AN ECOSYSTEMIC APPROACH TO WORK WITH CHILDREN WHO HAVE WITNESSED VIOLENCE IN THE HOME

by

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A Practicum
Submitted in Partial Fulfillment of the Requirements
for the Degree of

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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

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ABSTRACT

This practicum focused upon ten children between the ages of three and twelve years who had been exposed to partner abuse. The majority were living in families headed by single-mothers, most of whom had never sought refuge in a women's shelter and for whom the violence had ceased between seven months and seven years prior to referral. The primary therapeutic modality was individual play therapy from an ecosystemic perspective. A number of objectives were accomplished as many of the children were able to communicate their feelings and experiences related to partner abuse, experienced a therapeutic environment that was safe, fun and supportive, and became increasingly self-confident. Responses varied, however, as the consistency of attendance and environmental support influenced the achievement of therapeutic objectives.

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RATIONALE

The abuse of a woman by her intimate partner has been increasingly addressed within the social service sector. Clinical and research efforts, however, have focused largely upon the adult victims and perpetrators, thereby neglecting the influence of such violence on the children in the family. This practicum attempted to address the needs of children who have been exposed to violence in the home.

The repercussions of violent behaviour between the two primary caregivers in a family extend beyond the couple dyad. In particular, the impact of family violence upon the children may influence their present and future development, social interactions, academic performance and self-esteem (Garbarino, Dubrow, Kostelny, & Pardo, 1992; Jaffe, Wolfe, & Wilson, 1990; Mullender & Morley, 1994; Pressman, 1984; Westra & Martin, 1981). Additionally, research indicates that children may continue the *cycle-of-violence* as perpetrators and possibly victims in their adult lives (Rosenbaum & O'Leary, 1981). While counselling might be beneficial for the adult perpetrators and victims, children should not be excluded from this process of healing. Intervention thus needs to be directed toward children in the context of their environments. In order to address this need, this practicum employed play therapy from an ecosystemic perspective.

OBJECTIVES

There are a number of personal and client-centered objectives which the therapist hoped to achieve through engaging in play therapy with children who have witnessed violence in their homes.

Client-Focused Objectives

1. Create a therapeutic environment that is safe, fun and supportive.
2. Help the children to communicate their feelings and experiences related to family violence.
3. Help children understand family violence so as to alleviate self-blame and attribute responsibility for the violence to its true source.
4. Help children develop non-violent conflict resolution skills to be used in peer, family and future intimate relationships.
5. Bolster children's self-esteem.
6. Create a foundation of safety and coping skills to be used in relationships, possible confrontations and in response to other stressors.
7. Help caregivers recognize and address the needs of children who have been exposed to violence.
8. Strengthen the caregiver-child relationship.

Personal Objectives

1. Increase knowledge about the impact on children of witnessing violence in the home. Specifically, what are the common symptoms, behaviours and attitudes among children in this population.
2. Effectively employ a balance of directive and non-directive play therapy methodologies in working with children who have witnessed violence in the home.
3. Evaluate the efficacy of this intervention using qualitative and quantitative methods.
4. Provide a positive adult role model to children and their caregivers.

LITERATURE REVIEW

Introduction

A major social problem in North America is the abuse of women by their intimate partners. Whether it is called *family violence*, *partner abuse*, *domestic abuse* or *wife assault*, the implication is that emotional, physical, sexual and/or financial abuse is perpetrated by the partner toward the female victim within the physical and metaphoric boundaries of the home. Unlike random acts of violence enacted by strangers, abuse of a woman within an intimate relationship tends to be chronic and influences more than the victim and perpetrator. The term *family violence* implies that the consequences of the problem extend beyond the couple dyad to include the children.[1]

It is difficult to estimate the number of children affected by parental violence as the secretive and domestic nature of the problem discourages overt identification. It has been estimated, however, that one in ten Canadian women are abused by the male partner with whom they reside (Jaffe, Wilson, & Wolfe, 1986); therefore, approximately 500,000 Canadian households per year live with violence. Additionally, nearly 70% of women who stayed at transition houses in 1985 brought children with them and 17% brought three or more (MacLeod, 1987). Based upon an estimated average of two children per household.

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[1] The term *family violence* is confusing in the literature as it can include any type of abusive behaviour among its members, such as direct abuse of children. In this literature review, however, the term *family violence* or *partner abuse* will be used to denote abuse of the female by her male partner. (While partner abuse can also be an issue in homosexual relationships, the literature on children's exposure to violence has yet to address this area.) Although such abuse can take many forms, most authors do not differentiate between levels of abuse in their analyses of the effects of family violence on children. As threatening and assaultive behaviour is overt, it appears that research in this area is commonly based upon this type of abuse.

it can be calculated that approximately 1 million Canadian children are at risk regarding the consequences of exposure to parental violence.

