalized varied according to each client, however each was addressed.

Recording requirements were also consistent with those established at the E.H.C.C. An intake assessment was required by at least the fourth session which included a social history, clinical impressions, and treatment goals. At the point of termination with a client, a report was required which summarized the history of the presenting problem, and outlined the therapy process. Conclusions and recommendations were also required in the report. In addition to the formal intake and termination reports, session contact notes were also made for each client and kept in the client's file. The progress of clients, was monitored through these reports and session contacts.

Videotaping was also used to facilitate learning. This procedure facilitated my learning by providing the supervisors with an opportunity to observe the therapy directly and provide feedback. Clients were made aware of the requirement of the E.H.C.C. to videotape sessions from the onset, and were required to give their permission in writing for videotaped observation. The tapes were erased following the practicum to ensure confidentiality.

Supervision

Supervision was provided by the members of the practicum committee. The chairperson was Diane Hiebert-Murphy who provided the majority of the supervision. Meetings were held on a weekly basis to discuss cases and review progress. Through supervision my understanding of the application of structural therapy and ecological models was enhanced. Other committee members included Enid Britton who was a clinical social worker employed at the E.H.C.C. and assisted with providing supervision on one case. Faculty member Barry Trute provided supervision on two of the cases. The members of the committee were selected for their background in clinical social work and their availability to me through their involvement with the E.H.C.C. Linda Perry was asked to replace Barry Trute toward the end of the practicum as a result of his absence.

Learning Goals

It was proposed that specific educational objectives would be achieved in the completion of the practicum. These included becoming knowledgeable about the etiology of family violence and becoming familiar with applying the ecological perspective as a framework with which to understand violence in families. A second objective was to understand the ecological perspective both as a theoretical construct as well as a working model upon which to base intervention. In addition to this, structural family therapy was to be studied in order to achieve an understanding of family systems. Practical experience was to be gained in combining ecological and structural approaches to families where violence had occurred. Another goal was to gain clinical experience in implementing purposeful and planned family therapy consistent with the ecological and structural family therapy models. And finally, the evaluative component of the practicum was to provide experience in using clinical measures both as a diagnostic tool and an outcome measure.

Evaluation

Clinical measures were selected to evaluate the intervention with families, as well as to enhance clinical assessment. The Family Assessment Measure III was selected as a measure because it was well suited to the practicum for several reasons. The FAM III is a comprehensive instrument which evaluates several areas of family functioning including task accomplishment, role performance, communication, affective expression, involvement, control, and values and norms (Skinner, Steinhauer, & Santa-Barbara, 1983). One of the advantages of the measure is that it can be completed in approximately 20-30 minutes.

Another attractive feature of the FAM III is that it is based on a process model of family functioning that integrates different approaches to family therapy and research. The process model emphasizes that family functioning is influenced by a variety of processes including those within the individual and the environment (Skinner et al., 1983). For this reason the administration of the FAM III was well suited to evaluate the use of structural family therapy and ecological theory.

The process model of family functioning provides the conceptual framework for the FAM III. The framework is reflected in the 9 subscales which make up the measure. In the first subscale, task accomplishment, the family's ability to meet tasks such as the continued development of family members, providing reasonable security, and ensuring sufficient cohesion are assessed. In role performance, family members' ability to identify, assign, and carry out roles is assessed. Communication is assessed by looking at how well messages are sent and received by family members. In affective expression the content, intensity, and timing of feelings of the messages being sent between family members is assessed. Affective involvement refers to both the degree and quality of family members' interest in one another. Control is assessed by looking at how family members influence each other, for example are they rigid, flexible, laissez-faire, or chaotic. Values and norms

assesses how rules are generated and implemented in families. Important elements consist of whether family rules are explicit or implicit, the latitude or scope allowed for family members to determine their own attitudes and behaviour, and whether family norms are consistent with the broader cultural context (Skinner et al., 1983).

The FAM III assesses the family from three different perspectives. The General Scale focuses on the level of health-pathology in the family from a systems perspective. It consists of seven subscales plus two subscales which assess social desirability and denial. The Dyadic Relationships Scale focuses on relationships among specific pairs (dyads) in the family. The Self-Rating Scale focuses on the individual's perception of his/her functioning in the family. For the purpose of the practicum, only the General Scale was used.

The psychometric properties of the FAM III suggest that it is both a reliable and valid standardized measure for assessing family functioning. The internal consistency reliability, using the coefficient alpha, is .93 which demonstrates strong internal consistency between subscales. There are no data reported on test-retest reliability, construct validity, or predictive validity. Skinner et al. (1983) state that family members may be less consistent or reliable if the FAM III is administered while the family is undergoing a crisis. Validity was assessed using a multivariate comparison of problem and nonproblem families. The study revealed that the measure significantly differentiated between problem and nonproblem families (Skinner et al., 1983).

The FAM III is based on standardized norms which provide a means of assessing families. The majority of scores for non-clinical families should fall between 40 and 60. Scores outside this range are likely to indicate either very healthy functioning (40 or below) or considerable disturbance (60 or above). Scoring is simplified by the assessment forms which convert raw scores into T-scores, and allow for charting of the results on the measure itself.

The Brief Symptom Inventory was also used both as a pre- and post-measure, and a diagnostic tool (Derogatis & Spencer, 1982). This standardized test is designed to assess the psychological symptom status of psychiatric and medical patients as well as non-patient individuals. The BSI is a brief form of the SCL-90-R, another self-report symptom inventory.

There are nine primary dimensions that make up the BSI and they are as follows: somatization, obsessive-compulsive, interpersonal sensitivity, depression, anxiety, hostility, phobic anxiety, paranoid ideation, and psychoticism. The authors state that clinical significance should be the primary requisite of all symptom constructs, and such was the case with the primary dimensions of the BSI. There are four items of the BSI which are not part of the primary symptom dimensions and these are referred to as additional items. These items contribute to the global scores on the BSI and are intended to be used configurally. They are considered clinically significant and include items such as "thoughts of death or dying", "poor appetite", and "feelings of guilt".

The scoring of the BSI results in a number of subscale scores and three global indices which provide more flexibility in overall assessment of the client's status. Raw scores are converted to standardized T-scores and are dependent upon the norm of interest (i.e.. non-patient. psychiatric outpatient, etc.), and gender. The development of gender appropriate norms is based on the consistent observation that females in our culture report significantly greater numbers of psychological symptoms than do males and tend to do so with increased levels of intensity (Derogatis & Spencer, 1982).

The psychometric properties of the BSI reflect good reliability and validity. Internal consistency across the nine dimensions ranges from .85 to .71 (using Cronbach's coefficient alpha). Test-retest reliability was also conducted and the coefficients range from .68 to .91 across the dimensions which reflects consistency of measurement across time. The validity of the BSI is supported by several research studies. Derogatis and

Spencer (1982) state that data from predictive, content, and convergent-discriminant and other types of validation studies serve to contribute to the ultimate validation of the hypothetical constructs that the test serves to operationalize. It is import to realize that this process is represented by a systematic series of studies that serve to constantly extend and redefine the limits of generalizability of the test as a definition of the construct.

The BSI was a helpful diagnostic tool for the practicum as it provided a psychological "snapshot" of the client. It highlighted significant psychological issues to assist in formulating therapeutic plans, and prioritizing the focus of intervention. It was particularly helpful in working with women who were in an abusive relationship as the outcome from the measure could be considered in relation to the woman's ability to protect herself. One of the disadvantages of the test, like all self-report measures was the fact that the client had to be cooperative in order for the results to be considered accurate. In one case the client may have felt pressured to be seen in a positive light and therefore the results had limited utility.

The third measure used with some clients was the Rosenberg Self-Esteem Scale (RSE). This is a standardized test which is one dimensional and provides a measure of self-esteem. The RSE is well established and one of its greatest strengths is the amount of research that has been conducted with a wide range of groups on this scale over the years (Fischer & Corcoran, 1987).

The RSE demonstrates both good reliability and validity. Internal consistency was measured at .92 using a Guttman scale coefficient. Two studies of two week test-retest reliability show correlations of .85 and .88, indicating excellent stability. A great deal of research demonstrates the concurrent, known-groups, predictive, and construct validity of the RSE (Fischer & Corcoran, 1987).

The RSE is a brief 10 item measure and is therefore easy to score, and is easy to complete. It was not administered with every client, only in cases where self-esteem had

been identified as a concern by the client, or by the therapist. In most cases it was used as a diagnostic tool.

SECTION THREE: CASE SUMMARIES AND ANALYSIS

Review of Practicum Cases

The following section will include a review of all the cases seen during the practicum. A structural and ecological framework was applied to all of the cases and this will be described in detail in three of the cases.

Kay

Kay was referred to the E.H.C.C. by a counsellor from a resource center whom she had been seeing for approximately four years. Kay was 24 years of age and was in a common-law relationship with a man who was 32. They had been together for two years and had a child together who was 16 months of age. Kay's partner had been physically and emotionally abusive which had resulted in physical injury to Kay. She was employed outside the home, but her support system was limited. Her goals for therapy were to improve her self-esteem and self-confidence, and she indicated a desire to remain in the relationship to achieve these goals. Kay attended three sessions and canceled two. It became evident that Kay was maintaining contact with her previous therapist; ongoing counselling with two helpers was not considered helpful. In discussion with the client a decision was made to terminate the counselling at the E.H.C.C.

One theme which emerged during the brief contact was the fact that much of Kay's difficulty in functioning was related to the effects of living in an abusive environment. Her ability to make substantial changes in her life was compromised by these circumstances. Counselling would help her to explore this and other issues such as her tendency to view her partner in terms of black and white thinking (i.e., "he's a great father but a bad mate"). Safety planning and exploring family of origin issues as well as a previous abusive relationship were also identified as issues for therapy. As previously discussed however, termination was indicated given that Kay was already in therapy with a

longtime counsellor. Termination was planned within the next 6 months with her other

therapist, and it was suggested that Kay refer herself at that time should she chose.

The BSI (Brief Symptom Inventory), and the RSE (Rosenberg Self-Esteem Scale)

were administered as pre-test measures. The GSI (General Severity Index) of the BSI

gave a rating of a T-score of 55. This would suggest that Karen did not present with any

significant mental health problems and would be considered within a typical range of

functioning. The results of the RSE reflected problems with low self-esteem with a raw

score of 30.

Betty

Approximately one year prior to the practicum Betty was seen at the E.H.C.C.

along with her husband Karl for marital counselling. The presenting problems included

Karl's excessive drinking which seemed to be related to aggressive behaviour. The couple

had been contemplating separation. They had a daughter together who was three years of

age. Betty was Filipino and Karl was Polish. Their social network was small however

they had some close friends and were close to Karl's family, particularly his mother. At

that time, marital counselling was terminated and the couple expressed increased

satisfaction in their relationship. One year later Betty contacted the E.H.C.C. and

requested individual counselling for herself. She had separated from Karl following a

violent incident and was living on her own with her daughter Anna, now four years old. It

was at this point that Betty became involved with this practicum.

Betty attended a total of six sessions. The issues that she presented in therapy

related to the stress she was experiencing in her relationship with her husband, from whom

she was separated, her daughter, and her mother-in-law. Clearly Betty was having

difficulty adjusting to the marital separation. An effort was made to assist Betty in

formulating goals for herself in terms of what she wanted to see different in her life and in

her relationships. Boundary issues were identified as a problem in Betty's relationship

with her daughter. The relationship had become enmeshed as Anna was being used to

meet Betty's emotional needs. Some intervention strategies to address this problem included helping Betty to define her role as a parent, and finding ways for her to connect with other adults in order to create relationships that would provide the emotional support she was seeking from her daughter. Betty terminated therapy prematurely and most of the identified issues had not yet been resolved.

The RSE and BSI were administered pre- and post-test over a duration of four months. Her raw scores for the RSE were 18 pre- and 10 post-test suggesting an improvement in self-esteem. The BSI General Severity Index T-score was 45 for the pre-test and 43 for the post-test. These results indicate no significant change in functioning, and that Betty had no mental health problems. The results of the RSE are somewhat contradictory to the clinical impressions formed of Betty and the progress of therapy. It is suggested that this score may be inflated and therefore not entirely accurate. The reasons for such an exaggerated response from Betty are not known, however, it is possible that she felt the need to demonstrate a social desirable response even though she had terminated therapy early.

<u>Dawn and Kyle</u>

Dawn and Kyle were an Aboriginal couple who were referred by their C.F.S. social worker for counselling due to Kyle's violence toward Dawn, and Dawn's chronic abuse of alcohol and solvents. The couple had a daughter who was 19 months of age. The couple expressed concern with the videotaping policy of the E.H.C.C. and the communication that would occur between the therapist and their C.F.S. social worker particularly as it related to the child's safety and well-being. They did not return for a subsequent session and it was learned that Dawn had returned to drinking and Kyle took their daughter and returned to his home community. It should be noted that had the couple returned, further assessment would be required to determine whether couple counselling was appropriate or whether individual issues needed to be addressed initially.

Mary

Mary was referred by her C.F.S social worker for individual counselling around family relationships. Mary was a 38 year old Caucasian woman, living with three of her four children: Karla, 16, Dawn, 14, and Peter, 13. Her partner, Bob, and his son Dustin, 19, also resided in the home. Mary's youngest child Amy, 9, resided in a C.F.S. group home. Amy had been in care as a result of sexual abuse by Bob. Concerns of child neglect and physical abuse of the children from Bob also existed. Mary was reportedly also physically assaulted by Bob. She indicated wanting to separate from Bob and acknowledged the need for counselling in order to do this. Her participation in counselling also increased the likelihood of her daughter returning to her care. Mary attended the intake interview but canceled two subsequent therapy sessions. It was clear that Mary was not motivated to receive counselling and she indicated in the intake interview that she did not feel it was necessary. During the initial session it was learned that Mary has herself experienced a traumatic childhood, and a series of abusive relationships with men in her adult life. At the time, she was having difficulty making the necessary decisions to protect her children. Long-term counselling would be necessary to address the underlying issues that compromise her current functioning and ability to parent.

Rita and Rick

Rita and Rick were referred for couple counselling by their C.F.S. social worker due to Rick's violence toward Rita, and problems created by their alcoholism. Prior to being referred, both had received individual counselling to address personal issues including the violence. Although the agency did not support a reconciliation between Rita and Rick they acknowledged that the couple appeared to be determined to be together. The couple had three children: Mark aged 12, Kelly aged 3, and Bruce aged 11 months. Rick lived separately from the family because of a restraining order against him. It became evident during the intake interview that the couple was too unstable and volatile to

commit to couple counselling. Both expressed uncertainty about whether they wanted to continue in the relationship.

Rita subsequently requested individual counselling for herself. She was uncertain about her desire to remain in the relationship with Rick and hoped that counselling could assist her with this and her overall coping. Four sessions were conducted with Rita. Some of these sessions included her son Mark. The goals of therapy were to help Rita keep herself safe from further violence from Rick, improve her self esteem, reduce her reliance on alcohol as a means of coping, and assist her in dealing appropriately with her son Mark with whom she was having some difficulty. Intervention focused on helping Rita and Mark communicate with each other, and assisting Rita in establishing structure in the family roles, and routines. After a period of a few months Rita reconciled with Rick and terminated therapy soon afterward. Although the presenting problems were not resolved, Rita's participation was sporadic, and she was indicating that "everything's fine" now that Rick had returned. It was decided to terminate given the changed circumstances.

The RSE and FAM III were administered and used as a diagnostic tool with Rita. The results of the RSE indicated very low self-esteem with a raw score of 32. The results of the FAM III (see Figure 1) indicate significant problems in family functioning with an overall T-score of 76. Of the seven subscales, role performance and control were the two areas of greatest weakness. In terms of role performance this would suggest difficulty in fulfilling her role as a parent or perhaps inability to adapt to her role as a single parent. With respect to control, the high score suggests difficulty in carrying out routines and structure in everyday family life. This may also reflect some of the difficulties she was experiencing in her relationship with Mark around limit setting and discipline. Her diminished power in the family may also have been a factor in her difficulty in carrying out these tasks. These results are consistent with the clinical impressions of the family, and of Rita.

FIGURE 1

FAM III PROFILE - RITA

FAM GENERAL SCALE
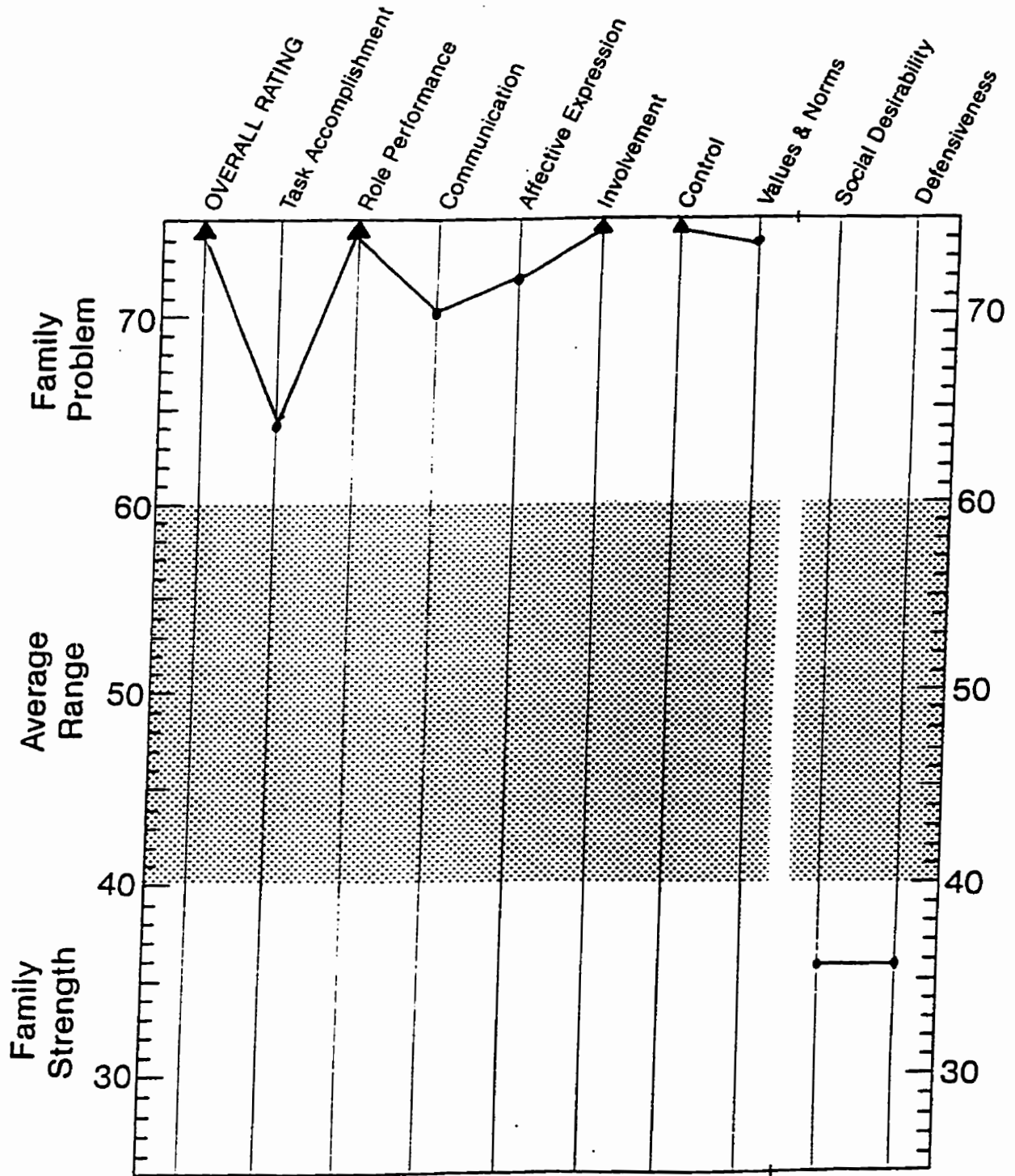
Suzie

Suzie was 41 years of age and the mother of three. Two of her children were disabled and she was referred for counselling by her support worker for the Society for Manitobans with Disabilities. Her presenting concern was her increasing dissatisfaction with her marriage. In particular she stated that her husband and son who was 17, were frequently in conflict and on one occasion a physical altercation occurred and the police were called. Another major issues was her husband's recent sexual assault of his two nieces. Suzie indicated that her husband had also been physically, sexually and emotionally abusive with her, but the physical abuse stopped after her first child was born.

Suzie was unclear about what her goals were for therapy and responded to the question by justifying why she was staying in the relationship, then describing how intolerable it was for her. Suzie was beginning to recognize that she was not responsible for the abuse she suffered as a child and as an adult. She expressed anger over how she has been treated by others as well as fear and shame. Suzie did not return after her second session. Perhaps the internal conflict she was feeling was overwhelming for her and the emotions she was uncovering, too painful. Therapy would have focused on empowering her and making her aware of the alternatives she had to her situation and resources available, should she decide to leave her husband. The therapist would have challenged Suzie's belief that remaining in the marriage was best for the children and encouraged her to make decisions that were in their best interest.

Burt and Sylvia

Burt and Sylvia requested counselling to assist them in coping with problems in their relationship. Burt was 39 and Sylvia was 25, and both had children from previous relationships. Mutual mistrust was identified as the primary problem by both members of the couple. They were residing common-law and had been engaged for the past three months. There had been a series of breakups since their engagement. Both Burt and

Sylvia were recovering alcoholics. Burt had maintained sobriety for a number of years, however, Sylvia continued to go on binges. Sylvia has been involved with prostitution before and during the engagement to Burt. The couple attended two sessions and canceled 4 subsequent sessions before deciding to terminate counselling. Sylvia had gone on a binge during this time and the couple had separated and reconciled at least once. Both Sylvia and Burt brought significant personal problems to this relationship (in particular Sylvia's alcoholism). Sylvia was directed toward addictions counselling through Addictions Foundations of Manitoba. The relationship remained unstable and therefore it was considered appropriate that Burt and Sylvia address their individual issues before couple counselling occur.