Rosenbaum and O'Leary (1981) refer to children who are exposed to physical and emotional abuse directed at their mother by her intimate partner as the "unintended victims of marital violence" (p. 92). While the abuse may or may not be intentionally directed at the child, they are nonetheless influenced by its occurrence[2]. Often couples whose relationship is abusive will minimize or deny their children's knowledge of the violence (Mullender & Morley, 1994), however, direct interviews with the children tend to reveal detailed knowledge of these incidents (Jaffe et al., 1990). The term *witnessing family violence* implies a range of experiences. Specifically, the child may directly observe the assault, overhear incidents from another room or see its aftermath in their mothers' injuries (Jaffe et al., 1990). Additionally, the pattern of witnessing the assault of one's mother by one's father-figure tends to be repeatedly experienced over time with multiple perpetrators. The chronic nature of these traumatic incidents will likely have a profound impact on the child (Garbarino et al., 1992; Sopp-Gilson, 1980; Westra & Martin, 1981).

The literature has yet to explore the specific impact on the child of each level of witnessing, however, authors agree that children who have been exposed to such experiences tend to display *externalizing* behaviour, such as truancy and aggression, and *internalizing* problems, such as low self-esteem and withdrawal (Jaffe et al., 1990; Morley & Mullender, 1994; Pressman, 1984). Additionally, they are vulnerable to other

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[2] This practicum attempted to focus primarily upon children who have not been directly assaulted by their parents. However, the research suggests that children who are living in a home with inter-parental violence are at risk for direct child abuse (Straus, Gelles & Steinmetz, 1981).

associated risks such as the possibility of being injured in the "crossfire" of violence (Roy, 1988), neglect or physical abuse by the primary caregiver (Fantuzzo & Lindquist, 1989; Silvern & Kaersvang, 1989) and experiencing violence in adolescent or adult intimate relationships (Echlin & Marshall, 1995). Regardless of these perceived consequences, little research and few services currently address the needs of this population.

Literature and practice relating to family violence has focused primarily upon resources for the female victim and male perpetrator. Only recently have the needs of their children begun to be acknowledged and addressed. Current authors agree, however, that there is a need for both more research on the manner in which family violence affects children and in specialized services for this population (Busby & Inman, 1996; Porter & O'Leary, 1980; Roy, 1988; Westra & Martin, 1981; Wolfe, Zak, Wilson, & Jaffe, 1986). A clear understanding of the determinants of these children's behaviour will ultimately guide appropriate methods of intervention.

Ideally, the family is the context within which children learn about themselves, relationships with others and the world in general. Family violence, however, creates an unstable and crisis-oriented context in which the child is repeatedly exposed to trauma. Neither research nor practice, however, have sufficiently addressed the emotional, social, cognitive, physical and developmental impact of exposure to family violence on the child. It is society's role to protect children from harm and therefore, it is our responsibility to provide services to this population. Effective interventions can be created and implemented by understanding the impact of exposure to family violence on the child.

This may be achieved by identifying symptoms and their connection to witnessing parental violence.

The Violent Family

The impact of family violence on the child is influenced by the lack of a nurturing family environment and strong child-centred caregivers. In particular, each parent tends to be focused on his or her own needs, as the child's mother is often overwhelmed by her own victimization and the father-figure is fixated on maintaining power and control in the home (Jaffe et al., 1990). A family in which the woman is being abused is characterized by extreme conflict and disorganization. This is in contrast to a child's basic need for a family environment that promotes emotional, cognitive and behavioural development (Jaffe et al., 1990).

The Violent Perpetrator as Father

A conceptualization of the family context of partner abuse necessitates an understanding of the perpetrator as an individual and father. The abusive behaviour of men is strongly linked with woman abuse in their families of origin (Rosenbaum & O'Leary, 1981). Consequently, many men have learned from parental role models that violence is the method whereby power and control can be secured in the family (Straus, Gelles, & Steinmetz, 1980) and in order to do so, they create an atmosphere in which wives are isolated, secrecy is maintained and fear and intimidation permeate the family. Stemming from their own childhood experiences, they often do not possess the verbal ability to "negotiate non-violent conflict resolution and have poor impulse control and a

rigid style of demanding and controlling behaviours" (Jaffe et al., 1990, p.26). Additionally, alcohol is a factor in approximately half of the assaults on their partners, which may intensify and provide an excuse for the incidents (Pagelow, 1984).

A study by Holden and Ritchie (1991) reported that these behaviour patterns were not exclusive to the couple dyad as the "irritability of...husbands appears to 'spill over' into fathering" (p.325). In this study, the data regarding the male perpetrators was collected from their previously abused female victims, thus, some caution needs to be exercised when interpreting its results. Nonetheless, given what is detailed in the extensive literature about perpetrators, the study's conclusions about such men as fathers appear to be logical. Specifically, male perpetrators' interactional style in the context of intimate relationships may well be similar despite the fact that one is between adults and the other is between adult and child. Additionally, Holden and Ritchie found that such fathers were less involved, more likely to use physical punishment and less likely to use induction and physical affection in child-rearing than the comparison sample of non-violent fathers. Although little is written about this topic, it is logical to assume that a father-figure who is concerned with maintaining family control through intimidation, isolation and assaultive behaviour would have difficulty employing positive parenting skills such as empathy, support and consistency.

The Abused Woman as Mother

Abused women often display characteristics of what Walker refers to as the battered woman's syndrome [BWS] (1984). In particular, they tend to feel isolated, can suffer from low self-esteem and can feel powerless to stop the violence and find safety

(Roy, 1988; Straus et al., 1980). Walker (1984) also reported that abused women commonly experience *learned helplessness*. In particular, they lose

> their belief that they can reliably predict that a particular response will bring about their safety...they narrow their choice responses, opting for those that have the highest predictability of creating successful outcomes. (Walker, 1993, p. 135)

This psychological state may persist even in the absence of the violent stimulus or after physical safety has been secured. Additionally, victims may deny or minimize the level of violence (Browne, 1987) which may lead them to "underestimate the lethality of the situation for themselves and their children" (Jaffe et al., 1990, p. 23). Furthermore, the situations of abused women are often exacerbated by a lack of economic or social resources (Straus et al., 1980) and/or a history of victimization due to physical sexual and emotional abuse in their families of origin (Hughes, 1982). These issues limit options for abused women and create barriers for healthy living.

Partner abuse also affects the female victims' role as mother. In particular, their parenting capabilities can be influenced by a number of factors. Firstly, they may have experienced abuse in their families of origin (Hughes, 1982); therefore, they may lack a foundation for positive parenting skills as they do not have the knowledge or role models to do so effectively. Secondly, the context of partner abuse influences the behaviour of the child, thus increasing the challenge of parenting. For instance, based upon observations at women's shelters, Pressman (1984) has noted that children who have witnessed the devaluation of their mother as a parent by their father-figure tend to "disregard her attempts to discipline or direct them" (p. 30). Finally, the overwhelming personal needs of the women as victims of abuse can contribute to their inability to be sufficiently available to their children both physically and emotionally (Jaffe et al., 1990).

As the majority of these women are the primary caregivers in their households (Jaffe et al., 1990), the children are ultimately influenced by their mother's victimization.

The Effects of Partner Abuse on Children

The direct and indirect exposure to partner abuse will undoubtedly impact upon the children in the family. The manner in which children are influenced, however, has only recently begun to be explored in the research. Understanding the impact of partner abuse on children will guide interventions.

- Exposure to violence as trauma

Some researchers have used the framework of trauma to conceptualize the influence of family violence upon children. It has been shown that a child who is exposed to traumatic events is at risk for developing a variety of psychological symptoms (Eth & Pynoos, 1985). Given that witnessing the direct or indirect abuse of one's mother by her partner is a traumatic stressor for a child of any age (Silvern & Kaersvang, 1989), researchers have argued that such children are at risk for developing symptoms common to other traumatized child populations. As a result, such children may experience post-traumatic stress disorder [PTSD], a diagnostic category that includes a number of symptoms related to psychic trauma. According to the American Psychiatric Association (APA), (as published in its Diagnostic and Statistical Manual of Mental disorders (1987) [DSM III-R]), PTSD requires that a recognizable stressor has been present. Additionally, the DSM III-R outlines that the main symptoms of PTSD include hyperarousal (such as difficulty sleeping, loss of appetite, exaggerated startle reactions and difficulty

concentrating), avoidance (for instance, withdrawal from activities or places, or constricted affect) and re-experiencing (such as recurring dreams, post-traumatic play or other types of preoccupation with the trauma) (APA, 1987). Arroyo and Eth (1995) emphasize that these criteria extend throughout all age groups. Overall, the trauma-based body of literature postulates that children who are exposed to the abuse of their mothers are exposed to a significant stressor that can produce such symptoms of distress.

Traumatic reactions are a reality for some children in this population as their internal or external coping resources are exhausted or unavailable (Arroyo & Eth, 1995). On the other hand, some children who experience trauma do not necessarily display the characteristics associated with PTSD. Garbarino et al. (1992) have linked the resilience exhibited by these children to resources in the community, support from parents and individual personality traits. Resilient children are able to connect with and use these resources in order to deal with the trauma in a healthy manner. The importance of a child's environment in contributing to and fostering resiliency from trauma thus bolsters the argument for perceiving trauma within the wider context of partner abuse and other environmental variables, such as poverty, which constitute the reality of a particular child.