<div align="center">

Kevin and Carol

</div>

Kevin, aged 21, and Carol, aged 25, were residing together in Winnipeg along with Carol's two children Mandy, aged 8 months, and Mark, aged 3 years. Kevin supported the family financially. The couple had known each other for a year and were experiencing problems in their relationship particularly around managing anger and stress. Although there was no physical abuse, there was a lot of verbally inappropriate and highly explosive interactions between them. Carol described a personal history of sexual abuse, family violence, and a suicide attempt in her family of origin. The couple attended two sessions in total and continued to experience a significant amount of conflict in their relationship, and separated after the second session. They reconciled a few days later but continued to struggle with the issues of mistrust and conflict. It should be noted that Kevin began individual counselling following a psychiatric referral by his physician for treatment of an obsessive/compulsive disorder. According to Carol, Kevin was refusing to take the medication prescribed to him by the psychiatrist. The couple terminated therapy and Carol was referred for individual therapy at the E.H.C.C. The relationship had been chaotic, and both brought significant personal issues to it. Had they continued in therapy, some basic

work around creating a framework for functioning as a couple, and a family would have had to be done.

Bill and Derek

Bill age 34, requested counselling for himself and his 10 year old son Derek. Bill was a single parent and had custody of Derek for the past two years. Prior to that Derek resided with his mother and step-father. Bill described Derek as having behaviour problems at home and at school and reported that he was being defiant, rude, manipulative, and disrespectful. He suspected that Derek's behavior may be related to the physical and possible sexual abuse he experienced while in the care of his mother. Bill requested individual counselling for himself. He stated that he was physically and sexually abused as a child and felt that this was impacting on his ability to parent. Specifically he couldn't give Derek the physical affection he needed because he found any attempt to do so made him "sick to my stomach".

The goal of therapy was to help father and son define their roles, and strengthen the parent-child relationship. Both Bill and Derek brought a significant personal history to the family relationships which were impacting on how they related together. Structurally the family was undefined in terms of clear boundaries, hierarchy and roles. Intervention also needed to address Bill's emotional unavailability to Derek, and to improve communication between them. The format consisted of individual sessions with Bill with Derek receiving play therapy. A co-therapy approach was used for family therapy sessions. Six sessions were held in total, including family sessions.

During family sessions some of the techniques included using a genogram to help Bill and Derek see the various changes their relationship had over the years from a two parent family, to Bill just visiting on weekends, to Bill being uninvolved, to Bill receiving permanent custody. This helped them to understand some of the difficulty they had been having in negotiating roles and expectations of each other. This also provided an opportunity to introduce the concept of hierarchy to the family and discussion occurred

with Bill around how to establish his role as a parent and how to differentiate that with his role as a son, a boyfriend, ex-husband, etc.

Individual sessions were used to assist Bill in creating a boundary around his own issues. It was also important for Derek to see that his father was taking some responsibility for the problems in their relationship and not blaming everything on him. The issues for Bill in individual sessions included his inability to express affection toward Derek both physically and verbally, and his reluctance to let Derek know his was committed to him, thus giving Derek the impression that he could be abandoned again. The third issue raised with Bill was his use of fear and intimidation to control and parent Derek. This was carried out through his use of physical punishment, his use of severe threats of punishment, and exposing Derek to violence that he perpetrated against other people. These issues were identified as key to the family functioning as a whole, and yet they were not appropriate to raise in family sessions. As a result, family sessions were put on hold while these issues were addressed. Bill was committed to working on them and some progress was noted.

The FAM-III was administered to Bill (see Figure 2). Derek was below the recommended age for the FAM-III. The pre-test results indicated an overall T-score of 90 suggesting some difficulty in family functioning which was consistent with clinical impressions. Of note was a high T-score of 80 in the area of role performance suggesting some difficulty on Bill's part in adjusting to his role as a single father. High T-scores of 72 were noted in the subscales of affective expression, involvement and control. The post-test (see Figure 3) was administered two months later and suggested some improvement with an overall T-score of 70. Improvement was noted in all areas except for the area of control suggesting continued problems with routines, setting limits and discipline. The most significant improvement was noted in affective expression on which a change of 14 points (T-score) was noted. The rates of social desirability were consistently

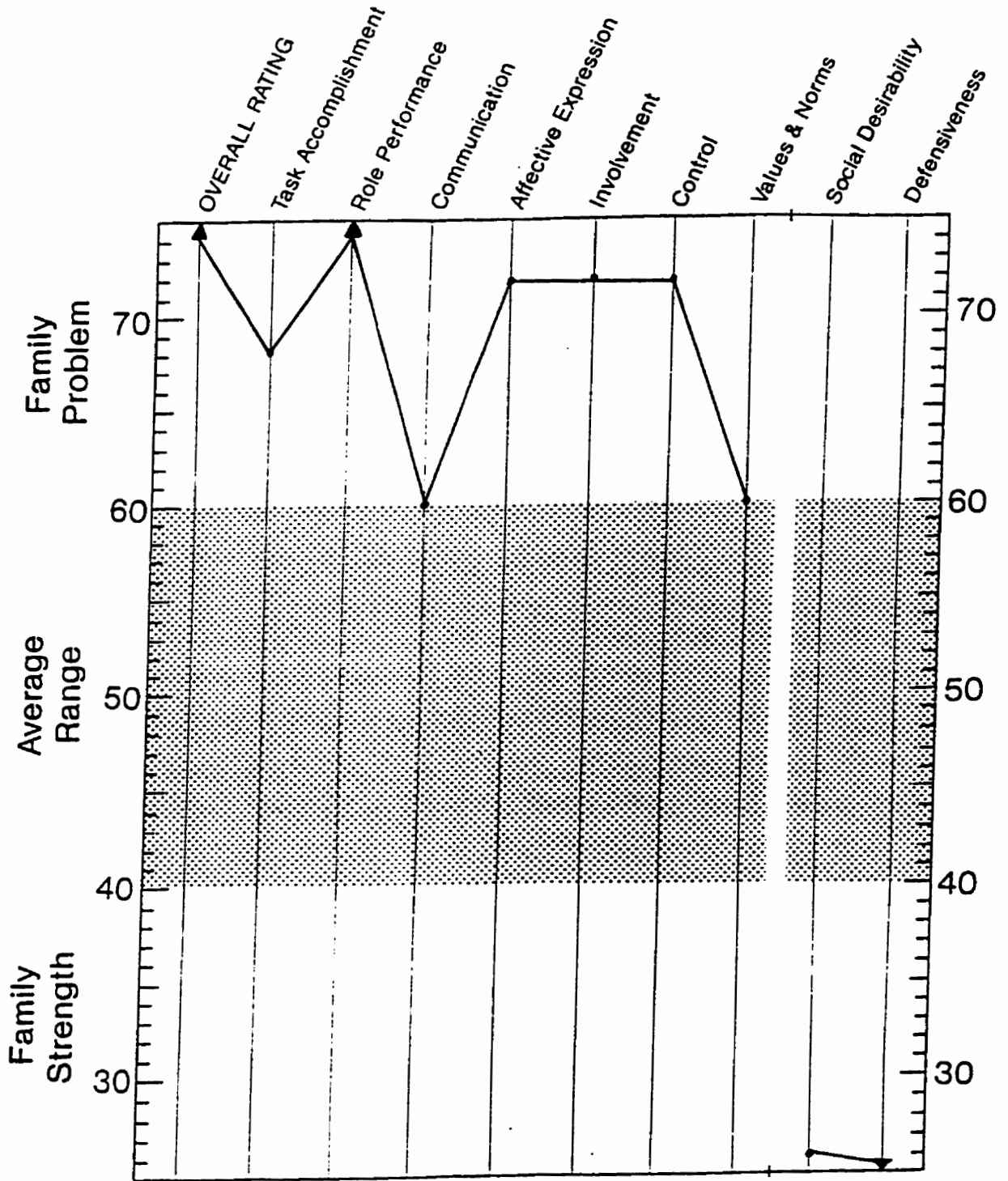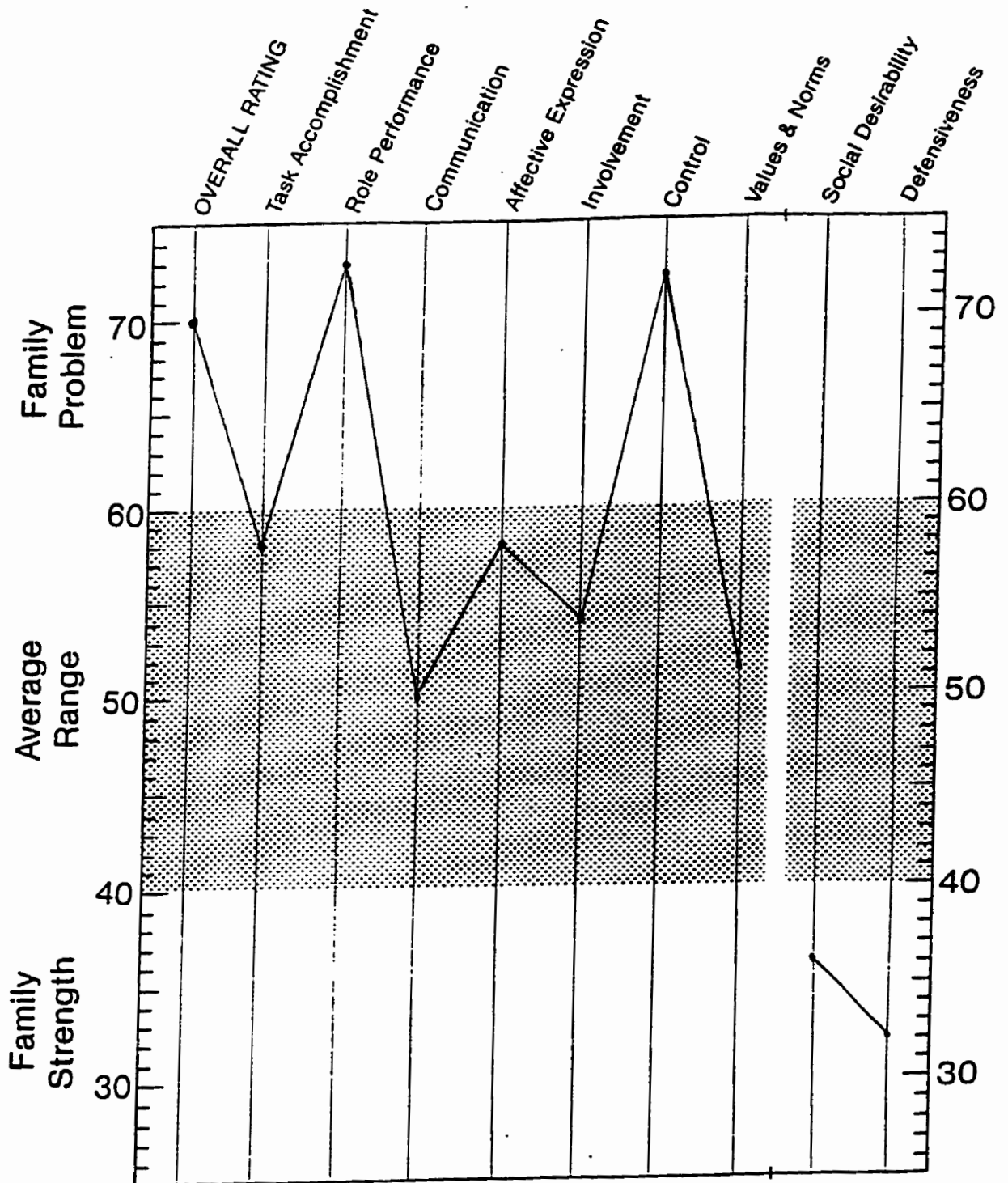FIGURE 2

FAM III PROFILE - BILL - PRETEST

FAM GENERAL SCALE

FIGURE 3

FAM III PROFILE - BILL - POSTEST

FAM GENERAL SCALE

low for the pre- and post-test suggesting a strength in openness. These results are consistent with clinical observation made through the course of therapy. Bill did appear to increase his understanding of his role and responsibilities as a parent, and some strategies were used to help him to fulfill his role as a parent. What is less certain however is whether Derek felt there was improvement, and how well Bill was able to apply what he had learned in therapy to his relationship with Derek.

Ellen

Ellen was the mother of 8 children who range in age between 20 and 9 years. The two oldest had been living outside the home for a number of years and the 5 youngest had been in and out of agency care three times due to physical abuse and neglect by Ellen. Most recently the children were brought into care under a six month voluntary agreement which would expire in three months. Initially access visits occurred at Ellen's home, then were moved to the agency at the children's request. The children expressed feeling uncomfortable about visiting their mother, and Ellen responded by stopping visits. While in foster care the children began to disclose serious emotional, physical and possible sexual abuse by their mother. It became evident that the children would be considered in need of protection if returned home. The C.F.S. social worker referred the children for counselling to assess why the children did not want to see their mother or to go home, and what would need to change in order for them to feel safe.

A total of eight therapy sessions were conducted with the children. The first two included all the children together, three were held with Mike and Mat, and three were with Hillary and Vicki. Enid Britton provided individual counselling to Ellen as part of the plan with C.F.S. The primary goal of counselling was to provide the children with an opportunity to discuss their feelings about the different things that had happened to them. Counselling enabled them to visit with each other in a neutral setting and discuss the things they had in common. It also allowed them an opportunity to relate as a sibling group, which was important given their placement in separate homes.

Some basic rules around behaviour were established in the sessions to provide a structure that would promote the children's feelings of safety and comfort. This also allowed for sessions to be manageable and enabled the therapist to maintain control of the session. The children described specific incidents of physical abuse, emotional abuse and rejection and alcoholism by their mother. They described taking care of their mother when she was drunk and described her behaving like a "baby". Therapy focused on helping the children identify their feelings around these traumatic experiences, to validate their feelings, to accept a range of emotional responses to these events, and to reassure them that they were not to blame for the abuse they experienced. A case conference was held with the C.F.S. social worker to discuss the information learned from the therapy sessions. It was recommended that the agency re-assess Ellen's ability to care, and develop a plan which reflected the children's needs and wishes.

<div align="center">

Diane and Victor

</div>

Diane and Victor were in their late forties and were referred to the E.H.C.C. for grief counselling following the death of their only son Brendan. He committed suicide suddenly and unexpectedly at the age of 23. The couple attended 7 therapy sessions and canceled two due to illness. Although initially uncomfortable with therapy, they began to relax and enjoy coming to sessions. The focus, although initially on Diane and how she was coping, began to shift to Victor and Diane as a couple. This was directed by the therapist as it was believed that in order to bring about resolution to their grief the couple needed to make some structural changes in the relationship. Victor responded well to this shift because it allowed him to express his feelings and have them validated. If Diane remained the "identified problem" this would not have been possible.

The focus of therapy, shifted early on from Diane to the couple. Clinically there were two major areas of focus for this couple. There was the processing of the event itself, which was particularly difficult for Diane. The second area was the impact of the event on their relationship. The couple demonstrated an ability to change their structure

as a couple. and shift to a stronger organization. This shift created new problems which they were able to identify and discuss. Termination was planned and discussed well in advance and the members of couple were able to identify their feelings around this process. The case was transferred to another therapist.

<div align="center">Hillary and Leroy</div>

Hillary and Leroy were both 37 years old and had one child, Matthew, who was aged 12. The family presented for counselling due to Hillary's difficulty disciplining Matthew, particularly when Leroy was away.. Initially Hillary presented as very anxious and frequently looked at Leroy before responding and rarely contradicted him. Leroy presented in a domineering manner and tended to appear disinterested if he was not in control of the conversation. The family was socially isolated and had only been in Winnipeg for a year and a half.

It became clear from observing the family interact that significant structural changes were needed. Leroy related to both Matthew and Hillary in an authoritarian manner. There was no evidence of hierarchy between Matthew and Hillary and consequently they related very much on a sibling level. Therapy attempted to strengthen the parental sub-system, thereby increasing Hillary's authority as a parent. The parents were encouraged to be supportive of each other in their role as parents, and be empathetic to each other in the challenges they encountered with Matthew. Efforts were also made to address Leroy's authoritarian style of parenting, and he was confronted regarding excessive discipline and restrictions he placed on Matthew. The parents were encouraged to relate to Matthew in ways that were supportive and nurturing and that fostered a sense of cohesion and relatedness as a family and promoted a sense of independence and self-worth in Matthew.

A total of seven sessions were held however there was little progress noted. I accompanied the parents to a meeting at the school. The family structure remained highly rigid despite the fact that the family attended sessions regularly and seemed to enjoy

coming. It is my belief that the lack of progress could be attributed in part to the fact that Hillary and Matthew were experiencing the most distress from the dysfunctional system, and yet had the least power. Leroy had the motivation and the ability to ensure that therapy resulted in the system maintaining itself as it was. He controlled the process thereby ensuring the outcome would be the status quo. Therapy terminated as a result of the practicum ending.

The FAM III was administered as a pre- and post-test measure over a time period of about three months (see Figures 4 and 5). The overall T-scores for family members reflected family functioning which fell within the normal range for Matthew (41) and Hillary (45). Leroy's results suggested however some difficulty with a T-score of 64. Social desirability and defensiveness fell below the 50th percentile and it can be assumed that the results were not greatly affected by these factors. Leroy identified communication as the most significant problem in the family with a T-score of 78. This was contrasted sharply by Hillary's rating of 46. It was interesting that these two parents had such vastly different perceptions of communication. Perhaps they can communicate well with some members of the family and not with others. Hillary, Leroy and Matthew all rated the subscale of involvement high at 64, 64 and 62 respectively. These results suggest problems with affective involvement between family members. In this family, members are over-involved with one another, but the involvement may be self-serving and may not promote autonomy. An identified strength was reflected in Matthew's subscale T-score of 38 for role performance. This suggests that family roles, as perceived by Matthew, are clear and family members know what is expected of them.

Post-test results (see Figure 5) indicated an increase in over all T-scores (Matthew 52, Hillary 56, and Leroy 68). The most significant change was noted for Matthew and Hillary both with a difference of 11. Leroy's overall rating was virtually unchanged. The results suggest that Matthew and Hillary's perception of family dysfunction increased as a result of the intervention or perhaps they felt greater power to acknowledge the

FIGURE 4

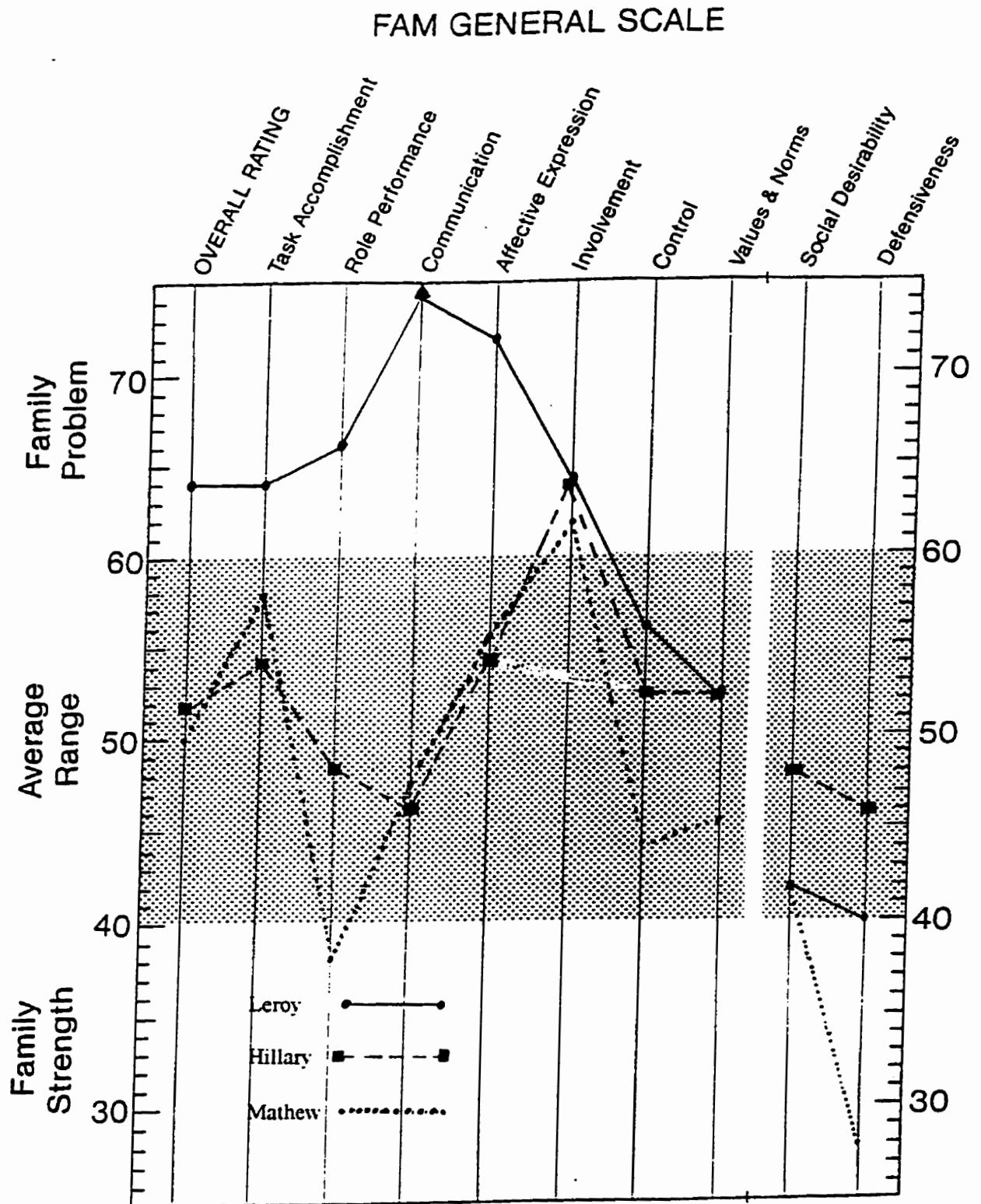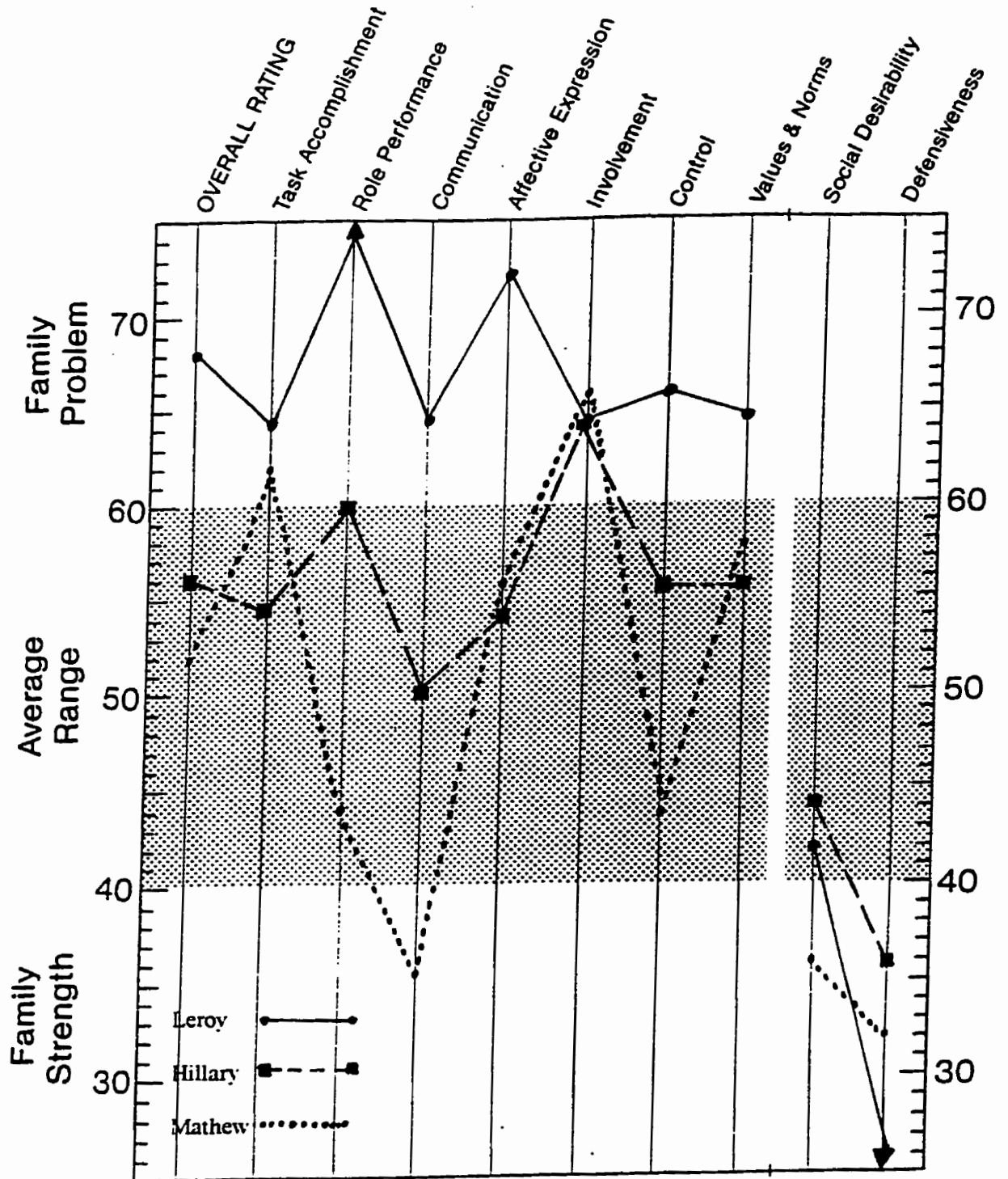## FAM III PROFILE - LEROY. HILLARY AND MATHEW - PRETEST