- Impact of the environment

Partner abuse creates an environment that influences children in a number of ways. The nature of such a context can affect the growth of children's internal resources and may prevent the establishment of internal coping skills. Additionally, exposure to partner abuse may limit access to the stress buffering potential of environmental factors

such as relationships with caregivers, other family members and the community (Garbarino et al., 1992).

The environment in which children grow is created by their parents. Ideally, they provide a guiding and supportive function to help children develop their own identities, gain self-worth, acquire and master societal knowledge and ultimately grow from dependent to independent people (Birns, 1990; Brooks, 1994; Dubowitz & Egan, 1990; Garbarino et al., 1992; Jaffe et al., 1990). Attachment theorists emphasize that caregivers play an important role in providing a physical and emotional foundation for the child's present and future development (Birns, 1988; Bowlby, 1982). James (1994) defines attachment as "a reciprocal, enduring, emotional, and physical affiliation between a child and a caregiver" (p. 2). This bond forms at infancy and persists even in the absence of the primary caregiver (Bigner, 1989; Karen, 1990; Steinhauer, 1991). A secure infant-mother attachment provides the foundation for the child's growth whereby infants can use their "mother as a secure base from which [they] can venture forth to explore the world" (Ainsworth, 1973, p. 80). Throughout the child's development, this early secure attachment contributes to healthy personality traits such as the establishment of trust, the capacity for intimacy (Steinhauer, 1991), and a sense of self-worth (Garbarino et al., 1992). In contrast, Ainsworth (1973) has noted that "infants reared under conditions in which they have insufficient opportunity to interact with a mother figure (i.e., are maternally deprived) may show anomalies of development " (Ainsworth, 1973, p. 77).

The quality of parental[3] involvement with the child is of primary significance for developing such an attachment. Steinhauer (1991) reported that the strength of an

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[3] When refering to "parent" in the present discussion of attachment, it is assumed

attachment depends upon "the extent to which [parents] are able to respond sensitively and consistently to the needs of the child" (p.14). The significance of parental involvement has also been emphasized by Brooks (1994) who wrote that

> children who grow up in homes with parental involvement become responsible, competent, achievement-oriented adults who are appropriately controlled and happy. Children growing up in homes where parents are self-focused and uninvolved tend to be impulsive, moody adults who find it difficult to control aggression. (p. 44)

The importance of a caring, nurturing, attentive and supportive parent for healthy child development cannot be disputed. By experiencing regularity and continuity in care by caregivers who are warm, involved and responsive, children develop the capability to experience trust (Garbarino et al., 1992), form healthy relationships by developing the capacity to experience intimacy and engage in the process of socialization (Silber, 1989; Steinhauer, 1991) and ultimately meet their biological potential (Bronfenbrenner, Moen, & Garbarino, 1984).

On the other hand, traumatization can prevent the formation of secure attachmements. James (1989) has indicated that attachment disorders may stem from a single traumatizing event that threatened a child's attachment, such as parental abandonment, or repeated traumatizations, "such as may happen with neglectful or abusive parenting, hospitalizations, or war" (p. 34). Therefore, children who have been exposed to violence in their families can be at risk for attachment disturbance. For example, the environmental context of partner abuse is often characterized by inconsistent and unavailable caregivers. The mother may attempt to deal with her own victimization and in doing so, she may model unhealthy coping skills while simultaneously failing to

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that the "parental-figure" can be the biological parent or other significant caregivers such as extended family members, foster parents, etc.

address the emotional needs of her children. Additionally, the father-figure tends to lack the ability to empathize with his children (Mathews, 1995). Therefore, he may be unable to offer support and encouragement as his violent outbursts model unhealthy methods of relieving stress. Such environmental circumstances, therefore, can be barriers to the formation of healthy attachments and thus create ongoing obstacles to the development of healthy relationships and coping skills for children.

The environment of children influences their worldview. Thus, children exposed to partner abuse will learn associated values and attitudes. For instance, Jaffe et al. (1990) have noted that children in this population tend to share a number of problematic characteristics which they refer to as "subtle symptoms" (p.51). These are usually covert and may be present in the absence of more extreme emotional and behavioural adjustment problems. These authors classify the symptoms into three categories. The first encompasses attitudes about conflict resolution. In particular, children learn that violence and threats are effective means to resolve conflict, maintain power and control, and relieve stress in intimate relationships (Straus et al., 1980). The second category refers to the manner in which responsibility for violence is assigned. Specifically, they are unable to hold the batterer responsible for his violent actions and instead believe that victims are to blame by virtue of their behaviour or gender (Jaffe et al., 1990). Finally, the last category of symptoms relates to knowledge and skills in dealing with violent incidents. For instance, children may blame and hold themselves responsible for the violence in their home; as a result, they may feel that they have to be perfect. Additionally, they may believe that it is their duty to "prevent the violence by defusing their father's anger and

protecting their mother" (Jaffe et al., 1990, p. 53). While these attitudes may be exhibited by children in this population through such behaviours as negative remarks to female teachers or aggressive peer interactions at school, other symptoms are more covert and require careful investigation in order to detect and address.