FAM GENERAL SCALE

FIGURE 5

FAM III PROFILE - LEROY, HILLARY AND MATHEW - POSTEST

FAM GENERAL SCALE

difficulties. The reasons for this change are not known, however, it may be related to the fact that the process of therapy itself brought to light the difficulties this family was having in adapting. Conflict may have increased between family members as a result of the issues being brought to light in therapy and a disruption of balance within the family system. Matthew and Leroy noted a significant improvement in communication with a T-score difference of 12 and 14 respectively. Hillary rated it about the same. Other significant differences included an increase (12) in role performance difficulties as perceived by Hillary. This suggests that Hillary's perception of her role changed during the intervention and she may have felt there was lack of agreement about roles, or that their roles as family members were not changing to adapt to their evolution as a family. In general the result of the evaluation are consistent with those gained in therapy and suggest that little progress was made with this family.

Case Analyses

Family # 1 Jill and Ken

History and Presenting Problem

Jill aged 31 years, is the mother of two girls, Patricia, 13, and Pam, 12. Their birth father had no contact with the twins since their birth. Jill married Ken when the girls were toddlers. They remained an intact family until 1992 when Ken and Jill separated, and eventually divorced. The girls had regular access to the ex-partner/step-father who lived nearby.

Jill described her childhood as unhappy. Her mother died when she was young, and she was raised by her paternal aunt and uncle. She feared she may have also been sexually abused by a family member. She became sexually active at the age of 13, and began using drugs and alcohol on a regular basis. She dropped out of school and became pregnant when she was 17, and moved in with her older sister. She planned to place the child for

adoption. but changed her mind after the child was born. Jill found herself unprepared for the role of a parent. She was angry over the lack of support from her family and stated that she "took it out on the children". Jill described herself as a controlling and punitive parent.

Jill married Ken when the girls were two years old, and three years old respectively and as a result he was the only father-figure they ever knew. Jill stated that she never really loved Ken but that he was the first man who showed any interest and love in her.

In 1992 Ken's cousin Bill, age 17, came to live with the family. He appeared to settle in well with the family and was well liked by all members. Approximately 10 months later Patricia and Pam disclosed to Jill that Bill had sexually abused them. Around this time Jill and Ken were experiencing conflict and Ken physically assaulted Jill which precipitated their separation. Bill remained in the home following the separation.

Jill admitted to having some suspicions around possible sexual abuse of Pam and Patricia because of behavior she had witnessed between Bill and the girls such as holding hands. and sleeping together. She was also developing an attraction to Bill during this time and eventually she and Bill developed an intimate relationship. When the girls disclosed she confronted Bill. and he remained in the home as Jill believed that he was no longer abusing the girls.

In January 1994, Patricia disclosed the sexual abuse to her counsellor at school. Bill had not stopped abusing the girls after Jill had initially confronted him. An investigation by C.F.S. and the police resulted in Bill being charged with sexually assaulting Patricia and Pam. They disclosed that he had sexually abused them since he moved into their home. The abuse consisted of fondling and kissing. They also described incidents of Bill ejaculating onto their stomachs and into their mouths. The sexual assaults occurred when Bill was alone with either Patricia or Pam. Bill pled guilty and was sentenced to several years in prison. He subsequently appealed the sentenced and it was reduced to two years. He was not permitted contact with Jill or the girls.

Jill requested therapy for herself and the girls in February of 1994. They were on the waiting list until September 1994. Prior to involvement in this practicum Pam and Patricia were seen individually for 5 sessions by a therapist at E.H.C.C. The intervention took the form of play therapy directed at issues of sexual abuse. The therapist identified a need for family therapy, and although Jill was initially resistant to this she eventually agreed. Other services involved with the family at the time included a support worker from C.F.S. and a psychiatrist who provided individual counselling to Jill.

This family attended a total of eight sessions. The first session was a transfer interview conducted with the previous therapist and the family. Ken only attended this first session. Two months passed before the next session which included Jill and the girls. Another month passed before the following session. The last six sessions were attended consecutively every week, the last three being with Jill on her own. Efforts were made to motivate the family to commit to a regular course of weekly therapy. However this proved challenging.

Structural Family Analysis

This family initially obtained counselling for the two children, but then was encouraged to participate in family therapy, and agreed to do so, all be it, with some reluctance. The shift from individual to family counselling was important in order to assist them to continue to cope with the impact of the sexual abuse. It was a significant step for the family to shift from focusing on an external stressor (the sexual abuse) to focusing on the internal stressor (their relationships with each other). It was believed that the girls' ability to fully cope and overcome the impact of the sexual abuse would be limited if there were not significant changes to relationships within the family and the structure of those relationships. Their experience of the sexual abuse was compounded by their mother's response to their disclosure, specifically her own sexual relationship with their abuser. Their step-father's departure from the home during this time may have also jeopardized

their safety, and further complicated the situation. Clearly there was an identified need for a focus on family work. It was also evident that there were aspects of the family structure that created a framework in which the abuse occurred, and contributed to the perpetuation of unhealthy dynamics within the family. Although the sexual abuse of the children was the catalyst for the family crisis, the family structure which allowed it to continue existed before the abuse occurred, and would continue to exist without intervention.

Family members had difficulty shifting their focus from individual to family counselling as evidenced by numerous cancellations after the transfer interview. Jill usually gave excuses relating to various family crises for example the death of a pet. Eventually Jill stated that Ken was resistant to attend as he was not ready to discuss certain issues and did not want other members of the family raising them. Jill was not prepared to hold back her feelings in counselling. Eventually Jill and Ken separated again and Jill and the girls returned to counselling on their own. This revealed some possible issues around Ken's role in the family. Clearly his membership was unpredictable, as the couple had separated and reconciled several times since their divorce. His power in the family also appeared to fluctuate. It would appear that Ken lacked power within the family, especially in his relationship with Jill, but used violence, or controlling behavior as an inappropriate, if desperate means to achieve power. This will be explored further at a later time. Jill's reluctance to attend family therapy may have been related to the family's reaction to dealing with a new therapist, and issues of trust, but more than likely she felt threatened by the prospect of uncovering some painful, potentially explosive issues. The family had achieved a certain homeostasis, and were reluctant to have this unbalanced in any way.

Boundaries

In considering aspects of family structure, problems with boundaries were revealed. The relationships between family members were characterized by enmeshment.

There was little recognition of privacy and individual space. For example Jill, Pam and Patricia all slept in the same bed. The enmeshed boundaries within this family would be considered outside the range of normal family functioning. Transactional patterns revealed that subsystems within the family, and the family as a whole were also enmeshed. As previously stated family members lacked physical boundaries which was demonstrated by them sleeping together. There was a lack of boundary around the sub-system of Ken and Jill as parents, and Patricia and Pam as children. This was demonstrated by both parents sharing adult information, often about the other parent, with one of the children. For example Ken confided in Patricia about his feelings of hurt and anger towards Bill. On her own Jill also lacked a boundary as a parent, confiding personal information to the girls about her relationships with Ken and Bill, and expecting the girls to understand her feelings for Bill even after the abuse. Jill perceived Patricia more as a threat to her relationship with Bill and stated that she was "hurt that he (Bill) didn't chose her". Again this placed Patricia in a position of equal status to her mother, blurring the boundary between parent and child.

The boundary around the family as a whole was blurred and diffuse. Bill's easy assess to the family demonstrates this characteristic. Finally there was a blurring around individuals in terms of their thoughts, feelings and identity. For example as Jill stated "I see myself in Patricia, all she wants is a man" and Pam stated, "when my mom gets sad, I get sad". It is possible that Jill saw the girls as an extension of herself and as a result the three had been unable to differentiate their own emotions from one another.

The enmeshed boundaries which characterized this family's functioning limited their ability to adapt both to the sexual abuse and to the developmental transition of the girls' progression through adolescence. These two events required a change in the family's functioning and when it did not occur it resulted in deterioration and stress. Patricia in particular was scapegoated and seen as rebellious by her mother and sister. Expressions of autonomy and independence were considered threatening, creating a sense

of disequilibrium within the family. Significant conflict resulted and Jill threatened to abandon Patricia for her "rebellious behavior". Issues around the girls' functioning in the extrafamilial world made up the majority of the content of sessions. Jill expressed heightened anxiety around their safety, and concern about their ability to make decisions. This was contrasted with her view of them as rivals in her relationship with Bill within the family context and apparent lack of concern for their safety in her own home. Transactional patterns were consistent with parent-child rather than parent-teen, or young adult relationships.

Subsystems

The functioning of subsystems was consistent with the boundary characteristics. The spousal subsystem consisted of Jill and Ken and although this was not the focus of the intervention it was clear that as a couple they were having difficulty coping with their relationship. Jill admitted to not loving Ken, and over time the couple experienced a pattern of separation and reconciliation. Both Jill and Ken had significant individual issues which made it overwhelming for them to meet the needs of one another. There was little evidence of role complementarity or accommodation and the couple seemed disconnected from one another even when they were together. The spousal system did not provide the source of support from the stress inherent in daily living. In addition to the spousal sub-system lacking in essential characteristics, both Jill and Ken behaved in ways that were deliberately hurtful to the other person, thus eroding the trust and caring that are necessary for a stable relationship.

The boundary around the parental subsystem was diffuse, allowing the children entry which led to the couple using the children to meet their own overwhelming individual needs. The diffuse boundary around the spousal subsystem also meant that stresses in other parts of their lives, reverberated into their relationship. Relationships

with friends. and with their role as parents increased the stress in the spousal subsystem, and led to its dissolution.

Jill formed a spousal subsystem with Bill when they began an intimate relationship. She described how she loved him and cared for him in ways that she never felt about Ken. She did not recognize how Bill betrayed her by sexually abusing her daughters and managed to compartmentalize the abuse from her relationship. It is possible that Bill's attraction to Jill was not genuine and was in fact a means of ensuring his connection to the family and therefore his contact to the girls. Jill was unable to recognize how Bill was closer in age to her daughters than to her, and he was given the status and power consistent with a member of the spousal subsystem. Bill was able to meet Jill's individual needs in a way that Ken was not able to. He made her feel good about herself in ways that Jill desperately wanted. He made her feel "chosen". Despite this strong connection however, the spousal subsystem made up of Jill and Bill, was inherently dysfunctional. It was formed as a consequence of the sexual abuse disclosure and by meeting each other's needs, and by supporting each other's functioning a context was created which allowed the sexual abuse to continue. The boundary around the subsystem with Bill and Jill was less diffuse than with Jill and Ken. Jill excluded the children from this relationship, perhaps because she saw them more as a threat, and also because she recognized on some level that her relationship with Bill would be not condoned and should therefore be more contained.

The parental subsystem consisted of Jill on her own initially, then Ken and Jill together. Both parents had used physical discipline with the girls in a manner which would be described as excessive, or abusive. Jill talked of rejecting her role as a parent initially, and this may have had an emotional impact on the girls. As parents, Jill and Ken were faced with the task of socializing their children, using their authority to enforce appropriate limits. and providing emotional nurturing. Although these tasks don't change

over time, they are exercised in a way that is consistent with the child's development and personality.

For the most part the parents performed these tasks with some difficulty in light of the excessive discipline, and difficulty connecting to the girls emotionally. The couple attempted to support one another in their parenting despite their limitations in meeting the girls' needs. In fact, even when the couple were separated, Jill supported Ken's continued contact with the children, and would even involve him in times of crises around discipline. As previously discussed Jill was experiencing difficulty modifying her parenting to reflect the girls' changing developmental needs. This served a functional purpose at the time because it met Jill's personal needs, plus it was comforting to the girls, during this time of crisis of the sexual abuse to be reassured by their mother's closeness. The comfort this brought was short-lived however because Jill was not completely supportive of the girls, and once the crisis passed, the girls desired the autonomy, and independence consistent with their development. Conflict and stress resulted and the system entered a state of disequilibrium.

Pam and Patricia experienced a close relationship and formed a sibling subsystem. They presented as sensitive to one another's experiences and feelings. The boundary around the sibling subsystem was diffuse, allowing for overinvolvement from parents in the girls' interaction with peers. This resulted in heightened stress experienced by the girls around such things as relationships with boys. For example Jill read a "love letter" that Patricia had written to a boy in her class in which she said she "loved him, and wanted to kiss him". This caused Jill a great deal of anxiety and she confronted Patricia, and restricted her freedom to ensure no contact with the boy. She also demanded to know from Pam who this boy was and asked that she report to her about any contact between Patricia and the boy. This interaction reflects an invasion of privacy that would be considered inappropriate, given Patricia's age. The behaviour is age appropriate and should not be intruded upon by a parent. This was contrasted by Jill's reaction to the

sexual abuse of the girls where Jill had knowledge of inappropriate behaviour and did not intrude. This suggests that Jill was underfunctioning in one aspect of her role as a parent and overfunctioning in another. She also aligned with Pam to "observe" Patricia. The pattern was played out in family sessions. When the three were together, Pam would align with her mother, but when Jill was not there the girls would align with one another.

The girls had difficulty relating to peers, and had trouble in school related primarily to some minor but obvious developmental delays. They frequented the community club but their privileges here were often restricted by Jill. Patricia had recently been caught shoplifting as well. The girls' difficulty in functioning in the outside world may have been related to their lack of autonomy, and overinvolvement by a parent in their sibling subsystem. It may also been related to the impact of the sexual abuse. The family's social isolation as a whole may have also contributed to the children's difficulty in functioning in other systems.

Alignment and coalition

Transactional patterns revealed efforts on the part of the parents to form a coalition with one child, against the other child or against the other parent. For example, a coalition existed between Jill and Pam, against Patricia. This was demonstrated by their scapegoating her for the family's difficulties. This coalition also served the purpose of detouring the stress in the relationship between Pam and Jill. The parents aligned with the children, forming a coalition against the other parent. For example Ken would align with Patricia against Jill, forming a stable coalition. These coalitions had negative effects for the children and placed them at risk of developing symptoms as a result of the stress. Pam and Patricia experienced increased power as a result of being part of the coalition with their parents. The transaction patterns that supported the coalitions had become rigid and inflexible, ultimately contributing to increased stress for the family.

Hierarchy and power

As part of the structural problems which existed in this family, there were obvious difficulties with hierarchy and power. As previously stated the girls possessed increased power when they were joined as part of a coalition by a parent. Ken appeared to have diminished power within the family. It appeared that Jill determined whether he was a member of the family or not, as she initiated the separations and reconciliations. His membership in the family was therefore unpredictable because the couple had separated and reconciled several times since their divorce. Ken lacked power within the family and used violence or controlling behavior as a means to achieve it. In contrast to Ken, Bill had extreme power in the family. He moved quickly from being a border, outside the family structure, to being included as a family member. Although not an adult himself he was given adult status. His status increased when the sexual abuse of the girls was revealed as a result of the sexual relationship with Jill. Once he departed from the home, Jill had difficulty re-establishing her authority with her daughters. Her relationship with Bill continued even once he went to jail and she planned to continue to have a relationship with him once he was released. She continued to hold him in a position of status, even though he was no longer in the home.

Ecological Systems Analysis

Ecological theory is helpful in considering the impact of the sexual abuse on Pam and Patricia. Bill was responsible for the abuse he perpetrated against Pam and Patricia and for continuing it even after he was confronted by Jill. His behavior was purposeful. In considering the impact of the abuse and the context in which the abuse occurred, the problems within the family system served to exacerbate the trauma and impact of the sexual abuse. The actions and inactions of Jill and Ken created a context within which the abuse continued.

In considering Jill as an individual, she certainly suffered deprivation as a child that compromised her function. Her children were also raised in an environment lacking in emotional warmth and caring. This in turn affected their development, and relationship with their mother. Patricia and Pam experienced physical abuse and emotional neglect, which left them vulnerable to the sexual abuse from Bill. They had learned early on that the adults in their life were inconsistent in protecting them and meeting their needs. On a positive note both parents believed their children's disclosure which was a mediating factor. The intervention of outside systems, including C.F.S., the police and court system, was effective in removing Bill from the home when Jill was not in a state emotionally to be able to do so. These systems also worked effectively in that Bill was convicted, the children did not have to testify, and conditions were placed restricting Bill's contact with Jill and the girls, even after he was released from jail.

The family was disconnected from other systems such as extended family, church, and community resources. One strength of the family was that even though Ken was separated from the family, he remained involved with the children, often bringing them to therapy. The fact that the family participated in therapy is also a strength. The family appeared to like coming to therapy, even though at first they were reluctant to participate. They would often come up to an hour early and play cards as a family. They would bring Ken, or a friend of the family, and genuinely seemed to enjoy "therapy" as a family activity separate from what actually occurred in sessions.

Some information about the family's actual living environment was gathered in the assessment. It may have been useful to have done a home visit to further assess their home situation. It was known that the family was supported by social assistance, although Ken was employed periodically. Jill was being encouraged by her social assistance worker to participate in job training which was causing her a great deal of stress. Family members did not identify any problems in their immediate physical environment. Jill had intended to move to a new community, but this was to escape the shame and rejection she was

experiencing as a result of the sexual abuse. The family had established stability in their community, and moving would have caused additional stress.

Jill and Ken had established a small network of friends in their community which was a support to the family. Once they separated though, renegotiating their relationships with the friends became challenging, especially for Jill. She felt that the friends were choosing to support Ken, and this was a tremendous source of stress for her. She also recognized the fact that people rejected her for having a relationship with the man who sexually abused her children. As a result of this, Jill had diminished support to cope with the responsibilities of parenting, and protecting her children. This isolation seemed to draw her even closer to Bill, whom she felt was the only one who could understand what she was going through and would not condemn her for her actions.

With respect to other systems, Jill felt supported by the C.F.S. professionals who were involved with her family. In particular she had a good relationship with her family support worker, and was confident in her abilities. Jill's own personal characteristics impacted on how people related to her. She presented as personable, articulate, and had a good sense of humour. This impacted on her ability to connect with people including professional supports.

Jill and Ken were both Caucasian, and the family's cultural background was not known. The family exhibited typical mainstream cultural values and beliefs. Religion did not appear to be a major influence for the family members.

Therapeutic Goals

The goal of the initial stages of therapy was to gather information and to assess the family. At the same time the goal was to engage the family to promote its participation in therapy. The first priority was to establish a clear boundary between mother and daughters, and to strengthen the parental subsystem, and the sibling subsystem. Another goal was to facilitate communication around the sexual abuse that had impacted the family

and to assist Jill in responding protectively and supportively to her daughters around this issue. As well. a goal was to assist family members in coping with the developmental changes that were accompanying the girls' entrance into adolescence and to help them adapt the structure of their relationships and patterns of transaction. The goals which were derived from the ecological assessment were to assist the family in their interaction with the community including friends, peers, the school and the community center.

Intervention

As previously stated the shift from individual to family therapy was an important step in assisting this family to cope with the impact of the sexual abuse. It was also known that this shift was resisted by family members especially Jill. My ability to join with the family was crucial in order to increase the likelihood that they would continue in therapy. Since it was clear that Jill was most resistant to therapy, effort was focused on supporting her and empathizing with the stressors she was experiencing. For Jill this was significant as she recognized how most people would be disgusted by her behavior with the man who sexually abused her daughters. Providing an atmosphere of respect and acceptance enabled her to feel comfortable and willing to participate in the therapeutic process.

The family recognized me as being in a position of leadership which facilitated the use of restructuring techniques in subsequent sessions. It is my experience during this practicum that families do not always assume the therapist is in a leadership position. This may be a result of the actions of the therapist rather than the family. Confidence, experience, and the ability to accommodate are all factors which influence the therapist's ability to maintain a leadership position with a family.