A foundation for self-esteem, ego resilience and hope for a favourable future emerges from a secure attachment between the primary caretaker[s] and the child, and the ability to cope effectively stems from "a sense of being valued and a feeling of coherence" (Garbarino et al., 1992, p. 104). In particular, "a stable emotional relationship with at least one parent or other reference person" (Garbarino et al., 1992, p. 103) will contribute to the child's sense of security and confidence. Additionally, primary caregivers and/or extended family members can model positive coping skills by providing support and reassurance to the child during stressful periods in order to foster understanding (Anthony & Cohler, 1987). Yet, the environmental impact of partner abuse on the children creates obstacles to meeting their potential. Instead, the disorganization, insecurity and unpredictable nature of the violent family can create an environment in which the caregivers are unable to nurture, guide and reassure children who have been traumatized while potentially creating a foundation for unhealthy coping mechanisms and poor attachments.

- Variables determining children's responses to partner abuse

Although children who have witnessed parental violence exhibit a number of similar symptoms, each child is unique. The literature states that individual responses are determined by a number of variables, such as the parent-child relationship, the community

context (Garbarino et al., 1992), the role in the family (Pressman, 1984), repeated separation and moves (Jaffe et al., 1990), availability of resources (McAlister Groves, 1991), and type and intensity of violence (Shirk, 1990). It is generally agreed upon, however, that age, gender and developmental level will determine the effect on children and their mode of reaction (Garbarino et al., 1992; Jaffe et al., 1990; McAlister Groves, 1991; Miedzian, 1995; Porter & O'Leary, 1980).

(1) Age and developmental level

The age at which children first experience family violence will influence their ability to process and cope with the traumatic stressor. Davidson and Smith (1990) have outlined that children are more vulnerable to trauma if it occurs prior to eleven years of age. Older children are more capable of coping with new stressors (Werner, 1990) as they possess a foundation of internal and external resources that have been acquired through experience. Thus, age as a variable determining children's reactions to parental violence is linked with their levels of development.

Child development refers to the process by which the child matures by acquiring the skills required to function independently in the world (Garbarino, 1992). Ideally, the family is used as a foundation within which the child gains "social competence, a secure and positive sense of identity, proficiency in thinking and speaking clearly, [and] an understanding of the many ways in which people communicate with one another" (Garbarino et al., 1992, p. 8). Each developmental stage is characterized by certain cognitive abilities and adaptation skills so that "children at various stages of development are differentially able to understand and cope with what is happening between their

parents" (Jaffe et al., 1990, p. 40). While developmental level will influence the child's understanding of parental violence, the familial context created by violence may affect the child's ability to master developmental tasks.

Infants are extremely vulnerable to the effects of parental violence. In particular, children from birth to 8 months old are dependent upon adults to administer responsive physical care (Miller, 1992). Mothers who are victimized through abuse by their partners, however, have difficulty managing the stressful demands of an infant and therefore, the infant's sleeping and eating schedule may be inconsistent. Not only will this affect their physical health, but children may also encounter difficulty establishing basic trust as a result of the principal caretaker's distance and unavailability. Additionally, infants' small physical size places them at risk for harm caused by assaultive behaviour directed toward their mother (Jaffe et al., 1990) and, as they have yet to develop the verbal ability to communicate their needs, they cannot access resources outside of the family (McAlister Groves, 1991). Consequently, the effects of parental violence are immediate as infants are at risk for physical neglect or injury, and long-term in that the formation of basic attachments are discouraged.

Clinical observations of the responses of infants and pre-schoolers are similar in that both reflect the developmental needs not being met. Infants, for instance, tend to have poor health, inadequate sleeping patterns and scream excessively; behaviours which may in fact place the mother at risk for further violence (Davidson, 1978). As the children acquire motor skills, they tend to show signs of terror "as evidenced by ... yelling, irritable behaviour, hiding shaking, and stuttering" (Jaffe et al., 1990, p. 40). Additionally,

pre-schoolers who witness family violence often have a number of somatic complaints, perhaps a reflection of their need to communicate their trauma but lack of the verbal ability to do so (Jaffe et al., 1990). Furthermore, they may display regressive symptoms, such as clinging behaviour or decreased verbalizations (Garbarino et al., 1992; Jaffe et al., 1990). Few authors have sufficiently addressed the reactions of infants and pre-schoolers. Instead, the literature has focused primarily upon school-age children and adolescents.