As previously stated, the goal of the initial stage of therapy was to assess the family. The content of most sessions was dominated by discussion around developmental issues. Tracking questions were used to gather information, and to establish a sense of the transactional patterns within the family. Family members were encouraged to express

themselves. and to respond to what others were saying. This served a restructuring purpose by identifying roles, and differentiating thoughts and feelings between family members

Through the use of these techniques tentative goals were established. A clear boundary needed to be established between mother and daughters; Jill needed to clarify her role as a parent and distinguish that from wife and girlfriend. Education needed to be provided about adolescent developmental issues to normalize Patricia's behavior and change Jill's response to it. Further education also needed to occur for Jill around the impact on her and her children of sexual abuse.

Interventions aimed at delineating boundaries permeated the work with this family. When it became clear early on that Jill lacked the ability to refrain from sharing personal and often inappropriate information in front of the children, she was given a separate session in which discuss her issues. This served a protective as well as restructuring purpose. It provided Jill with an appropriate outlet through which to express her feelings in a supportive environment and it served to redirect individual issues out of family sessions to Jill's individual sessions. This intervention demarcated a boundary around the subsystems of Jill as parent. and Patricia and Pam as children; forced Jill to develop skills in recognizing how her needs were different from her children's; and removed the girls from the stress of the adult world that their mother continued to expose them to.

Jill responded well to individual sessions and used the time to explore why it was difficult for her to adjust to the girls' changing developmental needs and why their independence was threatening to her. She described the significant events in her life that had impacted on how she parented the girls. Jill also began to discuss her feelings for Bill and her past relationship with him. Jill minimized the impact on the girls of her ongoing relationship with Bill. She glorified their family life when Bill was living with them before the disclosure was made, and she continued to have strong feelings of love for Bill. Individual sessions provided an opportunity to confront Jill about the impact of her

relationship with Bill on the girls, both at the time of disclosure and currently. Jill began to express and process strong feelings of failure as a parent, guilt around the sexual abuse, and concern for how the girls would view her when they are grown up. In an effort to assist with problem solving, Jill was encouraged to recognize what she couldn't change and what she could. Therapy shifted to her relationship with the girls and the impact of her ongoing relationship with Bill and plans for reconciliation. Jill was confronted about the possible consequences for the girls and her relationship with them should she chose to continue to have a relationship with Bill. In addition to helping establish boundaries, individual sessions provided the opportunity to support, educate and confront Jill about the issues she was dealing with.

The content of family sessions was dominated by discussion about Patricia's rebellious behavior and family members seemed firmly entrenched in scapegoating her for their troubles. Jill described how Pam was different and (implying better than) Patricia. The family was assisted in establishing rules and consequences around behavior. There continued to be resistance in discussing any issues that related to Bill, Ken, or developmental changes in the girls. This resistance came primarily from Jill, as she minimized the impact of these issues on the girls. The girls frequently looked to their mother before responding and were very guarded in what they said.

Restructuring techniques were used to improve communication and help establish boundaries. For example family members were encouraged to talk to, not about, each other. Patricia and Pam were reluctant to speak for themselves and were encouraged to do so in the session. Jill was encouraged to support the girls' self-expression. I joined with the children when necessary in order to assist them in communicating with their mother. After several sessions the girls became more open toward their mother and discussion, which was initially superficial, became more meaningful. For example during one session, Pam stated "I don't think my mother wants us to grow up". This was extremely significant in the therapeutic process. It represented a change in boundary

between Pam and Patricia as a sub-system, weakening the alignment between Pam and Jill, and legitimating Patricia's position of diminished power within the family. It also highlighted the underlying issue of much of the family conflict which was not so much about curfews and homework, but about the girls' need for autonomy. It facilitated discussion and allowed the family to transform itself and begin to adapt to its changing needs. It was interesting to note as well that Pam made this statement in front of her mother, but not to her mother. This less confrontational, indirect approach was effective in providing a buffer for Jill and she was able to hear and accept Pam's comment. Pam was also aware that therapy was a safe place to disclose her thoughts and feelings, and may have been more guarded with her mother outside of the session. When the comment was made, everyone was so taken aback that it produced laughter from everyone in the room. This laughter was perhaps reflective of the family's relief in being free to move forward in their development.

It should be noted that this family terminated therapy early, after only eight sessions. These sessions were not consecutive and there were often several weeks which passed between sessions. Three of the eight sessions were held with Jill on her own. Clearly there was a need for further involvement, however, Jill terminated her involvement as she felt she needed to think about things on her own for awhile, in particular her relationship with Bill with whom she continued to plan to reconcile once he was released from prison.

The difficulties in this family, although felt most by Patricia, were greatly impacted by Jill and her personal problems. These personal issues had a significant effect on her relationship with her daughters and her ability to function as a parent. She had strong feelings of inadequacy, and loneliness which were so overwhelming that her needs took precedence over her children's. Jill had been seeing a psychiatrist to assist her to cope with her mental health problems, but terminated this relationship just prior to our

involvement. She was encouraged to reconnect with a psychiatrist at termination to further assist her to cope with her personal issues.

From an ecological perspective, family members were encouraged to discuss their experiences with systems outside the family including relationships with friends, school, and social agencies. Jill was threatened by the girls' connections to peers, and was removed from other systems such as their school, and their community club. Jill was experiencing stress in a number of areas of her own life, including her relationships with friends, the community, social assistance, and the court system, who were preventing her from maintaining contact with Bill. During individual sessions, Jill was assisted with problem solving around issues that were stressful in her interactions with other systems. If the family had remained in therapy intervention may have included identifying ways that Jill could have been more involved and aware of the connections the girls had outside the family. This may have reduced her own isolation, further established her role as a parent, and reduced her fear of the girls' connection to peers.

Evaluation

The FAM-III was administered to the family as a diagnostic tool (see Figure 6). It was intended to be used as a means of evaluation however the family terminated prematurely and therefore a post-test was not administered. The General Scale was administered and provided a rating of family functioning in seven different areas. Not surprisingly, the results revealed problematic functioning in most areas.

In terms of task accomplishment, this was seen as somewhat problematic for Jill (T-score 64) and Pam (T-score 62). Patricia's results suggest this was an area of strength for her family (T-score 38). Role performance was viewed as problematic for Jill (70) and Patricia (64), but less so for Pam (56). Communication was identified as a problem by all family members, and affective expression was within the normal range of family functioning for all members. Affective involvement was rated highest by Jill and Patricia,

FIGURE 6

FAM III PROFILE - JILL, PAM AND PATRICIA

FAM GENERAL SCALE
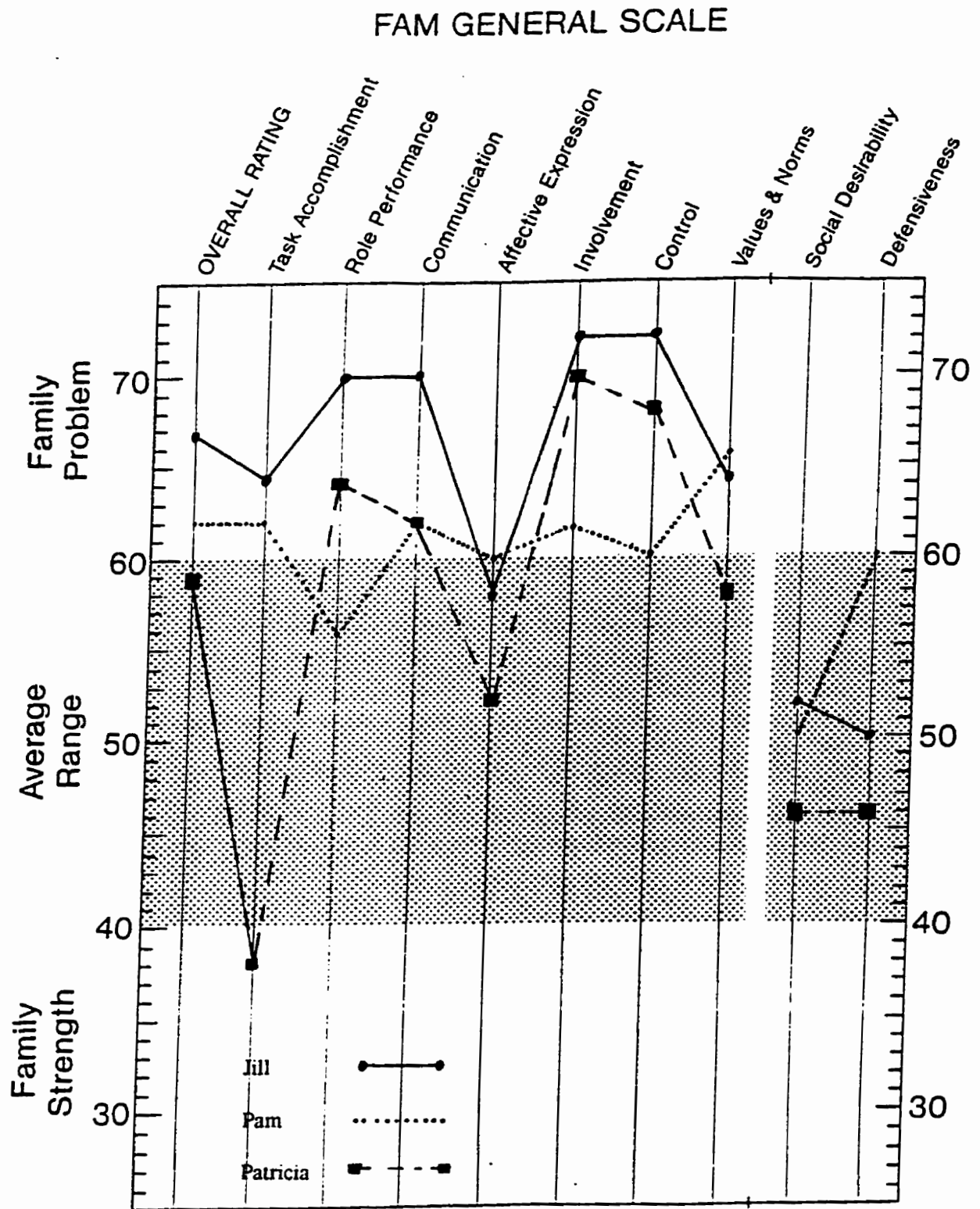
which revealed the lack of autonomy and lack of appropriate emotional connection between family members. Control was rated high for Jill, Patricia, and less so for Pam. Values and norms were reported similarly between family members with T-scores between 58 and 66. It was interesting to note that Jill and Patricia shared similar perceptions of their family's difficulties. In general, affective expression was seen more positively by Pam, and involvement and control more negatively. Pam's perceptions were different and tended to reflect a more positive perception of family functioning over all. Pam rated high (T-score 60) for defensiveness which might account for her different perception of family functioning. For Jill and Patricia, their scores in the areas of defensiveness and social desirability were within the normal range. In summary the FAM-III provided verification for the clinical assessment of the family. In this case it provided further insight in the family's perceptions, and how they were similar and different from one another.

Conclusion

This case was both challenging and rewarding to work with. In many ways this family typifies families who are dealing with multiple forms of abuse simultaneously. This was a multiproblem family which presented as moderately resistant. The issues of resistance and working with multiproblem families will be dealt with in the clinical themes chapter in greater detail. This family more than any another highlighted for me the overwhelming pain that family members feel that keeps them immoblized and locked into their repetitive and often destructive patterns of interaction. Understanding this process helped me to gain further insight into the systems concept of equilibrium and its connection to resistance.

Family #2: Sue

History and Presenting Problem

Sue (23) was referred for counselling by her C.F.S. worker due to concerns about childhood sexual abuse, emotional neglect, depressed mood, and drug and alcohol use. She was the mother of a two year old boy named Kevin, who was in foster care at the time of the initial referral. Sue had been a victim of domestic violence from the father of her child. It was hoped that counselling would help Sue cope with past trauma which was believed to be at the root of her current parenting problems.

Sue came to the attention of C.F.S. when Kevin was born. She was not providing adequate physical and emotional care due to her alcohol problem, depression, and involvement in an abusive relationship. Kevin was apprehended when he was 13 months of age, and placed in foster care. It was anticipated that he would be returned to Sue's care in a few months. Sue had been having supervised access with Kevin once a week for two hours. She was initially uncooperative with C.F.S. and "went through the motions" with alcohol treatment. The visits were generally not a positive experience for Kevin or Sue. Kevin appeared to resent his mother and sometimes acted fearfully toward her. Sue did not cope well with what she perceived as rejection from Kevin, and she withdrew from him. She began to attend visits sporadically, and according to the C.F.S. worker, on at least one occasion Sue was stoned during the visit.

For about four months prior to the referral it was noted by the C.F.S. social worker that Sue was making improvements. She had been cooperative and willing to communicate her feelings around Kevin and his rejection of her. It was as a result of this new openness that Sue was referred for counselling.

At the time of the initial interview, Sue was 7 months pregnant with her second child. She was tall and thin in stature and not noticeably pregnant. Her mood was

depressed. and she frequently complained of being tired. At times she had trouble focusing on the conversation at hand.

Sue was the eldest of three children in her family. Her parents separated when she was 15 years old. Her relationship with her mother was conflictual. Sue's sister, now 17, was recently discharged from a secure facility for adolescent girls with behaviour problems. Sue described her sister as "unstable". Her brother 15, lives with their grandfather. According to the referral source, Sue's father was alcoholic, and was abusive towards his wife. Sue was emotionally neglected by both parents and as a result went into foster care. Sue stated that she left home at the age of 13. She did not discuss her foster care experience where reportedly she had been sexually abused.

Sue completed grade 11 and received counselling throughout her school years from the Child Guidance Clinic. She eventually completed her grade 12 as a mature student then completed a legal secretary course. She did not pass the final exam and therefore. never became qualified. She had an outstanding student loan of $9000. Sue was not employed at the time of counselling and was supported by social assistance. She stated she began drinking in early adulthood. She became pregnant with Kevin when she was 20 years old. She denied drinking during either pregnancy. Sue realized that she was getting drunk as a way to cope with her problems, in particular with Kevin's rejection of her. She also commented that "drinking kills the boredom".

Sue did not discuss Fred, Kevin's father, except to say that he was in jail for a period of time and was not allowed contact with her or Kevin. As a result , he was not a support to her at the time. Sue described herself as socially isolated. She had few close friends who were a support to her. Her mother had offered her support, however, Sue had feelings of confusion and anger towards her mother. She was angry with her for staying with her father as long as she did and for not supporting Sue when Kevin was born. Her mother reported Sue to child welfare authorities which resulted in Kevin being removed from her care. Sue expressed skepticism about the apparent change in her

mother's attitude and added she had trouble trusting other sources of authority including C.F.S. and myself. This was explored with Sue in terms of what her worker's expectations were and what Sue wanted. Other sources of support included Sue's AA sponsor whom she had known since she left home.

Sue expressed feeling confident about the ability to manage Kevin when he was returned to her care. She had been sober for about a year and continued to attend alcohol treatment once a week. She acknowledged that she had to maintain sobriety for Kevin. She also articulated the difficulty Kevin would experience as he separated from his foster mother and reattached to her. She anticipated that there would be a transition period for Kevin as he reintegrated into her home. She expressed being prepared during this time for the fact that he may be angry and resentful toward her as he had been during visits. One overnight visit was planned by the agency before Kevin was returned on a permanent basis. Sue had "babyproofed " her apartment to prepare for Kevin's return. She acknowledged the difficulty in doing this because he was at a different developmental level now than when he left her care.

Part of the justification for Kevin's return had been the fact that Sue was planning on placing her expected child up for adoption. During the intake interview however, Sue indicated she was unsure about her plans for the child. She had been in contact with Pregnancy Distress and understood she must now commit herself to a decision. This caused her distress and she had experienced difficulty sleeping. She discussed keeping the child but believed she could only do so with constant involvement of a homemaker through C.F.S., which she did not want. It was questionable how well Sue could manage both children. Her second child was born during Sue's involvement in the practicum.

Sue was a young woman who has experienced deprivation and abuse during her childhood and adolescence. She was a victim of domestic violence in her current relationship with her children's father. She had some post secondary education and presented as being capable of articulating her thoughts and feelings. Her mood was

depressed and she appeared fatigued. She appeared underweight and frail. The impact of her alcohol use and her poor physical health as well as the welfare of her children were of concern. Sue stated a reluctance to discuss childhood issues or issues in her past as she did not feel that she was different from anyone else in that respect. She did express a desire for counselling around Kevin's return to help understand "his psychological, emotional and developmental stages". The plan was a suitable therapeutic goal and also suited the goals of the C.F.S. agency worker.

Structural Family Analysis

This family consisted of Sue, and her two young children, Kevin (2) and Tyler (1 month). Fred had been a member of the family recently up until his arrest and removal from the home approximately 6 months previously. He was known to have been abusive towards Sue during their relationship, causing her physical injury at times. Although Sue minimized his role in the family given his absence from the home, she continued to maintain a relationship with him while he was in jail, and brought the children to visit him on occasion. The impact of his abuse and his current relationship with the family were an influence for them.

Boundaries

There were numerous changes throughout the short time Sue was in therapy in terms of the structure and membership of the family. Initially, she and Fred were together and Kevin was in care. Then Fred went to jail, Kevin was returned, and Tyler was born. These changes in the family required changes in Sue's role and relationship to family members. The most significant change was the role of parent. In a relatively short period of time Sue went from being part of a two parent family, to having no parenting responsibilities, to having to care for two young children as a single parent. These changes also required her to modify the boundaries between her and the children,

becoming more or less disengaged or enmeshed as the circumstances required. Not surprisingly, Sue had difficulty fulfilling her role and adapting to the relationship changes.

Tyler and Kevin were both at a developmental stage that required a close relationship with their mother. The boundaries between mother and child at this time should be diffuse, and family members are considered enmeshed with one another. This closeness is adaptive in that it allows for parents to recognize and meet their child's needs. As children develop, boundaries between parent and child increase in rigidity to allow for the child's growing autonomy. In this case the boundaries between mother and child were too rigid for the developmental needs of the child. The result was that Sue was unresponsive to the children's queues for care and attention, which inhibited the facilitation of attachment between mother and child. Although not deliberately neglectful, Sue lacked the capacity to be emotionally available to the children. This may have been related to the fact that she herself had not experienced a safe nurturing environment in her family of origin.

Whereas the boundary between Sue and the children could be described as inappropriately rigid, the boundary around the family as a whole was inappropriately diffuse. There was little sense of stability and consistency around who was a member of the family, and whether family members were committed to one another.

The involvement of professional helpers also contributed to the boundary confusion. Due to Sue's inability to perform her role as a parent, she was dependent on others to take over her responsibilities. This reality created confusion around subsystem functioning as well as the boundary around the family. In some respects, Sue functioned in the capacity of an adolescent, while the professional helpers in her life functioned as parents. She wanted to be a parent but was unable or unwilling to function in a parenting capacity. She would quickly give up the responsibility of caring for the children to the helpers. She would then be angry towards the helpers for being intrusive in her life, but would not take the necessary steps toward independence. She was frustrated by C.F.S.

for not providing more homemaking services, but at the same time resented their constant intrusion as she felt she was being "watched". She remained in a state of perpetual crisis which allowed her to avoid dealing with underlying issues.

Subsystems

As previously stated this family went through numerous changes in the time that Sue was involved in therapy and consequently new subsystems were forming and existing subsystems were changing. For example the spousal subsystem which previously consisted of Sue and Fred had changed now that Fred was out of the home. Given that this relationship was abusive, it can be assumed that this couple's ability to provide each other with mutual support was compromised as a result of the violence. It was known that Fred was approximately 10 years older than Sue, which may have explained their attraction to one another, and the dynamics and structure of their relationship. The age difference may have also reinforced the power imbalance between them. The exact patterns of this subsystem are not clear given that Fred did not participate in counselling, nor was Sue open to discussing this relationship in therapy.

The parental subsystem consisted of Fred and Sue initially, then with Sue on her own. The task of this subsystem involves meeting the needs of the children and fulfilling their role as parents. Both Fred and Sue had difficulty fulfilling their roles as parents. Fred had reportedly been physically abusive to Kevin on at least one occasion. Sue's difficulty in dealing with her role as a parent was revealed in her relationship with the children and her difficulty meeting their needs. She had difficulty putting their needs ahead of her own. She became easily frustrated by Kevin's behaviour which she interpreted as stubbornness and defiance. She ascribed adult motivation to the child's behaviour and had difficulty accepting the fact that Kevin was not purposefully frustrating her but rather was acting out his own issues around the transition he was experiencing. Sue's relationship with the children should have been close during this time, however she

remained emotionally distant, and inappropriately disengaged. She continued to be ambivalent about her intentions to parent Tyler. She relied heavily on family and friends to care for Kevin if she was feeling overwhelmed.

It is not known how Sue functioned as a parent when she and Fred were together. It is likely that her autonomy was restricted in this relationship given Fred's violent and controlling behaviour. Sue would have had limited authority, and perhaps she may have functioned structurally on the level as a child. As an adult Sue had limited opportunity to develop a sense of independence and responsibility. Perhaps the role of professional helpers, although necessary, also stifled her attempts to be independent as they perpetuated the fact that Sue could not take care of herself. Perhaps if the professional involvement from the various helpers had been better coordinated then Sue could have benefited more from their involvement.

Within Sue's family of origin, the structure of the relationship with her mother reflected that of parent-teen rather than parent-young adult. Sue was functioning like an adolescent which led to significant conflict, and unresolved feelings in her relationship with her mother. Sue wanted her mother's assistance on her terms, and was unable to see her mother's point of view. For example she was angry at her mother for not leaving her abusive father, yet Sue herself remained in a violent relationship herself. The result of this existing conflict meant that Sue's mother was restricted in her ability to be a support to Sue in a way that would have assisted her and the children.

Alignment and coalition

Sue aligned herself with specific professionals involved against other professionals as a means of influencing others or gaining more power. This was a fairly deliberate act on her part to manipulate the people around her to get what she needed. It was also fairly easy for her to do so because there was limited communication between the systems involved, and helping professionals can be easily persuaded by clients who are complaining

about another agency or professional. For example, Sue tried to align with me against her C.F.S. worker as a means of having more influence with her worker. She also aligned with her C.F.S. worker against her support worker, who she claimed was not providing adequate care. Sue may have established power in these ways as she found that she was ineffective on her own to bring about the changes she wanted. This may have been a result of inadequate skills on her part to advocate and assert herself in appropriate ways, or she may have learned this pattern of relating from previous relationships, or perhaps she found that it was the most effective way to mobilize the resources she needed.

Hierarchy and power

As previously stated, Sue likely had diminished power in her relationship with her partner Fred as a result of his violence towards her and the children. It can also be stated that Sue appeared to function in the capacity of a teenager in many of her relationships such as those with helpers and with her mother. It is possible that with her partner gone and the children returned to her care Sue was having to function as an adult for the first time. Her difficulty doing this was obvious. The extensive involvement of helpers may have exacerbated her difficulty functioning as an adult. Perhaps if the professionals were better coordinated and aware of each other's role and relationship with Sue their involvement could have been helpful.

Ecological Systems Analysis

Ecological theory was helpful in considering the different systems impacting on Sue's life and the relationships between those systems. On an individual level Sue was a young woman with significant personal problems which were long-standing and probably rooted in her family of origin and early adulthood experiences. She used alcohol and drugs as a means of coping which now presents her with a new set of problems. She presented with signs of clinical depression for which she had received psychiatric treatment in the past.

Relationships with family continued to be a source of stress rather than a source of support. She was removed from her parents' care only to be placed in an environment where she was sexually abused. Feelings of distrust and anger toward helping agencies likely resulted from this experience. These early experiences left Sue vulnerable in subsequent relationships, and she was further victimized in her adult relationships.

The intervention of the child welfare system in Sue's life had both positive and negative consequences for Sue. It provided a safe place for Kevin to live while Sue attempted to address the issues that interfered with her ability to parent.. She made significant gains in maintaining sobriety, and in increasing her emotional security. Clearly further gains were required before she was ready to parent, however Sue did not recognize this nor did the agency. Kevin was returned toward the end of Sue's pregnancy with Tyler. Two weeks after Kevin returned, Tyler was born. Kevin was required to stay for two weeks with a combination of friends and relatives while Sue recuperated from a difficult delivery. Undecided until the last minute whether to parent the child, Sue was unprepared for the baby's return home. She described setting up the crib the same day Tyler returned from the hospital. The decision to return Kevin to Sue's care was set by an arbitrary timeline which did not take into consideration Sue's pregnancy. As a result the family was off to a difficult start.

The risk to the children was mediated by the role of helping agencies. Although at times this was a source of stress for Sue, it does reflect positively on her that she was involved and cooperative, often initiating contact. Another strength was Sue's ability to maintain sobriety and to make use of appropriate supports such as AA, alcohol treatment and her sponsor. She was open about her abuse of prescription drugs and the ease with which she could obtain medication. Another mediating factor was Fred's absence from the home. An atmosphere of safety existed due to his incarceration. It was believed that he was in jail for crimes other than violence against Sue. She remained emotionally connected to him, although physically safe for the time being.

In terms of larger systems that affected Sue's situation, she was a single mother who was supported by social assistance and therefore dependent on others for financial support. She lived in poverty, residing in poor housing conditions, in a high crime neighborhood. She was Caucasian, and presented as having mainstream cultural beliefs and values. As a single parent, supported by social assistance, she required the support of additional services to parent her children. Although extensive services were put in place, the lack of coordination, and communication resulted in each professional paying sole attention to his or her role and responsibility. For example, doctors made house calls, support workers provided respite, and various counsellors provided support around their given area of focus including addictions, depression, and parenting. The focus of involvement seemed to be on resolving the immediate crisis rather than coordinating a plan that would eventually lead to reduced involvement and dependency on the various agencies.

Sue's personal network was also problematic. Many of her friends were still involved in substance abuse and she was attempting to sever her connections with them in an effort to maintain sobriety. This was complicated by the fact that she lived in a neighborhood where drugs were readily available, and substance abuse was prevalent. Efforts to establish a network of healthy relationships would be challenging. Sue identified her sponsor as being a significant support for her not only around her drinking but also in providing emotional support. During the time of the practicum however, Sue's sponsor was experiencing serious health problems and was unavailable to Sue at times. This was stressful for her. Sue lacked some basic social skills that would have benefited her in establishing friends and a social network. Her overwhelming personal problems would have limited her ability to be a support with others. Unlike professional relationships, friends and family require "give and take" in order maintain the relationships. Sue would have been compromised in her ability to do this and her network was relatively small.

Therapeutic Goals

Goals of therapy were identified by the referral source, and included assisting Sue in coping with her family of origin issues, and the issues of her current abusive relationship. This counselling was part of a larger plan devised by the C.F.S worker that would lead to Sue's children being returned to her. It was clear that Sue's primary motivation for counselling was to have her children returned.

During the intake process, Sue made it known that the agency's goals for therapy were not her own and she would prefer to work on her relationship with Kevin. The goal was to assist Sue in reconnecting with Kevin emotionally, and to build a relationship with him. Child-management and discipline techniques were also identified as goals for Sue. It was believed that although these goals may not reflect all of the issues that had been identified, they were legitimate goals none-the-less, and related directly to the safety and well-being of the children. It was also felt that through dealing with Sue's identified goals relating to her relationship with Kevin other issues such as family of origin would inevitably surface. It would be preferable therapeutically to deal with those issues at Sue's state of readiness. rather than imposing them as goals.

Intervention

It became evident during the intake assessment that Sue's commitment to therapy was tenuous at best and attempts were made to join with Sue in an effort to shift what was an external to an internal motivation to seek counselling. It was made clear from the beginning that one of the expectations was that the therapist provide feedback to the C.F.S. worker. I demonstrated the ability to be a support to Sue around dealing with C.F.S. in a way that did not undermine her relationship with her worker. I was cautious to join but not side with Sue in her frustration. Other methods used to join with Sue included respecting her difficulty in leaving the house to attend counselling sessions. Home visits were provided as a means of respecting the demands on Sue. It also provided

an opportunity to observe Sue interacting with other helpers, as well as the children. Child care was provided during these times.

Establishing a clear therapeutic contract with Sue remained a challenge. The barriers to this included primarily her lack of motivation, and the overall lack of stability in Sue's life, and the goals imposed externally by the C.F.S. worker. Numerous appointments were canceled primarily due to illness either of the children or Sue. Although child care supports were in place for her to attend therapy she often chose to sleep while the homemaker was there, rather than participate in therapy.

Restructuring Techniques

Sue presented as perpetually overwhelmed and on the brink of a crisis during much of my involvement. Therapy focused on assisting Sue in problem solving in these situations and moving on to more goal oriented thinking. For example rather than being frustrated with Kevin's behaviour, Sue was encouraged to think about how she would like her relationship to be different.

Tracking questions were used to help map out behavioural patterns between Sue and Kevin. For example Sue was having difficulty getting Kevin to eat. Through the use of tracking questions it was learned that Sue rarely eats herself which might have had an impact on Kevin. Child management skills were taught.

Sessions provided Sue with an opportunity to express her feelings about her relationship with Fred, as well as with her mother. Helping her sort through her feelings about these relationships assisted with processing the impact these individuals had in her life. This was a positive first step for Sue who had been reluctant to discuss these relationships to any great extent. Clearly long-term counselling was required to address the underlying issues, however for Sue it was important that she have control over what she shared and with whom. It was important to respect her autonomy in this regard.

Treating Sue as an adult who was responsible for the decisions she made and the

consequences that came with them was an important restructuring technique. This contrasted with how other systems interacted with her, keeping her in a dependent position. Interestingly, one of the biggest sources of stress in Sue's life was the professional helpers. The services included daily homemaking, parenting classes, AA meetings, public health, the C.F.S. worker, her AA sponsor, and frequent visits from Envoy for herself and the children. Sue also maintained ongoing contact with Pregnancy Distress. Sue would be content for therapy sessions to be dominated by expressing her frustration with these agencies. She was also assisted in problem solving to increase her effectiveness in relating to the helpers. She was assisted in expressing her views appropriately during a case conference, which included a number of agencies. An effort was made to have a structural impact on how Sue related to the helpers involved that reflected her adult status.

Therapeutic Outcome

Five sessions were held in total with Sue including the intake session. Three of the sessions were home visits, two were conducted in the office. As previously stated, a case conference was also held. Sue's commitment to therapy remained tentative throughout, and she demonstrated this by canceling numerous appointments. At termination Sue was struggling to care for her two young children and herself. Despite the number of intense supports in place, her ability to provide an appropriate level of care was questionable. She remained resistant from the beginning to discuss family of origin issues or her relationship with Fred. This situation reflected the difficulty when an outside agency selects the therapeutic goals and the client is not willing or able to cooperate with them. Sue had difficulty with basic day to day functioning as she struggled with eating and sleeping problems and depressed mood. Not surprisingly she had difficulty caring for two young children. It is likely that by keeping herself in perpetual crisis she avoided having to deal with painful experiences in her past, and it also served as a means of keeping formal

supports involved. It is possible that therapy wasn't what Sue needed at the time and that she may have benefited more from living in a supportive caring environment, without the responsibility of caring for her children

Evaluation

Two measures were administered to Sue: the Brief Symptom Inventory, and Rosenberg's Self Esteem Scale. The tests were used as a tool to assist in clinical assessment. Sue's BSI General Severity Index was a T-score of 45, and the RSE was 16. These results suggested minimal difficulties in the area of self-esteem, or with personal functioning, as measured as by the BSI. These results contradicted my clinical assessment of Sue and suggested one of two things, namely, that I over estimated Sue's mental health difficulties, in particular her depression, or Sue did not answer the items with complete accuracy and truthfulness. It is believed that the latter is true given the mandated nature of Sue's involvement, and her motivation to be perceived in the best possible way. Neither of the scores provided a means of assessing social desirability, or defensiveness such as the FAM III does. The measures were therefore limited in their utility.

Family # 3. Lynn and Terry

History and Presenting Problem

Lynn and Terry were married and had three children David (11), Ted (9), and Tommy (7). Both Lynn and Terry immigrated to Canada from South East Asia when in their early 20's. They had different racial, cultural and religious backgrounds. Terry was Catholic and Lynn, although raised Buddhist, had converted to Baptist. Both were fluent in English and were employed. Lynn contacted the E.H.C.C. and requested counselling for her family due to arguing and fighting between herself and Terry. She indicated that Terry had been physically and emotionally abusive toward her throughout their marriage. The violence was severe at times, resulting in injury to Lynn however she had never

sought medical attention, or pressed charges against Terry. The couple was prompted to seek counselling as Lynn had threatened to separate if Terry refused to get help.

The couple was assessed and it was determined that marital counselling was not appropriate at this time. Although Terry acknowledged his violent behaviour, he felt that it was "mutual". For example he would push Lynn and she would push him back. He held Lynn responsible for his violent behaviour because she made him angry and he felt she provoked him to be violent. He described at length the ways that she angered him, shamed him and failed to meet his expectations. Terry clearly minimized the frequency and severity of abuse he perpetrated against his wife. Given his level of denial, and the on-going nature of the abuse it was determined that Terry needed to address his violent behaviour before the couple could be seen together in therapy. Terry was referred to the EVOLVE program and Lynn continued with individual counselling at the E.H.C.C.

Lynn was born in the Philippines and had seven sisters and two brothers. Three of her sisters and her mother were in Winnipeg. Her father died when she was sixteen. Terry also came from a large family many of whom also immigrated to Winnipeg. His parents lived with Lynn and Terry and assisted them in raising the children and maintaining the household. Terry's mother died last year, and his father continued to live with them.

Lynn stated that she met Terry soon after she immigrated to Canada. They dated for two years and then got married. Violence began when she was pregnant with her second child and Terry was angry with her for getting pregnant so soon after their first child. He came after her with a knife when she informed him of the pregnancy, chasing her into the bathroom while holding David in his arms. He broke down the door in an effort to get to Lynn. She stated that Terry had been violent with her about once a month throughout their marriage. The most recent incident occurred two weeks prior when the couple was arguing and Terry gripped her neck and tried to choke her. Lynn stated she was peeling vegetables at the time and had a small pearing knife in her hand. She went to cut his arm in an effort to stop him and he quickly withdrew his hands.

There was significant conflict between the couple around family obligation and loyalty. Both Lynn and Terry indicated feeling unwelcome with their in-laws to the point where they avoided contact. They did support a continued relationship between their children and the respective families of origin. Both parents felt a strong sense of support and obligation to their own families of origin.

Other areas of difficulty had been around the children. Both parents expressed concern about the impact of the children witnessing violence between them. In the beginning the couple tried to keep their fighting away from the children however now that the children were older this was not possible. Terry accused Lynn of turning the children against him. There were disagreements between the parents about raising the children in terms of their religion, culture, and education.

The couple identified a change in their relationship occurring after Terry's mother died. There had been an increase in conflict and violence. This may have been related to the change in roles and responsibilities within the family. The paternal grandmother provided the family with assistance in terms of cooking, child care, and cleaning. Now that she was not there Terry expected Lynn to complete these tasks, and Lynn expected Terry to.

Structural Analysis

The structure of this family reflected the effects of ongoing domestic violence. In many ways Lynn and Terry ceased to be a couple, and functioned like two individuals. Lynn's pattern of relating to Terry, and to her children was shaped largely by the violence and her efforts to keep herself and her children safe.

Subsystems

The marital subsystem consisted of Terry and Lynn and was formed when the couple met and got married. Lynn described the first few years of their marriage positively and it would appear that the members of the couple were able to support one

another. Both came from traditional patriarchal backgrounds and both fulfilled their traditional roles in a complementary manner. This was functional for the couple for a period of time but then conflict increased and the marital subsystem began to deteriorate. Terry became violent, causing further destruction to the relationship. The couple were distanced from one another and their needs were not being met by one another. When the couple presented for therapy, the marital subsystem was not at all functional, and the couple were not providing support to one another. The basic tasks of the marital subsystem were not being met and the marriage was coming to an end.

The parental subsystem was troubled in that both parents were punitive and restrictive in their parenting approach. The parents' ability to nurture, guide and control was likely affected by the same issues that affected their marital relationship. The existence of violence was also very damaging to the children in terms of their ability to trust. and feel safe in their environment. Although the children's basic needs were met, the emotional climate was conflictual, and unpredictable. Terry and Lynn involved the children in their conflicts which exacerbated the effects on the children. The couple had difficulty making the necessary adjustments around roles and responsibilities in terms of running the household and caring for the children. Lynn worked two jobs and Terry was unemployed. Despite this he insisted that she perform the majority of child care and housekeeping duties. This issue was managed adequately when the paternal grandmother was in the home, however when she died the couple failed to make the necessary adjustments to adapt to the change.

The sibling subsystem consisted of the couple's three boys. They were all school aged and had contact with systems outside the family. Less was known about the boys' relationships with one another as they were not involved with counselling. It is known however that the family as a whole was isolated and Lynn in particular did not want the boys involved in any outside activities. Their contact with peers was restricted and they were not involved in any activities outside of the home. The task of the sibling subsystem

is to have enough independence from parents, to begin to experience social contact which will eventually prepare them for the outside world (Minuchin, 1974). It is likely that these boys were preoccupied with the parents' problems and their own concerns for safety to focus on their relationship with each other. Their ability to master these functions would therefore be compromised.

Boundaries

The boundary around the marital subsystem was diffuse and this led to problems for the couple. In particular it resulted in intrusion by the in-laws from both sides of the family in the couple's problems. Both had maintained a closeness and an alliance with their respective families of origin. Over time Terry and Lynn became closer to their families of origin than they were to each other. Although the boundary around the marital subsystem was diffuse, the boundary around Lynn and Terry as individuals was rigid. The problems which resulted from this impacted the marital subsystem which has already been described above.

As a result of the diffuse boundary around the marital subsystem, the parents related to their children not as a unit, but as separate individuals. This also contributed to alignments and coalitions which will be discussed later. The boundary between Lynn and the children was diffuse and she and the children were extremely close to one another. This closeness evolved as a protective function for the children, and perhaps for Lynn as well. The children were often physically close to her, for example sharing the same bed, which may have been effective at times in keeping Terry at a distance. Although this closeness was functional at times, it brought the children closer to the parental conflict, and placed them at greater risk both physically and emotionally. The diffuse boundary and enmeshed relationship also resulted in family members being overly sensitive to each other's feelings and emotions as the boundary failed to block these from reverberating from one person to another.

Less is known about the boundary between Terry and the children. It can be assumed however that his violence resulted in emotionally distancing him from the children thus the boundary would be more rigid than what would be considered appropriate for a family at this stage of development.

The boundary around the family as a whole was very rigid, particularly for Lynn and the children. She was very distrustful of the outside world, a belief which she passed along to her children. Consequently they were isolated, and somewhat dependent on Terry as their contact with the outside world. This increased his power within the family, contributing to the vulnerability of the other members. The children were isolated from relationships with peers. Lynn stated that on one occasion she allowed the boys to have a friend over and he stole something from the house. They had not been allowed to have friends over since that time.

<u>Power and Hierarchy</u>

A significant power imbalance existed within the marital subsystem which affected the entire family and its structure. Terry used emotional abuse, threats and violence to maintain power and control in his relationship with Lynn. This had a destructive effect on the marital subsystem and resulted in Terry being in a higher position hierarchically than Lynn. Lynn's authority with the children was compromised as well because of her diminished power in the family. Lynn had very little influence with her husband in such matters as renegotiating roles and responsibilities for child care, and housekeeping tasks. As a result she worked two jobs, functioned as primary caregiver, and maintained the household. The couple needed to adapt to its changing circumstances (i.e., death of the grandmother, and Terry's unemployment) however the change was resulting in Lynn being burdened with the majority of responsibility. She had limited power to influence a more positive adaptation to these new circumstances.

Alignment and Coalition

The problems with hierarchy and diffuse boundaries between subsystems created circumstances for alignments and coalitions to form within the family. Lynn became aligned with the children against the father. Terry saw this alignment as Lynn's deliberate attempt to turn the children against him. This alignment between Lynn and the children may have served a protective function for Lynn as well as the children against Terry's violence. Lynn may have achieved some power in her relationship with Terry when she was aligned with the children. Terry recognized this and made efforts to sever the alignment. For example Terry refused to allow Lynn to speak to the children when she was away from the house at work. This was an unhealthy dynamic for the children and the patterns in the family revealed that the children were frequently used as pawns in the marital conflict. As this family matures, in particular as the children get older they may take on more adult functions for example, one of the children may act as protector for Lynn, one may be a mediator between Lynn and Terry. The coalitions and alignments became part of the way the children adapted to their circumstances of being caught in an ongoing marital battle.

Ecological Systems Analysis

The larger systems that have an impact on this family should also be taken into consideration. Those systems included the culture and religion that Terry was a part of and the culture and religion that Lynn was a part of and the broader culture which was different from both of those. Terry was Pakistani, and was Catholic. Lynn was from the Philippines, and was raised Buddhist, but recently became a Baptist. Terry brought to the relationship a background which was patriarchal in nature. Lynn brought a family of origin history which in itself made her vulnerable to violence as she has been a victim in the past and witnessed domestic violence between her parents.

The experience of immigration can be stressful for individuals, and they can experience racism once arriving in Canada. The couple connected to their own families in part as a means of maintaining culture, familiarity, and a sense of belonging. These may have been difficult to obtain through other social interactions due to cultural differences. After a period of time, Lynn enjoyed participating in social activities in the Filipino community usually without Terry. This highlighted a dilemma for the couple. Because they were biracial (Pakistani and Filipino) they had no shared community. This created stress for them, contributed to their isolation, and intensified the bonds with their own families origin, all of which contributed to conflict between them.

There had been very little involvement with outside agencies prior to Lynn's request for counselling. The police had been called on one occasion by Lynn when Terry refused to allow her to talk to the children. The police attended the home to check on the children and advised Lynn not to return home that evening out of concern for her safety. This was a significant learning experience for Lynn given that the police were not able to assist her in any way and she remained in a position of diminished power outside the home. It was after this incident that she contacted a lawyer who advised that she obtain counselling with her husband before they legally separate. She was referred to an agency that provided counselling to women, but would not include men in the process. These were very frustrating experiences for a woman who was being battered and was trying to seek help.

Lynn's employment was a significant system to which she was connected. She reported frequent conflicts with coworkers and employers, and her work seemed to be an ongoing source of stress. She resented the fact that she worked two jobs and her husband was unemployed. Her employment although stressful, did reduce her isolation. Despite these two jobs it would have been difficult for Lynn to have supported herself and the children due to the fact that the jobs did not pay well.

Lynn's social relationships consisted primarily of those with her immediate and extended family. Terry's controlling nature made it difficult for her to establish relationships outside of the family. She was fearful of leaving the children alone with Terry and as a result, when she wasn't at work, she tried to spend as much time with the children as possible. This had an isolating effect on both her and the children which was exacerbated by her inherent mistrust of people. This extended to the various systems the children were connected with such as peers and school. Lynn was beginning to establish connections to the Baptist church. This provided contact with peers for the children, and opportunities for connecting with other adults for Lynn. It was a safe place where Lynn could be assured that Terry would not likely ever be a part of.

Therapeutic Goals

Lynn presented for therapy with the hope that she and her husband could receive counselling together. She agreed to individual therapy but needed to shift her expectations of what therapy could provide, specifically that individual counselling for her would not change her husband's behaviour. She recognized the limitations of individual therapy to change her situation, and over time began to use therapy as a means of dealing with individual issues. The general goal of therapy was to help Lynn to remain safe by assisting her in realistically appraising the level of risk for herself and the children and implementing a safety plan. Another goal was to provide support around her decision-making with respect to the relationship. Lynn identified that she wanted to become more emotionally independent. Lynn's relationships with family of origin, and coworkers were also areas she wanted to make changes in.

Intervention

A total of 12 sessions was held with Lynn over a three month time span. Lynn was initially guarded in therapy and admitted that she had difficulty trusting people. This may have originated from abusive family of origin experiences, or perhaps her experience of

immigration. Her way of relating to people reflected her overall view of the world and of people as dangerous. This perception contributed to her isolation, and the isolation of her children. Exploring her feelings on this issue helped Lynn to understand her own behaviour. More importantly though was that the relationship with me became a means by which she could have a positive, trusting relationship, an experience which may change her view.

Joining techniques were used to engage Lynn in the therapeutic relationship. She became more open over time, and spoke openly of the areas of her life that were causing her stress and that she wanted to change. It is interesting to note that Lynn did not disclose any incidents of violence during the entire time of therapy despite my inquiries. In retrospect it was possible that Lynn may not have chosen to confide in me regarding violence because of the possible consequences or perceived consequences. Lynn always said that if Terry was ever violent with her again she would leave him. By not reporting any violence to me she permitted herself to stay in the relationship.