School-age children rely upon caregivers to model appropriate behaviour and to create a safe and supportive environment in which the children can master their developmental tasks. On the other hand, children who witness violence in their homes lack this feeling of safety and instead "live with fear and anxiety, waiting for the next violent episode" (Jaffe et al., 1990, p. 28). In response, children in this population often display a number of what Jaffe, Wolfe, et al. (1986) refer to as "externalizing...and internalizing" (p. 2) problems. For instance, children may engage in physical fights with their peers as they have learned that violence is an appropriate and effective method of resolving conflicts. Such externalizing problems may exacerbate adjustment at school "and trigger consequences from the school system that aggravate the existing stressors in their home" (Jaffe et al., 1990, p. 27). Internalizing problems may include difficulties stemming from conflicting emotions such as being ashamed of their family because of the secret, while concurrently hoping that someone will find out and help them (Davidson, 1978). Additionally, these children tend to suffer from anxiety disorders, depression and low self-esteem (Morley & Mullender, 1994; Pressman, 1984), have little empathy (Roy, 1988), posses lower verbal, cognitive and motor abilities for their developmental level

(Westra & Martin, 1981), and feel guilty or blame themselves and their behaviour for the violence (Jaffe et al., 1990). Furthermore, they often feel a sense of divided loyalty in wanting to protect their mothers from harm, but simultaneously fearing and respecting the right of their fathers to control the family. They are too young to be aware of resources or alternatives to the situation they are experiencing, and in feeling alone, their confidence in the future is undermined (Jaffe et al., 1990).

The behaviour of adolescents will also reflect their developmental level. For instance, adolescence is characterized by increased independence outside the home. As a result, those who experience family violence often find relief in spending more time away from the family and may run away for extended periods of time or indefinitely (Jaffe et al., 1990). Furthermore, overt feelings about the violence may be exhibited. In particular, they may confront their mothers verbally regarding their dissatisfaction with the violence (Davidson, 1978) or physically through threats and/or assaults (Pressman, 1984). Parental assault may be linked with the adolescent's perception that safety can be secured by siding with the perpetrator (Pressman, 1984) or it may have been learned to be an effective tool to relieve frustration and establish control (Straus et al., 1980). Additionally, this overt and often violent expression of frustration and anger may include "self-destructive behaviours, such as substance abuse,... promiscuity, [and] life-threatening re-enactments" (Garbarino et al., 1992, p. 52) which can lead to involvement with the criminal justice system for both males and females (Jaffe et al., 1990).

Adolescence is also a crucial stage that will determine whether or not the cycle of violence will continue. This period is characterized by the development of the individuals'

first intimate relationships in which they can play out learned sex roles and communication patterns. Following their parental role models, adolescent males may use intimidation and physical force, while their female partners may accept the threats and violence (Jaffe et al., 1990). Although Rosenbaum and O'Leary (1981) point out that female victimization is not necessarily correlated with a history of parental violence, nonetheless, prevention and intervention is needed to stem any possibility of repetition of the cycle.

(2) Gender differences

Gender differences in terms of the immediate and long-term effects of exposure to parental violence have been recognized. For instance, Sopp-Gilson (1980) noted that shelter workers observed differences in the behaviour of boys in contrast to that of girls. In particular, boys were disobedient, defiant and destructive at the shelter; while girls tended to be withdrawn, dependent and displayed clinging behaviour. These characteristics may be linked to identification with same-sex caregiver role models. Specifically, the socialization of boys encourages violent behaviour (Miedzian, 1995) while girls learn that "victimization is inevitable and no one can help change this pattern. Suffering in silence is reinforced" (Jaffe et al., 1990, p. 27). A number of authors have suggested that childhood gender-specific behaviours are precursors to the intergenerational transmission of violence (Jaffe, Wilson et al., 1986; Roy, 1988; Straus, 1990; Straus et al., 1980) and therefore identification with the same-sex perpetrator or victim may extend into adult life. While this may occur, a study by Porter and O'Leary (1980) indicated that it is not necessarily the norm for both sexes. In particular, their

results outlined that witnessing parental violence was strongly predictive for males to become adult perpetrators, but not for females to adopt a victim role as an adult. The possibility for children to perpetuate the cycle of violence in their adult relationships further reinforces the need for appropriate services for this population.

- Resiliency in children

Some children who have been exposed to partner abuse do not exhibit symptoms and instead, embody resiliency. The concept of resilience refers to "the ability to withstand and rebound from crisis and adversity" (Walsh, 1996, p. 261). Individual personality traits, environmental resources and parental support are integral factors in the development of resilience in children (Garbarino et al., 1992; Rutter, 1983). Resilient children are able to connect with and use internal and external resources so as to deal with stressors in a healthy manner.

The concept of resiliency is especially important regarding children who have been exposed to partner abuse as some display internalizing and externalizing symptoms while others do not. Although some goals for interventions focusing upon children who have been exposed to partner abuse may centre upon processing past trauma, a further therapeutic objective is to bolster their ability to cope with potential stressors they may encounter in the future. These interventions can be guided by delineating the factors which can contribute to resiliency in general and outlining the barriers to resiliency generated by the context of partner abuse.