Another goal identified by Lynn was to achieve a sense of emotional independence. She recognized that she entered the marriage with Terry with the expectation that it was her role to make Terry happy and his role to make her happy. We explored the ways in which Lynn could develop emotionally satisfying relationships and activities that would enrich her life and would not place her at greater risk in her marriage. Lynn's ability to identify this goal reflected insight on her part on her dependence on others to make her happy. Perhaps she was also aware of Terry's limitations in meeting her emotional needs. Lynn began to develop a close relationship with her sister, and they attended some social gatherings together. Lynn expressed an interest in taking a course in hair cutting or flower arranging and I directed her to the appropriate resources. By reconnecting with her sister, Lynn found a relationship which could meet her needs in a way that would not put her at risk with her husband. This relationship may have facilitated changes in Lynn that would impact on her relationship with her children, friends, co-workers etc.

Assertiveness was another area addressed in therapy. We discussed some of the difficulties Lynn encountered at work because of her inability to express herself. It became evident that Lynn could be very effective in some situations, particularly when she was advocating on behalf of other people, like her mother or her children. Identifying these strengths was helpful to Lynn and she was encouraged to use the same skills in different relationships. It was also acknowledged that there were times when Lynn may chose not to assert herself because it would place her at risk. She was encouraged to consider reframing being silent as a conscious choice, and not something that diminishes her assertiveness. These skills assisted Lynn in realizing her options.

Family of origin relationships were also a focus of therapy for Lynn due to her history of physical abuse from her mother and witnessing violence between her parents. Lynn also had struggled to cope with the death of her father as she felt a tremendous amount of guilt around his death. Lynn felt like a burden had been lifted from her shoulders as she had never shared her feelings about her father with anyone before. Processing her feelings around these early experiences assisted her in relieving some of the stress they caused in her life.

From an ecological perspective there were many layers of systems that were impacting on this family. This perspective was helpful in my own understanding of Lynn's situation and her connection to her culture, religion, extended family, etc. If therapy continued, other ways of reducing Lynn's isolation may have been explored. She and the children may have benefited from connecting to activities they could enjoy together outside the home, or she may have benefited from connecting with their school.

In summary, therapy assisted Lynn in creating options beyond remaining in the abusive relationship. She could not change her husband in therapy and it was believed that he did not attend the group he had been referred to. Lynn had given thought to separating but was clearly overwhelmed with what her life would be like on her own. Therapy was directed at helping her broaden her world so that she was less isolated and less distrustful.

It also gave her some skills in assertiveness which could be beneficial in all her relationships.

Therapeutic Outcome

Lynn appeared to enjoy the therapeutic relationship and was motivated in identifying and working towards goals. What was most challenging for Lynn was the fact that her ability to make changes in her life was limited by her relationship to Terry, and the environment she was living in. As previously discussed, she had limited power in her relationship to bring about changes, and the majority of her difficulties were arising from the circumstances of the abusive relationship. Therapy may have been helpful in connecting Lynn to relationships outside her immediate family and increasing skills in dealing with those relationships. This was important whether Lynn chooses to remain in the relationship or not.

Evaluation

The BSI and the RSE were administered with Lynn as pre- and post-test measures. The pre-test results of the BSI, General Severity Index, converting to T-score was 57, and the post-test was 54. Although these results suggested a slight improvement, it was minimal. Similarly with the RSE, the score at pre-test was 27, and at post-test was 22. Lynn clearly enjoyed the therapeutic relationship and verbalized a sense of improvement in her life as a result of therapy. She expressed a desire to continue her therapy at termination and therefore the case was transferred to a different therapist at E.H.C.C.

SECTION FOUR: CLINICAL LEARNING THEMES

This final section will explore some of the clinical themes which emerged during the practicum. Many families were difficult to engage in the therapeutic process and I wanted to better understand their "resistance". In particular I wanted to explore the reasons behind the resistance that was encountered, and any connection to the dynamics around family violence. Some families were defined as "multiproblem" and they brought unique issues to the therapeutic process which warranted further discussion. It was found that some families that were coping with violence were also dealing with other problems including alcohol abuse. It was important to understand the relationship between these issues, and some of the intervention strategies available in the current literature. Finally, ethical considerations were explored as a means of highlighting the key issues from a broader perspective which impact therapy with families where violence has occurred.

Resistance

During the practicum experience it became evident that many of the families seen appeared resistant to therapy. Resistance is considered anything which works against positive change for an individual or family. This was demonstrated in a number of ways but one of the most obvious was the termination of therapy after two or three sessions. As a result, it was difficult to obtain the required number of clients for the practicum, and it wasn't until after 12 clients in total were seen that a relatively committed group remained.

McCown and Johnson (1993) identify different types of resistance encountered in family therapy. The first group resists the initial referral for treatment. They add that this can occur even when the family is mandated to attend. The second group demonstrates superficial cooperation but acts in ways that prevent effective treatment. The third occurs when the family attempts to dictate the terms of treatment to the therapist. For example family members may insist that certain individual members be included or excluded.

Another group are those who "therapist shop" and never remain in therapy long enough for there to be any benefit. Another way of resisting is through scapegoating an individual family member. For example when the therapist working with the resistant family refuses to accept the belief that the family's problem does not extend beyond that of one or two targeted members, the family will typically react with anger towards the therapist (McCown & Johnson, 1993).

Being relatively new to the field of family therapy, one tends to feel responsible when families terminate therapy early. McCown and Johnson (1993) state that when the family abruptly terminates treatment or fails to comply with the therapist's recommendations it is often assumed the therapist was inexperienced, careless, or in error. Although it cannot be assumed that every client that terminates early is resistant to therapy, early termination and its relationship to resistance warrant further discussion.

Resistance can be encountered in a variety of ways, not just in the early termination of therapy. It was my experience that resistance was encountered in some form in the majority of clients seen in the practicum. For this reason it is important to be aware of resistance and its various forms and to consider it a key to how the family functions as a system. It should not be avoided but rather it should be incorporated into the therapist's ongoing conceptualizing and intervention.

From a family systems point of view families resist change because there is comfort in the system maintaining itself the way it is. Minuchin (1974) states that the family offers resistance to change beyond a certain range and maintains preferred patterns as long as possible. This is a necessary function of families in order that they can maintain a sense of stability and therefore it should not be seen necessarily as negative. The concept of homeostasis describes how the family as a system will attempt to maintain a state of equilibrium. Fishman (1993) states that homeostasis does not describe a totally static state, lacking growth and development, but rather a consistent steady state that all living things must have in order to exist. He adds that in the family that is functioning well, the

process is fluid and dynamic and by its nature incorporates developmental change even as it lends stability. Families can become "stuck", however, and continue repeating the same dysfunctional patterns. These families are resistant to intervention aimed at finding new ways of coping with their situation. In the face of stress these families increase the rigidity of their transactional patterns and boundaries, and avoid or resist any exploration of alternatives (Minuchin, 1974).

Thus change is stressful for families and whether the pressure on the family is external or internal they will sometimes resist changing in response to it and they may resist interventions which encourage change. Hoffman (1980) suggests we can think positively about resistance, since it often generates the momentum needed to accomplish change. In average families, the therapist relies on the mobilization of family resources as a pathway to transformation. In resistant families, the therapist needs to become an actor in the family drama, entering into transitional coalitions in order to skew the system and develop a different level of homeostasis (Minuchin, 1974). The structural family therapy model in particular anticipates resistance in working with families. Anderson and Stuart (1983) state that structural therapists are viewed as responsible for avoiding or overcoming resistance, and are asked to modify their timing, their style, and their interventions to accommodate to what families can use. It is important therefore that resistance be seen in a larger context, as a function of the system, and not something which should be personalized by the therapist. This perspective allows for creative thinking around alternatives for intervention.

There are additional considerations when working with families affected by violence who are resistant to therapy. There may be safety risks to family members who speak out about the violence, therefore there is pressure to resist intervention by all members not just those who are responsible for the violence. Power imbalances within families may make it difficult for some to speak freely in therapy and therefore it may be difficult to obtain accurate information that reflects the family's functioning. Feelings of

shame may also contribute to resistance. McCown and Johnson (1993) state that even when abuse has already been identified as a problem and is the reason for the referral to therapy, resistance to change can be encountered. Eliciting family dynamics surrounding the issue is still likely to be impeded by both shame and family expectations of privacy, as well as concern that the therapist's discoveries could be used to harm certain family members in court situations (McCown & Johnson, 1993). For these reasons, many families who are dealing with violence do not seek therapy voluntarily for the above reasons. As a result they are often referred or mandated to attend by C.F.S or legal authorities. It should be noted as well that in my experience these families who are violent and resistant may also be hostile. This presents certain challenges to the therapist as personal safety also becomes a factor.

A review of the literature was conducted to identify strategies for intervening with resistant families. It was discovered that resistance was rarely dealt with as a separate issue and in fact there was resistance in the family therapy movement to it being identified as an issue at all. In one view, the concept of resistance is central to psychoanalysis and therefore as having no place in the brave new world of family therapy (Anderson & Stewart, 1983). As previously stated structural therapy incorporates resistance into the schema of family functioning, in particular, by the term homeostasis. It could be said that all structural intervention techniques are aimed at addressing resistance. Anderson and Stewart (1983) state that the emphasis placed by structural family therapists on "joining" maneuvers, and the careful attention they pay to the way in which tasks and directives are presented can be seen as prescriptions for avoiding, minimizing, or overcoming resistance even if they are not presented as such. Structural therapy however, does not identify the unique issues for families dealing with violence and the resistance that might result.

McCown and Johnson (1993) developed a model called the consultation-crisis intervention model. They propose a series of interventions designed to reduce treatment resistance and potential crisis-proneness while maximizing the desire of the system to

overcome its dysfunction. Their strategy is to intervene first in the presenting crisis, defusing it sufficiently so that the family can function, but not so stringently that the family's motivation for treatment is dissipated. Following this, they advocate a change of therapeutic roles to that of consultant, working with the family to avoid their propensity for early termination. Unlike many traditional family therapy interventions, the techniques they advocate empower families to change themselves, rather than mandate them to respond to system disruption. The power of the therapist in the family system is de-emphasized, with greater consideration placed upon allowing the family to change its own environment and eventually itself (McCown & Johnson, 1993). This model is creative and insightful, and recognizes the complex cycle many families experience of repetitive crisis and early termination of treatment. Its applicability to families affected by violence may be limited, and the authors caution that a more directive approach may be needed particularly when the family may be prone to making decisions for itself which may be hurtful to other members.

Weakland and Jordan (1990) identify a framework for working with reluctant clients in a child welfare setting. Although this was not the focus of the practicum, the issues were similar to what a child protection worker may encounter, and therefore the strategies are relevant. As previously stated, many clients seen during the practicum were referred by C.F.S. and were mandated to attend. Some had difficulty adequately meeting their children's needs for a variety of reasons, and safety concerns were apparent throughout therapy. The model addresses the needs of the situation, and the strengths and values of the family; and suggests that change formulated in terms that the family sees as both positive and consistent with its values is more likely to be accepted, adhered to, and incorporated into the ongoing fabric of family life (Weakland & Jordan, 1990). The importance of building cooperation quickly, forming an agreement of what the problem is, and building a safety net and network of support are key aspects of the framework. This

model is applicable for working with abusive families, and is more directive than those previously discussed.

The following case examples will explore how resistance was expressed, what impact it had on the therapeutic process, and what intervention strategies were used to deal with it. Kay was a 25 year old woman who requested therapy to assist her with self-esteem issues as she was feeling depressed in her current situation. She described her partner as physically and emotionally abusive and she had experienced abuse in her family of origin as well. During the process of therapy is was learned that she was seeing another individual therapist for the same issues. This was considered unhelpful, and it was suggested that she terminate with one of the therapists to avoid duplication and confusion. She resisted this directive as she seemed to gain a sense of comfort from the involvement of both therapists. This had an impact on therapy in that she spent a lot of energy considering any similarities and differences between the two therapists' approaches. Although this was not overtly resistant, it clearly had an impact on the ability of the intervention to be effective. It was a strategy which allowed the client a means to delay change and resist exploration of alternative ways of coping. The other therapist was contacted with the client's permission and it was learned the client had been referred to the E.H.C.C., but proper termination had not occurred with the previous therapist. She did not see the harm in maintaining an ongoing therapeutic relationship while her client was being seen elsewhere. The matter was raised again with the client and it was suggested that therapy be terminated if she remained involved with her previous therapist. This case highlights the subtle but effective ways clients can receive the "benefits" of therapy; the supportive environment, empathic listening etc., while avoiding the stressful aspects of making changes to how they live their lives.

Jill and Ken demonstrated resistance in different ways during the course of therapy. As previously discussed this family was referred to the E.H.C.C. as a result of the sexual abuse of Jill's daughters by a friend of the family who later became the mother's

boyfriend. The step-father of the children had been accused of being physically abusive to the mother. This family battled resistance from the onset. They had difficulty accepting the impact of the sexual abuse on them as a family. This was demonstrated by a series of cancelled appointments. It is interesting to note that although the family was resistant to attending therapy, they did not want to terminate therapy. This family experienced frequent crises and relied on me to provide support and assist them to alleviate the presenting problem. This dynamic was effective for the family because it alleviated the stress caused by the immediate problem, but also eliminated the need and motivation to participate in planned therapeutic intervention. McCown and Johnson (1993) state that interventions must effectively challenge the family to implement genuine modification or change. Otherwise, such interventions merely provide a temporary solution to a dysfunctional system, changing nothing in the process. With this particular family they were able to maintain their state of homeostasis by staying connected to me, but not actually doing any therapeutic work.

Once my response to the family's behaviour changed, they reacted differently and attended therapy. Phone calls were limited, and attempts were made to deal with crises in session rather than at the time they were occurring. Resistance presented itself in other ways however, and the family attempted to control who attended therapy. In particular the step-father opted not to attend. His absence was a reflection of the family's attempt to maintain equilibrium, and the mother's attempt to control the process of therapy. This was accepted as it was clearly necessary for the mother that he not attend and it was not crucial for the therapeutic process that he be present. Contracting was also used to deal with the family's pattern of canceling appointments. This was effective in challenging their ongoing pattern of resistance and avoidance. Eventually the family became somewhat more open to therapy and the resistance level dropped from an extreme to a moderate level. McCown and Johnson (1993) state that structural and strategic therapies have been particularly effective in developing techniques to overcome mild or moderate resistance.

This family responded well to restructuring techniques once their initial resistance was diminished.

In two cases where the women had been referred by their C.F.S. worker, there was resistance over the goals of therapy. These examples highlight how the referral process itself can contribute to resistance to therapy. In both cases the women had children who were in agency care and were involved with abusive men. Both had been abused in their families of origin. Clearly there was a need for therapeutic intervention, however, their needs were often more immediate in terms of food, safety, stability, etc. and therapy may not have been the most appropriate intervention at that time. Weakland and Jordan (1990) stress that the needs of the situation must be addressed in order to be effective. In both these cases the issues had been identified by C.F.S. and the focus of therapy predetermined. This proved to be counter-productive because although the worker may have been accurate in her assessment of what the issues were, the client may not have perceived the problem in the same way and was therefore, resistant. For example the worker may believe that the woman's parenting difficulties were related to her family of origin issues and identified the resolution of these issues as the goal of therapy. This may not be relevant to the client, and in the case of one woman she did not see her childhood as being any different than any one else. It should be noted that these clients were already resistant to change, and this strategy added weight to their struggle to resist, and avoid therapy. Even mandated clients should have control over the goals of therapy otherwise it is unlikely that they will invest in the therapeutic process.

The literature supports this approach as well. Weakland and Jordan (1990) suggest that an important issue in working with resistant clients it to agree on what the problem is. They state that success will depend greatly on how well the case worker can give advice in terms that "make sense" to the client, that is in terms that recognize and fit with the client's own views and language. Starting with the client's view of the problem is as relevant in child protection as it is in therapy. Imposing the worker's view of the

problem will likely be met with resistance, as was the case for the women that were seen during the practicum.

Efforts were made to work with other systems around increasing flexibility around therapeutic goals. It should be noted that in some cases the workers identified what needed to change in order for the children to be returned. Therapy often would then address this issue or issues as part of a plan for reunification. A woman may chose to work on other issues in therapy however this may not lead to the return of the children if there is not sufficient change in the targeted area. In my experience it is preferable for referring agencies to specify the desirable outcome of therapy, not the process or goals, or not state that the client simply attend therapy as a goal in and of itself.

In conclusion, the practicum provided a learning experience of the issues related to resistance. Of particular relevance was the way that resistance is a function of the family system and that intervention should address the part of the system which keeps the family "stuck". Resistance is expressed in different ways and even clients who are "voluntary" can display resistance to change. It was also learned that in exploring resistance, other contexts need to be considered such as the impact of other systems or the therapist him/herself.

Multiproblem Families

The term "multiproblem" is used to describe families with specific characteristics, not just those that are encountering multiple problems. One of the characteristics of multiproblem families is that the problems they face exist in multiple layers of the systems in which the family is embedded. Suarez, Smokowski, and Wardarski (1996) list the following problem areas which are typically found in multiproblem families: income, housing, parental help, child behaviour, family relationships, education, foster care and physical health. Families often lack the resources to deal with these problems.

Multi-problem families tend to be socially isolated and unconnected with the community, and many are in need of social skills training to help them to locate and utilize resources and supports (Saurez et al., 1996).

Rothery (1993) describes multiproblem families as those who are poor, deprived of social and concrete resources, are often highly (though not happily) involved with a number of formal social service agencies, are prone to crises and are frequently regarded as impossible to help in any lasting sort of way. Multiproblem families are distinct because of their belief that their attempts to solve their own problems will be inadequate and they are easily overwhelmed as a result. Schlosberg and Kagan (1988) state that the most striking thing about multiproblem families is their resistance to change, despite the orders, pleas, exhortations, and combined efforts of multiple community agencies. For some families it is the involvement of the agencies themselves that they resist, rather than changing.

Multiproblem families are often at risk of abuse and neglect due to the combination of the characteristics described above. In fact, abuse tends to be the major situation in multiproblem families that comes to the attention of social service professionals (Suarez et al., 1996). In work with multiproblem families, some of whom were violent, Rosenthal and associates observed two extremes in family functioning. One extreme involved families that exhibited inertia, feelings of futility, feelings that they were no good, and had no control over their fates, and the other consisted of females that were involved in constant activity which often involved antisocial acts (Wells, 1981). Minuchin (1971) describes the style of communication in multiproblem families as one in which people do not listen or respond to one another, gain attention by yelling, do not resolve conflicts or develop themes, have a limited emotional range, and are not able to elaborate on questions or gather information. In a study assessing patterns of communication, Wells (1981) found that multiproblem families had a great potential for explosive behaviour. Given the

dynamics in multiproblem families and the lack of internal and external resources it is not surprising that abuse and violence are prevalent.

Rothery (1993) proposes conceptualizing family functioning along a continuum which is defined by the types of stress families characteristically deal with and the responses they favour as part of a model for assessing family ecology of multiproblem families. *Adaptive families* experience their stresses as manageable. Their resources are adequate for their needs, and they are effective at using them. *Stable families* experience their stresses as manageable until changes to established patterns are called for. They therefore emphasize stability maintenance even when adaptive change is required. *Crisis prone families* may be able to attend to members' developmental needs during stable times, but when perceived basic needs intrude (as they frequently do) stability becomes a priority. The family's sense of its own competence and resources is such that stress leads to a loss of organization within the family and escalating efforts to get external agents to help with problem-solving. *Chronically disorganized families* enjoy few periods of stability, and few extended periods when they are successful at meeting their members needs. The family's sense of efficacy is damaged to the extent that even relatively moderate stresses lead to internal loss of organization and a search for external supports (Rothery, 1993). It is the families at the least adaptive end of the continuum for whom traditional approaches to family therapy are often ineffective. Creative approaches to treatment to address the complexity of the problems are required.

An ecological framework is helpful in conceptualizing and intervening with multiproblem families because of the focus on the different systems impacting on the family. Families facing a multiproblem crisis need intrafamilial attention, as well as environmental assistance (Suarez et al., 1996). Given the importance of environment as both a source of stress and a potential resource for multiproblem families, many traditional family therapy approaches do not adequately address the needs of the multiproblem family. Traditional family therapy considers the family unit to be the focus of intervention, and

that work with this unit in isolation is necessary and sufficient for the relief of human pain (Rothery, 1993). The ecological model implies a range of general interventive goals: stress reduction, a strengthening of resources, empowerment through enhanced competence, and a therapeutic attention to belief systems (Rothery, 1993).

Engaging multiproblem families presents the first challenge of intervention. As previously discussed it can be anticipated that families will be resistant to change, and possibly hostile towards those who try to engage them in a process of change. Meeting people in their own environment is crucial in the engagement process. A therapist often picks up on vital clues during home visits (Schlosberg & Kagan, 1988). It allows for an assessment of the family's basic needs, and shows a sign of flexibility on the part of the therapist that he/she can accommodate the family in its own environment.

Once an assessment is completed then treatment modalities can be specified which meet the family's needs. Family and marital counselling can be used in interpersonal relationship issues. Group counselling, social skills training, and linkage to community organizations are all important in improving impoverished support systems and preventing social isolation (Suarez et al.,1996). Rothery (1993) emphasizes the importance of prioritizing services for families. Services should target basic needs for comfort, security and survival first. This does not imply that developmental needs can be disregarded, but simply that they cannot be effectively addressed until a family feels minimally secure about its basic needs.

Intervening to address a family's basic needs can be difficult. Problems such as poverty, inadequate housing, discrimination, and crime can seem outside of the control of both the social worker and the family. The social worker, however, can act as an advocate for family members as well as refer them to community agencies (Suarez et al., 1996). Families can be assisted in recognizing what part of a problem they do have control over, and focus on that as the target for change. For example if family members felt unsafe in their community due to high crime rates they could join the local

neighborhood watch, or they could sign up for a self-defense class. Although these acts may not address the problem of crime directly, they allow the individual or family to change their response to the problem so that they are not longer passively responding to the problem, but are taking control.

Creative approaches can be used to teach families new skills. In one project with low-income multiproblem families, concrete services were combined with activities such as arts and crafts or simple games (Wells, 1981). These activities became the vehicle through which problems were introduced and conflicts resolved (Wells, 1981). These activities also allowed children and their parents to have fun, experience success, and to learn to problem-solve through play. Other excellent opportunities for intervention may be organized around food, a basic socializer; learning to negotiate community services; and simply getting out of the house (Wells, 1981).