The literature has outlined a number of individual traits that contribute to the development of resiliency.

> Such traits as a happy, easy-going temperament, and a higher intelligence [have been found] to be helpful, although not essential, in building resilience. Such qualities tend to elicit more positive responses from others and to facilitate coping strategies and problem-solving skills. (Walsh, 1996, p. 264)

Children's degree of resilience will also be influenced by their developmental level. In particular, older children are better able to cope with new stressors (Werner, 1990). Furthermore, characteristics such as self-confidence and a positive self-image are undoubtedly at the core of resilient children. With a foundation of self-worth, they are able to exercise strong personal control, foster and maintain positive relationships and practice active coping skills (Garbarino et al., 1992) as successful past attempts at coping have bolstered confidence in their own abilities and in the support from outside resources (Murphy & Moriarty, 1976). Hawley and DeHaan (1996) have discussed Wolin and Wolin's (1993) Challenge Model which "suggests that some children buffer themselves from family-inflicted, potential damage by developing at least one of seven resiliencies: insight, independence, relationships, initiative, humour, creativity and morality" (p. 285). Consequently, internal characteristics are important for resiliency in children.

It can be difficult for children who have witnessed parental violence to use the external resource systems employed by resilient children. For instance, extended family members may be inaccessible as the perpetrator tends to isolate the family physically and emotionally. Secondly, such children may not be able to rely upon peer support as their social development may have been hindered due to factors associated with witnessing family violence. Lastly, school may not be a positive environment for these children for a number of reasons. For example, they may encounter few successes in the classroom due to concentration difficulties stemming from lack of sleep due to the violent incidents.

Additionally, the children might feel socially ostracized due to few peer relationships. Lastly, they may avoid using a female teacher as a positive role model due to negative gender stereotyping learned from the male batterer. Consequently, the context of family violence can prevent the development of effective coping mechanisms.

Overall, the traits of resilient children can be contrasted with the helplessness, poor peer relations and avoidance behaviours that can be characteristic of traumatized children. For instance, children who have been exposed to violence since infancy may not have the basic foundation of trust in their inner and outer resources. On the other hand, resilient children can use their experience-based ability to make sense of and reorganize their world to actively master the stress. Children living in a violent family, however, often have only experienced inconsistent relationships, disorganization and conflict management involving threats or assaults. Unlike resilient children who have a corpus of skills that can be used to positively cope with the stress, children who have witnessed family violence for the majority of their lives may instead create and maintain maladaptive defenses in an effort to cope with trauma.

The nature of children's social environments will influence the development of internal resources and affect accessibility to external resources. Family environments that are characterized by "strong parent-child relationships marked by positive interactions, nurturance, affection and consistent discipline " (Hawley & DeHann, 1996, p. 285) have been linked with resiliency in children. On the other hand, the family context, especially when violence is an issue, is not always a protective factor. Consequently, extended

family, close friends and/or teachers, can be valuable resources for children whose primary caregivers are unavailable or do not meet these needs.

- Summary

Exposure to partner abuse is a traumatic stressor for children. However, considering children's psychological sequelae isolated from their historical and current environmental context is potentially blaming and pathologizing. Additionally, focusing upon the individual restricts the range of choices for intervention to those which focus primarily upon psychological symptoms; thus, little may be done to affect the stressor itself. For instance, in situations in which violence is absent, the family may have a greater ability to comfort the child who has been traumatized by providing security, nurturance and confidence in the future. Consequently, the family context is able to be supportive of resolution and recovery from the trauma. This environment may not exist, however, when the family is marred by ongoing violence. As a result, the family may not meet the "most crucial role in protecting the child from traumatization and assisting in his or her recovery" (Jaffe et al., 1990, p. 72). Furthermore, such a family environment may discourage the child's access to healthy internal and external resources, thereby preventing the development of skills for resiliency. While it is a priority to secure the safety of all members by stopping the violence, interventions should ultimately build upon family strengths to bolster healing and prevent future victimization by incorporating a focus upon the child's individual needs and minimizing the family-based stressors.

Intervention

It is crucial that opportunities for intervention with the child be addressed. The need for child therapy may be recognized by professionals, such as when the child's caregiver seeks help through couple therapy or refuge at a shelter for abused women. Alternatively, the behaviour of children may ultimately draw them and possibly the family into therapy (Busby & Inman, 1996). As a result, appropriate training for teachers, marriage counsellors, police officers and shelter workers regarding the impact of family violence on children is integral to identify these crucial points of intervention (Hughes, 1982; Jaffe, Wilson et al., 1986; Roy, 1988). It has been noted that there is a shortage of services for children who have witnessed violence in the home (Sopp-Gilson, 1980; Westra & Martin, 1981). Despite recent attempts to extend such services, lack of funding and little understanding about the severity of the problem have hampered such efforts (Roy, 1988). Education for all professionals who have contact with such children will therefore create more windows of opportunity for intervention.