A careful analysis needs to be given to the family's support system and social network. The quality and adequacy of a family's social support system and the ability to mobilize these systems, particularly during crisis situations, affects the well-being of a family and its ability to function (Suarez et al., 1996). The family's ability to access its own resources will be the key to its ability to cope without the assistance of professionals. Families may need information, or social skills training to assist them to create and maintain a supportive network. They may not realize that being part of a network also means that they have to give support. Helping families members learn ways of being helpful to others can empower them and improve their feelings of self-worth and expand their social network.

Rothery (1993) identifies three goals for intervening with families' social networks. One goal is to reduce stress by changing the family's perception of the network and its demand on them. This recognizes that networks often contribute to problems as well as to solutions. Another goal may be to enhance access to the concrete, informational, emotional and affiliational supports required for problem resolution. Finally, networks

may support beneficial changes to family beliefs, and may model specific competencies and support their development in a client family.

What is important in treating multiproblem families is not to treat the individual problems of family members, but to consider how the problems are inter-related within the family and within the larger systems around the family. The following case examples will highlight some challenges of working with multiproblem families experienced during this practicum, their unique characteristics, and possible intervention strategies.

Rita and Rick were referred for couple counselling by their C.F.S social worker. Rick's violence towards Rita was the primary identified problem however, the couple also experienced problems with alcohol, parenting difficulties, criminal behavior, unemployment, transiency, and problems with personal coping and problem-solving. Their social network was limited and the most dependable resource was agency in-home support. The relationship between Rita and Rick was highly volatile and Rick had been abusive to Rita as well as his step-son Mark on several occasions. Mark had been in agency care for a period of time.

This family appeared to be in a state of perpetual change and chaos. Rothery (1993) states that families such as this find that stress reaches a threshold beyond which it has disorganizing effects. In this family, Rick would come and go from the home depending on the state of his relationship with Rita and the cycle of violence in their relationship. Mark's membership in the family also changed when he went into foster care, and when he was returned. This family was clearly having difficulty meeting the basic needs for safety and stability of its members. The parents were overwhelmed with their own problems and with Rick's violence. Wells (1981) states that several commonly recognized but not necessarily universal traits of parents in these families are impulsiveness (or conversely, apathy), immaturity, poor self-image, underlying rage or feelings of desolation, concrete thinking and inability to meet one another's over-whelming needs. These features characterized this family. Wells (1981) adds that these patterns may result

in the parents turning to their children for gratification and expecting more from the children then they are capable of giving. As the parental needs envelop the children, familial patterns of interaction are created.

Intervention, although initially targeted toward the couple, shifted to Rita herself as she requested individual counselling. This was supported as it was felt that safety was both Rita's and the children's basic need and that this could not be achieved conjointly with Rick in counselling. In-home supports were coordinated to allow Rita to attend individual counselling and have her children looked after.

Therapy focused on Rita's personal goals as well as issues in her relationship with Mark. Intervention was aimed at establishing appropriate boundaries between Rita and her son. Suggestions were made for them to enjoy activities together at home, such as playing a game.

Rita's social network was also explored and strategies for addressing her social isolation were discussed. Rita was restricted in her ability to connect with people she knew. She found that many of her friends still used alcohol and she was trying to find different friends to assist her maintaining sobriety. Rothery (1993) identifies one of the goals of intervening in social networks as modeling specific competencies, in this case modeling sobriety.

At the end of therapy Rita reconciled with Rick. This case was challenging because on her own Rita was overwhelmed with the responsibility for three children and struggling with her own alcoholism, social isolation, and poverty. Despite the risks Rick posed to her and the children, he provided financial support, and the much needed emotional support to Rita albeit unreliable and inadequate. Thus the entire family is caught in a cycle of chronic patterns that by their nature pull the couple together, then drive them apart. This family needed an entire team approach which could more directly include Rick rather than exclude him as well as a range of services and interventions that could have adequately met the family's needs. In retrospect a meeting could have been

held with the C.F.S. worker and Rita to discuss what services were needed to improve the situation for the family.

Similar to Rita and Rick, Kevin and Carol presented to the E.H.C.C. for couple counselling. This couple had been together for a year and were living together at the time of the therapy There were two young children in the family neither of whom were fathered by Kevin. This couple was coping with financial difficulties, parenting problems, as well as mental health problems. They had separated and reconciled numerous times in the year that they had been together. This family was in perpetual change and chaos which was a result of the highly volatile relationship between the couple. This family certainly had the characteristics identified by Wells (1996) including impulsiveness, immaturity, poor self-image, underlying rage or feelings of desolation, concrete thinking, and the inability to meet one another's over-whelming needs. Carol and Kevin were each referred for individual counselling which would give them a greater likelihood of success in their relationship. Their personal problems precluded their ability to function as a couple and therefore they needed to address these problems before any relationship counselling could occur.

In conclusion, there were some constraints in being able to provide the most effective intervention possible to multiproblem families seen during the practicum. These constraints included my own limited experience as a family therapist, and lack of familiarity with the city's resources. As my previous experience had been with a mandated agency, I felt relatively powerless to mobilize resources on behalf of families. The practicum experience offered me an opportunity to learn from other therapists ways of mobilizing agencies to provide the resources needed for families. This was an important aspect of my role as the E.H.C.C. did not have a range of both concrete and therapeutic services to offer clients and it was necessary to advocate on behalf of clients for these services. There were also some restrictions regarding outreach with clients which is

almost always necessary with multiproblem families. Other options needed to be considered such as arranging for child care to allow clients to attend.

Alcohol and Violence in Families

Alcohol and violence have been commonly thought to be associated with one another however, the precise relationship is unclear. For many couples caught in the cycle of violence, the relationship between alcohol and violence is presented as one of cause and effect (i.e., " If he would just stop drinking, then the violence would stop"). Research suggests that both perpetrators and victims tend to blame the alcohol for the violence (Cooley & Severson, 1993). Some professionals feed this myth by ignoring violence and focusing solely on alcoholism. In fact, because of the prevalence of violence in alcoholic families, many professionals have come to view violence as a part of the total picture of the "alcoholic family" profile. This has led to the adoption of the false premise that when abstinence is achieved, all other family problems will abate - including violence (Cooley & Severson, 1993). Understanding the link between alcohol and violence is important in order to help families cope with these two problems. From a systems perspective both alcohol and violence affect the entire family.

During the practicum, substance abuse was identified as a problem for at least one family member in five of the 12 cases seen. It is possible that the incidence of excessive drinking and drug use were higher than what was actually reported. In all but one of the five cases, domestic violence was also identified as a problem. In all but one of the cases, both members of the couple acknowledged having a problem with substance abuse as a problem, and in three of the cases the woman was perceived as having a greater problem with substance abuse than the man. In three of the cases other substances were abused along with alcohol. Those which were identified included prescription drugs and solvents. Child abuse was identified as having occurred in two of the five cases.

It is clear from the details of the practicum that alcohol and violence coexisted for many families. Conner and Ackerley (1994) identify a number of conceptual frameworks in the literature. One paradigm is the direct cause view, that alcohol directly results in aggression by anesthetizing aggression disinhibition centers in the brain (Conner & Ackerley, 1994). This theory has obvious limitations and has not been supported by research. Indirect cause explanations comprise a second major paradigm (Conner & Ackerley, 1994). Alcohol consumption produces certain physiological and psychological responses which may result in impaired basic coping skills, reducing the ability to problem-solve, biasing interpretations of others' behaviour, making it seem more provocative, narrowing time and perception, creating an intense concern with the present situation and lack of concern for further consequences of aggression (Conner & Ackerley, 1994). A third paradigm is an indirect cause conditional upon motive for drinking. It is hypothesized that when the motive for drinking is to achieve personal power in relationships men are likely to aggress. The last paradigm is that the relationship between alcohol and violence is spurious. According to this view, the association rests on cultural belief and not on the properties of alcohol. No one theory alone can adequately explain the existence of an association between alcohol and violence however, being knowledgeable of them can add further insight into the relationship between the two.

It is important to note that in exploring the relationship between alcohol and violence, alcohol does not cause violence. Research indicates that violent men are apt to be violent both when intoxicated and when sober (Cooley & Severson, 1993). These issues must be viewed as connected. When the victim also drinks the connection between violence and alcoholism becomes more complex. One study reported that the drinking of battered women does not differ from non-battered women. However victims may be more at risk to be battered on occasions when they do drink (Conner & Ackerley, 1994). It could be hypothesized that battered women who drink may do so in part to cope with the

effects of violence. This may in turn place them at greater risk of being beaten, as research suggests, which may, in turn serve to perpetuate their drinking.

In the case of Dawn and Kyle, violence and alcohol were identified as problems. In this case however, it was Kyle's violence, and Dawn's drinking that were the problems. The relationship between these two issues was not explored as the family terminated after one session of therapy. It can be hypothesized however, that there was a connection between the violence and drinking. The sober partner had more power in the relationship and exercised that power in abusive ways. Dawn's drinking may have been a way of coping with the effects of violence. With Burt and Sylvia, Burt was the sober partner, and although violence was not identified as a problem, there was a clear imbalance of power due to Burt's sobriety and Sylvia's chronic and severe substance abuse. The couples would have to experience a significant structural shift when the women maintained sobriety. The family systems may not have had the capacity to make this necessary transition. Given that both couples underwent numerous separations in a short period of time it can be suggested that they had difficulty achieving a balance of power in their relationships. It would be interesting to explore whether these women were at greater risk of abuse as they came closer to sobriety, and gained more power in the relationship. What power might the men have had to "push their buttons" and bring them to the point of substance abuse again? The cycle of alcohol abuse and violence is perpetuated under these dynamics.

When violence and alcoholism co-exist, a decision needs to be made about how to treat both problems. Cooley and Severson (1993) state that violence and alcoholism are similar in that they both have an impact on the family, even those not directly involved in the drinking and violent behaviour. They suggest that the first phase of treatment is to name what is happening for the family in order to address denial and minimization. Denial is a dissociated state that serves to protect people from the effects of violent behaviour

and alcoholism (Cooley & Severson, 1993). Issues of safety need to be addressed at this stage as well.

The next stage of treatment involves securing commitment to treatment. Certain behaviours must be stopped in order for healing to begin. Cooley and Severson (1993) state that the focus on abstinence from alcohol often must be dealt with for the alcoholic batterer to be in a position to terminate abusive violent behaviour. Conner and Ackerley (1996) indicate however that linking termination of battering to stopping drinking sets up a dangerous scenario, and one that is not likely to be achieved. They recommend a cognitive-behavioural approach in treating alcoholism and violence concurrently. There is considerable overlap in treatment because both treatments emphasize imparting skills for healthy coping and relating. During this stage of treatment, the focus is on individuals in the family and their respective needs.

Once alcoholism and violence have been named and reorganized, systems work can begin (Cooley & Severson, 1993). The prerequisite to this next stage is that individual family members have made sufficient gains in their individual work. This may include treatment groups such as anger management, or support groups such as AA or ALANON. Fostering empathy between partners is a powerful tool for healing and continued progress (Cooley & Severson, 1993). It takes time to reclaim a sense of self, to learn to live from that sense of self, and to be close to other people without resorting to violence or alcohol abuse. During this process, many recovering individuals find that they cannot continue in their current relationships and remain sober or free of violence (Cooley & Severson, 1993).

Two of the couples seen during the practicum, Dawn and Kyle, and Burt and Sylvia, were at the stage where they needed to focus on themselves as individuals, and to address their respective problematic drinking and violent behaviour. At times however they felt that the problems in the relationship were the most stressful and pressing, and they were unable to see how the violence and addiction were actually the source of the

problems in the relationship. For example, Burt's primary concern was his distrust and jealousy of Sylvia. His controlling behaviour, and her drinking were less a concern for the couple. It was hard for these newly formed couples to place the relationship on hold and tend to themselves and their own issues. In some ways the relationships were too new to focus on self. Perhaps there were dysfunctional aspects of the relationship that met the needs of the self. These couples may end their relationships due to the fact that they were using when they met, and they may find that once they become sober and non-violent that the dynamics that held the relationship together are no longer there.

Substance abuse is known to have an impact on children as well as the adults involved. Alcohol abuse by parents contributes to problems in the marital relationship which impacts the child, as well as problems in the parent-child relationship. Variables found to be associated with both substance abuse and child maltreatment are: parental inconsistency, poor limit setting, excessively harsh disciplinary measures, parental conflict, poor communication, parental absence or unavailability, and social isolation of the family (Tomison, 1993).

The exact incidence rates of alcoholism and violence against children are not known. Depending upon the study, the reported rates of alcohol abuse in maltreating families in the United States have varied from 25 to 84 per cent (Tomison, 1996). It can be assumed that the same factors that are at play with domestic violence and alcoholism are also at play with child abuse and alcoholism. Tomison (1996) summarizes three factors which contribute to violence against children in the alcoholic parent. Alcohol acts as a disinhibitor for the release of violent tendencies. The use of alcohol and/or drugs may exacerbate any psychiatric or emotional instability in the user, including such conditions as poor impulse control, bipolar disorder, low frustration tolerance and tendencies towards violence. Second, it has been contended that alcohol or other drugs lower the inhibitions that keep people from acting upon physically or sexually violent impulses. Finally,

frustration tolerance may be lowered by alcohol or drugs, leaving parents more likely to physically abuse a child when under the influence.

It is important when assessing these issues that a systems perspective be maintained. These are two variables which are related however their relationship is complex and the fact remains that the causes for violence in families is multi-determined. Alcoholism, when it is identified, needs to be treated as an important issue, however it is likely to be one issue of many that is related to the violence or other family problems.

Ethical Considerations

By its nature, family violence is a complex problem which is not just a clinical concern but also a legal, political, and societal concern. Safety of family members and sometimes the therapist can also be issues. Thus decisions made during therapy can have a direct impact on the safety of family members. Ethics should guide the therapist along every step of the therapeutic process.

Ethics can be defined as "moral duty and obligations to the community" (Websters Dictionary, 1991). All social workers are obligated to provide quality service to clients and to assist clients in ways that are believed to be most effective. In the field of family violence treatment however, the issues become complex. For example is the therapist obligated legally or ethically to report domestic violence to the police, particularly without the victim's consent? When should couples be treated for family violence, given the existing criticism that conjoint therapy can reinforce the belief that the woman is somehow responsible for the violence? Should women be encouraged to leave abusive relationships? These questions highlight some of the ethical considerations for a therapist working in the field of family violence.

Ethical practice should guide all family therapists not just those working with cases involving violence. It is of great significance however to therapists working in this field because unethical or inappropriate decisions relate directly to the safety of family members. For this reason it should be given special attention. That being said however, it is also important to note that anyone practicing family therapy should be prepared to deal with family violence. Failure to be knowledgeable and skilled in this area will likely lead to family violence being ignored, and the intervention may in fact reinforce the dynamics in the family with serve to support violent behaviour. The incidence rates are high enough that practitioners should expect to be faced with the phenomenon at some time during their career, regardless of their area of specialization. Being "prepared" means being knowledgeable about the indicators of family violence and its various forms, and knowing what to do about concerns or suspicions should they be present. Thus knowing what to look for and what to do about it should not just be a necessity of family therapists working with violent families, but for all family therapists.

Currently, mandatory reporting laws for domestic violence do not exist as they do with cases of child abuse. Cervantes (1993) suggests that in the absence of legal mandates regarding reporting, the ethical and legal issues can be divided into two categories: responsibility to provide effective treatment and duty to warn/protect. She offers the following guidelines for therapists to discharge their ethical responsibilities:

-thorough assessment for violence

-development of a safety plan with clients

-therapist knowledge of legal protections

-therapist knowledge of community resources (shelters, support groups, legal resources, and so on)

-assessment and reporting of child abuse (if children are present in the home)

-continuing education for therapists working with clients from violent homes

-treatment plans that address (a) potential for continued violence, (b) individual versus couples therapy (safety issues addressed and documented), (c) treatment for the perpetrator, and (d) monitoring and documentation of safety issues.

With respect to duty to warn and protect, Cervantes (1993) suggests that therapists have an ethical responsibility to protect victims of potential violence from harm. The therapist has a duty to warn when the client makes a serious threat of physical harm to an identifiable victim. If an abusive spouse is the client, then the therapist has a duty to warn the victimized spouse of potential physical harm. Thus providing ethical treatment, and exercising the responsibility to warn and protect are two areas of ethical consideration in working in cases of domestic violence.

Some ethical conflicts occur when considering how family therapists in particular should approach family violence. Traditional family therapists and feminist therapists cannot stand alone in addressing family violence. Bograd (1992) states that we must explore how understanding gendered patterns of violence and control can be enriched by clinical insight and how therapeutic practices can be deepened by political or sociological wisdom. Thus family therapy can be enriched by feminist principles and it can therefore deal more effectively with some of the ethical dilemmas that traditional family therapy has created. In particular, the feminist perspective identifies the women's safety as the first and foremost concern. This has provided the guiding feature for family therapists who want to incorporate feminist principles in their work.

For example, Bograd (1992) challenges the concept of neutrality and its appropriateness in cases of family violence. She states that although it is commonly argued that the imposition of values is counter-therapeutic, it is also true that the strategy of being noncommittal sometimes doesn't work because our silence about our values on family violence may be viewed as consent for certain actions. Although it can be agreed that neutrality is not an appropriate stance in cases of family violence, learning how to

appropriately express one's values is challenging. We must be cautious not to condemn the violent person while we condemn the violent behaviour, as this may have consequences in terms of the therapist's ability to maintain a relationship, or to engage the client. This is true as much when working with the offender, as with the battered woman.

With Lynn and Terry, both the husband and wife minimized the impact of violence, and it was important not to collude with them in doing this. However, it was important in hearing this information not to address it with the couple together as doing so may have increased the risk to the wife. Perhaps of even greater significance than my words, were my actions in this case. Terry was referred for individual counselling to address his violence. This was not a neutral decision, but one that recognized that violence was the problem, not marital conflict, and that he was the only one who could change that.

Secondly, throughout individual counselling Lynn became more open over time about the exact nature of the violence. She eventually started to make fun and be critical of her husband. As a therapist, I continued to condemn the behaviour not the person. Although I did not criticize her child-like behaviour, I did not mimic it. Maintaining neutrality about the person allows for the client to evolve over time and not feel the need to reflect the therapist's views of the violent person.

Bograd (1992) states that another dilemma which family therapists face is their role as social control agents vs. therapists. She adds that battering is both a crime and a clinical problem and therefore therapists often have a dual function. As social control agents we may be required to break confidentiality, as is the case with the duty to warn and protect the victim. Therapy on its own may have limited ability to address family violence, given its multi-determined nature. Bograd (1992) states that one program in New Jersey capitalizes on systems knowledge by enlisting the aid of nonviolent men in the community as sponsors for batterers. This program does not minimize what therapy can contribute but is well aware of the limited effectiveness of therapeutic contact isolated from the surrounding social context.

Another ethical dilemma relates to the limitations of therapy in any form, to prevent family violence. Bograd (1992) states that as we develop more complex treatment models, we cannot lose sight of how therapy may be significantly limited in its impact on family violence. By not recognizing the limitations of therapy we give victims, and perhaps abusers, false hope for change. Bograd (1992) states that the brutal and frightening realities of battering are not only terrifying, they also force us to accept limits to healing, understanding, and the capacity for change. As therapists we are not spared the batterer's attempt to wield subtle but pervasive control and this attempt compromises our alliances with other family members as well (Bograd, 1992). Clearly therapy is not appropriate in all situations, and there will be limitations to the therapist's ability to bring about change. Ongoing debate is required amongst professionals who intervene in cases of domestic violence. Although it can be expected that the debate will continue to be acrimonious, it is non-the-less important in order to challenge our thinking, and continue to refine and influence both theory and practice.

Family therapists have been challenged by Bograd (1992) and others to incorporate a more feminist informed approach. This recognizes the realities of male violence, its impact, and the socio-political structure of society which supports it. Concepts such as neutrality are challenged, and other dilemmas facing the therapist are brought to light. Flexibility is required on the part of the therapist in his/her conceptualization of theories to incorporate a feminist perspective, as well as flexibility in intervention. Meth (1992) states that therapeutic flexibility is both an ethical and a wise position that needs to take precedence over our loyalty to, familiarity with, and belief in systemic models that ignore individual treatment. Family therapists need to be flexible around who should be seen for therapy particularly in cases of domestic violence. In his commentary Meth states that "I hope that marriage and family therapists eventually learn to value two things: (a) not every problem fits neatly within our framework for therapy; and (b) one can see individuals and still maintain a systems perspective" (p. 260). Thus it

is not only just acceptable to be flexible in our intervention with families, and to see individuals using a systemic perspective, but in cases of family violence it is a necessary part of ethical practice to do so when required.

Again using the example of Lynn and Terry, the couple presented themselves for therapy due to marital conflict and violence. Both wanted couple counselling, however following an assessment, it was clear that Terry was not taking responsibility for his violence, and the violence was ongoing and severe at times. It was determined that he required individual counselling before he was ready to participate in conjoint therapy. Although he accepted this verbally in session, he did not follow through. Individual counselling was initiated with Lynn with ongoing attention to her safety, and with recognition of the limitations of her therapy on impacting on her husband's behaviour. A systemic perspective was maintained with Lynn in terms of her relationships with her husband, extended family, siblings, coworkers, children, and community and her interaction with those systems. This case demonstrated not only how it is possible to do systemic family therapy with one person, but also that it is ethical to do so.

Jenkins and Asen (1992) developed a framework for systemic practice with individuals. They state that systemic therapy is not a question of how many people are seen, but refers to the theoretical framework which informs what the therapist does. Systemic therapists focus on creating new connections between different patterns of relationships for the client as a first stage of developing a therapeutic climate for change (Jenkins & Asen, 1992). Using their framework, Jenkins and Asen (1992) suggest that the therapy system be considered "open" in that others may be included in the process at any time. They add that a major tool of systemic therapists is the asking of questions which are intended to lead the client to question the beliefs, expectations and roles for himself or herself and for those around him or her.

This framework is applicable to working with individuals who have experienced violence, but needs to be incorporated with the existing knowledge and experience about

intervening in cases of domestic violence. Systems theory states that change in one part of the system will lead to related change in others (Jenkins & Asen, 1992). Although in a pure sense this statement is true, it does not mean that a battered woman can change her husband's violent behaviour. Thus it is important in practice, when seeing clients individually, using a systemic approach that both the client and the therapist are aware of the limitations to this approach.

Jenkins and Asen (1992) state that individual systemic work is contra-indicated in cases where a child is the referred client. They state that failure to engage the family risks involving the therapist in covert alliances with the child. It also makes it more likely that the more powerful (adult) forces within the family can undermine any changes in the child. In some cases individual work may occur concurrently with family work.

CONCLUSION

In this final section the learning objectives will be reviewed, a critique of the models will be conducted, and some general conclusions of the practicum will be discussed. The motivation for this practicum came from my experience working with families primarily in a child welfare setting, who were experiencing violence and who had difficulty accessing service, particularly family counselling. It was difficult for them to speak openly about the violence that was occurring in their family, and there were few agencies that were willing or able to provide intervention to them. For the most part services consisted of gender specific counselling, with the man and the woman being seen at separate agencies. There were restrictions on couples who wanted to remain together and receive counselling which at the time for me, seemed unjustified. I felt that family therapy should be available as an option to families who were experiencing child abuse, or wife abuse, just like any other intervention.

One of the most important things I learned in this practicum was that family therapy needs to occur only when the violence has stopped, and that although it may appear "unjustified" to turn a family away from counselling, it is both ethical and essential to do so under certain circumstances. I learned that if family therapy does not occur under the right conditions that it can place victims at greater risk than if no therapy occurred at all. Thus one of the outcomes from the practicum was learning when and under what conditions family therapy can be conducted as an appropriate and effective intervention in cases of child abuse and domestic violence.

Ecological theory was chosen to be applied to theories of etiology of family violence as well as an intervention. This theory was highly applicable to the study of family violence for its ability to incorporate a multitude of factors and organize them into a framework which conceptualized human behaviour in relationship to the environment. It allowed for the consideration of the layers of systems from an individual, family, and

larger systems perspective which influenced and provided the context for human behaviour. The literature on family violence has evolved over the years and has moved from an individual focus to an ecological focus. What is important about the ecological perspective is that it considers the role of the individual as well as other systems such as the family and society. To some extent ecological theory has allowed for the integration of knowledge that has been gained over the years in this area and organizes it in a manageable framework.

The criticism of ecological theory is that it is so far reaching that it is difficult to test, and perhaps difficult to apply in practice. My experience was that ecological theory provided a framework to organize my thinking about a family. For example, I could look at the individual factors that were contributing to violence, the family factors, the societal values and structure, and the role of culture and religion and how they combined to contribute to violence in the family. It was from this way of thinking that the intervention was derived. Much of the intervention was focused on helping a family change the ways they were relating to other systems that were impacting on their lives. In retrospect, intervention could also have included more direct contact with those other systems such as child welfare, extended family, schools, etc., to not only change the family's interaction with the systems, but the systems' interactions with the family.

Structural family therapy was also studied and applied to work with families. This was a helpful model upon which to begin to understand family therapy. It is commonly used and therefore the terms such as boundaries, and subsystems have become widely accepted. Although I had a basic understanding of structural family therapy at the beginning of the practicum, my knowledge deepened once I developed experience with applying it, and then even more so during the writing of the practicum report. In retrospect I may have gained more from the experience if I had been more familiar with the model at the onset of the practicum.

There were other challenges with the practicum itself that limited my ability to gain the familiarity I had hoped with the model. As previously discussed, it was difficult to acquire a committed group of families who remained involved with therapy over a period of time. Many were mandated to attend, others terminated early, while others were experiencing such chaos in their lives that counselling was probably not what they needed at the time. I felt that these issues were not unrelated to the fact that the families were experiencing violence. Family violence by its nature causes extreme disruption in families, and it's not surprising that for those who attended therapy, they had difficulty committing to the process. Not all the families seen were experiencing family violence, and it was my experience that the model was more applicable as an intervention with the families that were relatively more stable. In addition to that, I was able to learn more about families, and the structural model with those clients who were relatively "healthier". My energies as a therapist with the other families were often directed at simply engaging them in the process and establishing a level of trust in order for therapeutic work to occur. In retrospect I may have learned more from the model if I had chosen to apply it to a clientele whose problems were not as severe as those I had decided to work with.

There were few examples in the literature of structural family therapy being applied specifically to families who were experiencing violence. Literature from feminist therapists, and family systems therapists in general were relied upon heavily to supplement what structural family therapy did not provide. This is particularly true of the assessment process, which is used to determine whether a family is a suitable candidate for counselling, or whether gender specific counselling is indicated. This is a crucial stage which the structural family therapy literature on its own does not address. There are some limitations on the structural family therapy model's application to families. However, when combined with other models, in particular the feminist model, these limitations can be adequately overcome. In fact, there now exists a growing body of literature of combined feminist and systems approaches to work with family violence. The structural

model, like other family systems approaches can be effectively combined with feminist principles, but on its own was not adequate to address the treatment issues for families experiencing violence.

Structural family therapy was very compatible with ecological systems approach both from a theoretical and practice viewpoint. There were examples in the literature of these approaches being combined in an "eco-structural" model. The consideration of the larger systems, and their relationship to the family was crucial in understanding family violence and these approaches, when combined captured these dynamics. As a result the learning objectives of gaining experience in combining these two approaches to understand the etiology of violence in families, as well as a practice approach, were met.

The final learning objective was to gain experience in using clinical measures both as diagnostic tools and outcome measures. The measures included the FAM III, RSE, and BSI. This was helpful in gaining experience in administering, scoring and interpreting standardized tests. There were some limitations in their use as outcome measures in that therapy was short term, and therefore little change was noted if any, in most situations. At other times, clients terminated therapy before post-tests could be administered.

As a diagnostic tool, the FAM III was particularly helpful. In most cases the results of the measure reflected my clinical impressions and provided further insight into my assessment of the family. It was easy to score, and the visual image created by the results provided an interesting "snapshot" of the family. In particular it was helpful in determining family members' different perceptions of their own functioning and how those perceptions impacted their relationships. The measures were well received by the families who completed them despite my initial concerns that they would be met with criticism or resistance. The results were not shared with clients however in retrospect this may have been helpful in some situations and could have been incorporated into the intervention.

The BSI is also a standardized measure and was used with clients who were seen individually. This is a comprehensive measure which assesses a wide range of mental

health problems. In most situations the measure did not match my clinical impressions in that clients who I thought were experiencing significant emotional distress were not identified as being outside the range of normal functioning. This might be explained by the fact that for some of the clients their emotional distress was a result of their environment and their abusive relationships as opposed to psychological problems inherent in their personality. In other situations, clients may not have wanted to reveal the emotional distress they were experiencing, and were guarded in their responses. As with the FAM III, the BSI did not reveal any significant change when used as a pre- and post-measure. The BSI was easy to administer, but difficult to score and interpret.

The RSE was somewhat more helpful that the BSI. It was easy to administer, and easy to score. One of the limitations of the measure was it was obvious in what it was trying to evaluate. There was no control for factors such as social desirability or denial. In some cases the measure had limited utility if the clients were not willing/able to respond honestly. Another limitation was that self-esteem was not always a focus of the intervention. Although it was helpful to know this information, it was not always the most relevant issue in therapy.

It may have been helpful in retrospect to have developed a client satisfaction survey to have a general sense of how clients experienced the therapeutic process. Standardized measures although helpful, do not provide the direct feedback that would have enhanced the learning process.

References

Anderson, C., & Stewart, S. (1983). Mastering resistance: A practical guide to family therapy. New York: The Guilford Press.

Aponte, H., & VanDeusen, J. (1981). Structural family therapy. In A. Gurman & D. Kniskern (Eds.), Handbook of family therapy (pp.310-316). New York: Brunner/Mazel.

Asen, K., George, E., Piper, R., & Stevens, A. (1989). A systems approach to child abuse: Management and treatment issues. Child Abuse & Neglect, 13, 45-57.

Bath, H., & Haapala, D. (1993). Intensive family preservation services with abused and neglected children: An examination of group differences. Child Abuse & Neglect, 17, 213-225.

Bloom, M., & Fischer, J. (1982). Evaluating practice: Guidelines for the accountable professional. Englewood Cliffs, N.J.: Prentice-Hall.

Bograd, M. (1992). Values in conflict: Challenges to family therapists thinking. Journal of Marital and Family Therapy, 18(3), 245-255.

Bolton, F., & Bolton, S. (1987). Working with violent family families: A guide for clinical and legal practitioners. Beverly Hills: Sage Publications.

Brower, A. (1988). Can the ecological model guide social work practice? Social Service Review, 2(3), 411-429.

Brown, A., & Finkelhor, D. (1986). Initial and long-term effects: A review of the research. In D. Finkelhor (Ed.), A sourcebook on child sexual abuse (pp. 143- 179). Beverly Hills: Sage publications.

Breunlin, D., Schwartz, R., & Kune-Karrer, B.(1992). Metaframeworks: Transcending models of family therapy. San Francisco: Jossey-Bass Publishers.

Caesar, P., & Hamberger, L. (1989). Treating men who batter: Theory, practice, and programs. New York: Springer Publishing.

Cervantes, N. (1993). Therapist duty in domestic violence cases: Ethical considerations. In M. Hansen & M. Harway (Eds.), Battering and family therapy: A feminist perspective (pp. 147-155). Newbury Park, CA: Sage Publications.

Conner, K., & Ackerley, G. (1994). Alcohol-related battering: Developing treatment strategies. Journal of Family Violence, 9(2), 143-155.

Cooley, C., & Severson, K. (1993). Establishing feminist systemic criteria for viewing violence and alcoholism. In M. Hansen & M. Harway (Eds.), Battering and family therapy: A feminist perspective (pp. 217-226). Newbury Park, CA: Sage Publications.

Derogatis, L., & Spencer, P. (1982). The brief symptom inventory: Administration, scoring & procedures manual - I. Baltimore, MA: Clinical Psychometric Research.

Elbow, M. (1982). Children of violent marriages: The forgotten victims. Social Casework: The Journal of Contemporary Social Work, 63(8),465-471.

Finkelhor, D. (1984). Child sexual abuse: New theory and research. New York: The Free Press.

Fischer, J., & Corcoran, K. (1987). Measures for clinical practice: A source book: Vol. 1. Couples, families & children (2nd ed.). New York: The Free Press.

Fishman, H. C. (1993) Intensive structural therapy. New York: Basic Books.

Garbarino, J. (1987). The consequences of child maltreatment: Biosocial and ecological issues. In R. Gelles & J. Lancaster (Eds.) Child abuse and neglect: Biosocial dimensions (pp. 299-315). New York: Aldine de Gruyter.

Garbarino, J., & Abramowits, R. (1992). Children and families in the social environment. New York: Aldine Publ. Co.

Geffner, R., Mantooth, C., Franks, D., & Rao, L. (1989). A psychoeducational, conjoint family therapy approach to reducing family violence. In P. L. Caesar & L. K. Hamberger (Eds.), Treating men who batter: Theory, practice, and programs (pp.103-133). New York: Springer Publishing .

Gelles, R. J. (1979). Family violence. Beverly Hills, CA: Sage Publications.

Gelles, R. (1983). An exchange/social control theory. In D. Finkelhor, R. Gelles, G. Hotaling, & M. Straus (Eds.), The dark side of families: Current family violence research. (pp. 151-165). Beverly Hills: Sage Publications Inc.

Gelles, R., & Maynard, P. (1987). A structural family systems approach to intervention in cases of family violence. Family Relations, 36, 270-275.

Gelles, R., & Straus, M. (1979). Determinants of violence in the family: Toward a theoretical integration. In W. R. Burr, R. Hill, F. I. Nye, & I. L. Reiss (Eds.), Contemporary theories about the family: Vol. 1. Research-based theories (pp.549-581). New York: The Free Press.

Germain, C. (1991). Human behavior in the social environment. New York: Columbia University Press.

Gil, D. (Ed.). (1979). Child abuse and violence. New York: AMS Press.

Gil, D. (1980). Violence against chidren, physical child abuse in the United States. Cambridge, Mass.: Harvard University Press.

Gilman, S. (1988). A history of the sheltering movement for battered women in Canada. Canadian Journal of Community Mental Health, 7(2), 9-21.

Goldner, V., Penn, P., Sheinberg, M., & Walker, G. (1990). Love and violence: gender paradoxes in volatile attachments. Family Process, 29(4), 343-364.

Gordan, L. (1988). Heroes of their own lives: The politics and history of family violence: Boston 1880-1960. New York: Viking.

Harway, M. (1993). Battered women: Characteristics and causes. In M. Hansen & M. Harway (Eds.), Battering and family therapy: A feminist perspective (pp. 29-41). Newbury Park, CA: Sage Publications.

Harway, M., & Hansen, M. (1993). An overview of domestic violence. In M. Hansen & M. Harway (Eds.), Battering and family therapy: A feminist perspective (pp. 1-12). Newbury Park, CA: Sage Publications.

Henderson, A. (1990). Children of abused wives: Their influence on their mothers' decisions. Canada's Mental Health, 38(2-3), 10-13.

Hoffman, L., (1981) Foundations of family therapy: A conceptual framework for systems change. New York: Basic Books.

Hugh J., & Asen, K. (1992). Family practice withiout the family: A framework for systemic practice. Journal of Family Therapy, 14(1), 1-14.

Hunter, R., & Kilstrom, N. (1979). Breaking the cycle in abusive families. American Journal of Psychiatry, 136, 1320-1322.

Kempe, C., Silverman, F., Steele, B., Droegemueller, W., & Silver, H. (1962). The battered child syndrome. Journal of the American Medical Association, 181, 17-24.

Leach, C. (1990). The abused woman and her family of origin. Perspectives in Psychiatric Care, 26(2), 14-20.

Martin, H. (1980). The consequences of being abused and neglected: How the child fares. In C.H. Kempe & R. Hefler. (Eds.), The battered child. (3rd ed.) Chicago: IL: University of Chicago Press.

Masson, H., & O'Bryne, P. (1990). The family systems approach: A help or hinderance? The violence against children study group, Taking child abuse seriously. London: Unwin Hyman.

McCown, W., & Johnson, J. (1993). Therapy with treatment resistant families: A consultation-crisis intervention model. New York: The Halworth Press.

Meth, R. (1992). Marriage and family therapists working with family violence: Strained bedfellows or compatible partners? Journal of Marital and Family Therapy, 18(3), 257-261.

Minuchin, S. (1971). Conflict-resolution family therapy. In J. Haley (Ed.) Changing families (pp.146-155). New York: Grune & Stratton.

Minuchin, S. (1974). Families and family therapy. Cambridge: Harvard University Press.

Murphy-Berman, V. (1994). A conceptual framework for thinking about risk assessment and case management in child protective service. Child Abuse & Neglect. 18(2). 193-201.

Pagelow, M. (1984). Family violence. New York: Praeger Publishers.

Pardeck, J.(1988). Social treatment through an ecological approach. Clinical Social Work Journal. 16(1), 92-103.

Pardeck, J.(1996). An ecological approach for social work intervention. Family Therapy. 23(3), 189-198.

Pressman, B. (1984). Family violence: Origins and treatment. Guelph: Canadian Cataloguing.

Rodway, M., & Trute, B. (1993). Ecological family therapy. In M. Rodway & B. Trute (Eds.), The ecological perspective in family-centered therapy (pp.3-19). New York: Edwin Mellen Press.

Rothery, M. (1993). The ecological perspective and work with vulnerable families. In M. Rodway & B. Trute (Eds.), The ecological perspective in family centered therapy (pp. 21-50). New York: Edwin Mellen.

Russell, M. (1990). Second-stage shelters: A consumer's report. Canada's Mental Health. 38(2-3), 24-26.

Schlosberg, S.. & Kagan, R. (1988). Practice strategies for engaging chronic multiproblem families. Social Casework: The Journal of Contemporary Social Work, 3-9.

Sgroi, S., & Dana, N. (1982). Individual and group treatment of mothers of incest vicitims. In S. M. Sgroi (Ed.). Handbook of clinical intervention in child sexual abuse (pp.191-214). Lexington Books: Lexington, Massachusetts.

Silvern, L., Kaersvang, L. (1989). The traumatized children of violent marriages. Child Welfare, 68(4), 421-436.

Skinner, H., Steinhauer, P., & Santa-Barbara, J. (1983). The family assessment measure. Canadian Journal of Community Mental Health, 2(2), 91-105.

Straus, M. A. (1973). A general systems theory approach to a theory of violence between family members. Social Science Information, 12(6), 105-125.

Stets, J., & Straus, M. (1990). Gender differences in reporting marital violence and its medical and psychological concequences. In M. A. Straus & R. J. Gelles (Eds.), Physical violence in American families: Risk factors and adaptations to violence in 8,145 families (pp. 151-166). New Brunswick: Transaction.

Suarez, K., Smokowski, P., & Wodarski, J. (1996). The process of intervention with multiproblem families: Theoretical and practice guidelines. Family Therapy, 23(2), 117-133.

Tierney, K., & Corwin, D. (1983). Exploring intrafamililal child sexual abuse: A systems approach. In D. Finkelhor, R. Gelles, G. Hotaling, & M. Straus (Eds.), The dark side of families: Current family violence research (pp. 102-116). Beverly Hills: Sage Publications Inc.
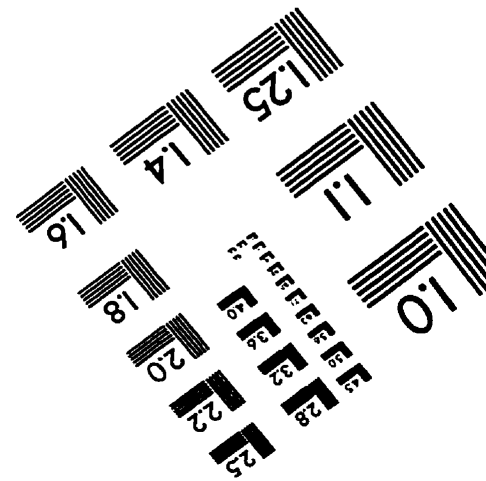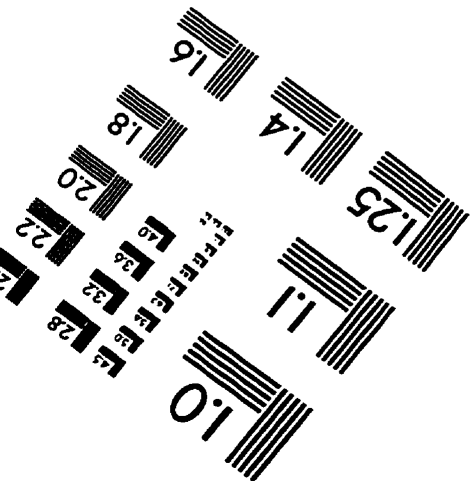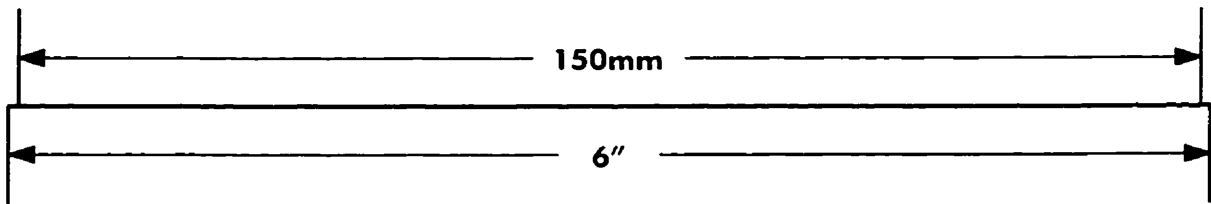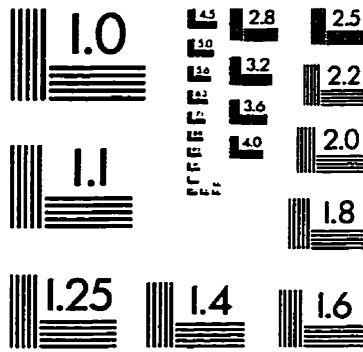
Tomison, A. (1996). Child maltreatment and substance abuse. National Child Protection Clearing House No. 2. Melbourne: Australian Institute of Family Studies.

Trute, B., Adkins, E., MacDonald, G., Vaughan-Jones, G., & Fedoruk, T. (1993). Reducing stress in families following the disclosure of child sexual abuse: Key practice elements for family crisis work. In M. Rodway & B. Trute (Eds.), The ecological perspective in family-centered therapy (pp.125-150). New York: Edwin Mellen Press.

Trute, B. (1998). Going beyond gender-specific treatments in wife battering: Pro-feminist couple and family therapy. Aggression and Violent Behavior, 3(1), 1-15.

Walker, L. (1979). The battered woman. New York: Harper Calaphon.

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

Walters, M., Carter, B., Papp, P., & Silverstien, O. (1988). The invisible web: Gender patterns in family relationships. New York: Guilford Press.

Washburne, C. (1983). A feminist analysis of child abuse and neglect. In D. Finkelhor, R. Gelles, G. Hotaling, & M. Straus (Eds.), The dark side of families: Current family violence research (pp. 289-292) Beverly Hills: Sage Publications Inc.
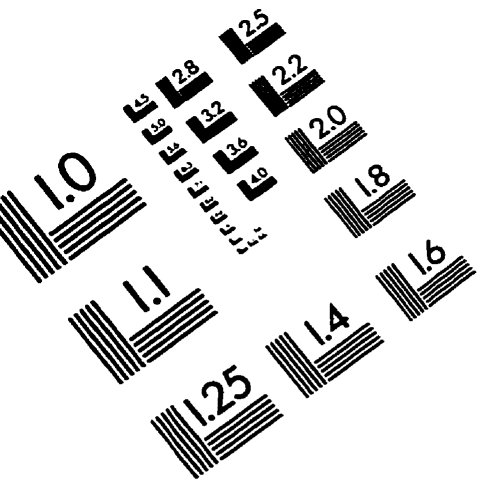
Weakland, J., & Jordan, L. (1990). Working briefly with reluctant clients: Child protective services as an example. Family Therapy Case Studies, 5(2), 51-68.

Wells, S. (1981). A model of therapy with abusive and neglectful families. Social Work, 26(2), 113-118.

Wilson, S., Cameron, S., Jaffe, P., Wolfe, D. (1989). Children exposed to wife abuse: An intervention model. Social Casework: The Journal of Contemporary Social Work, 70(3), 180-184.

Wood, K., & Geismer, L. (1989). Families at risk: Treating the multiproblem family. NewYork: Human Sciences Press.

IMAGE EVALUATION
TEST TARGET (QA–3)

150mm

6"