Objectives for intervention should be guided by the understanding that children in this population have been affected directly and indirectly by partner abuse and may or may not possess the skills for resiliency. Intervention can be enacted through the school curriculum, parental system, or directly with the child through individual or group therapy. The manner of intervention will vary depending upon factors such as the severity of symptoms and the availability of social service resources.

- School-based intervention

School is the place in which children spend the majority of their time outside the family. Consequently, education through its curriculum can foster prevention and maximize the opportunities for affected children to access resources. School is an especially important place for children from violent families as the associated isolation often prevents them from engaging in other activities or realms. Therefore, school provides a context in which the child is free to interact with peers and to learn from positive adult role models. It can also provide an opportunity through which the child and family can be linked with appropriate resources.

Programs within the school curriculum which focus upon family violence and preventing violence in intimate relationships are helpful for a number of reasons. Firstly, educating all children regardless of their family experience disseminates information to affected children without making them feel singled out. This may provide a window of opportunity for children to disclose and access supportive external resources for themselves and their families. While some children may not ultimately receive professional help, such classroom-based programs will send the message to affected children that violence within intimate relationships is wrong (Roy, 1988), they are not alone, and that there are people who are willing to help them and their families. These programs may therefore have immediate and long-term implications for children and adolescents as it may help to break the secrecy and stem the use of violence in future intimate relationships (Roy, 1988; Sudermann, Jaffe & Hastings, 1995). Teacher training focusing upon the issues associated with family violence is therefore necessary in order to administer such a

curriculum, to recognize children at risk and to be sensitive to the needs of the child both at the point of disclosure and subsequent to the onset of intervention (Hughes, 1982).

- Intervention with caregivers

Therapy with caregivers is another way to intervene with children. Specifically, Mathews (1995) and Bilinkoff (1995) have indicated that counselling for caregivers can transcend an exclusive focus upon personal and relationship issues to include consideration of the needs of their children. Although a concentration upon parenting can be used in couple counselling (Busby & Inman, 1996), it is more common for the man and woman to receive such guidance separately through same-sex groups or individual counselling. While couple therapy may help both caregivers to work collaboratively to address the needs of the child, such work may be impeded by safety concerns and obstacles related to common characteristics of violent relationships, such as powerlessness, control or shame. Same-sex groups, on the other hand, are more neutral contexts in which parents can learn from and be supported by men or women in similar situations. Furthermore, individual counselling can focus upon issues that are unique to that specific family context.

Empowerment as a parent is important for mothers. Although immediate personal issues such as securing safety for herself and her children or mourning the end of the relationship must take precedence, counselling should include the concept of effective parenting (Bilinkoff, 1995) and a focus upon the parent-child dyad. Specifically, children often witness the devaluation of their mother as a parent by their father-figure; as a result,

children tend to "disregard her attempts to discipline or direct them" (Pressman, 1984, p. 30).

Stemming from observations at women's shelters, some mothers who had been living with violence employ methods of control that are either too aggressive or passive "and frequently had insufficient knowledge of basic principles of child development" (Hughes, 1982, p. 497). Additionally, in a study by Holden and Ritchie (1991), reports from previously abused women indicated more inconsistent parenting in comparison with the sample of non-abused women. It was also observed that abused women "attended less and experienced more conflicts with their children than the comparison mother-child dyads" (Holden & Ritchie, 1991, p.324)[4]. Consequently, mothers often need the guidance to improve their parenting skills.

Hughes (1982) outlines two goals for child-focused therapy with mothers. The first is to improve "a woman's relationship with her children through teaching her how to interact in a more positive manner; and second, helping her set firm consistent limits by means of a 'timed-out' procedure" (p. 497). An additional goal should be to help the mother understand the impact of violence on her children. Given that she is able and motivated to participate in the process, the mother can be a partner in helping her children cope with the trauma (Busby & Inman, 1996). For example, she may address the secrecy by directly granting the child permission to speak about the incidents, allocating

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[4] In both studies, as in much of the associated literature, the samples of abused women were drawn from current or past shelter populations. However, in 1993, 77% of women who left an abusive partner stayed with friends or family and 13% stayed at shelters or transition houses (Statistics Canada, 1994). There is some debate, therefore, regarding the true representativeness of shelter-based samples as only a minority of abused women use such agencies (Westra & Martin, 1981).

responsibility for the violent behaviour by explaining that the child is not to blame, or offering empathy and support simply by expressing "regret and concern about the child's experience" (Silvern & Kaersvang, 1989, p. 429). This goal may be difficult for some mothers as they may continue to deny the impact of woman abuse on their child and/or may be unaware of their children's needs. Overall, this intervention should support the mother in strengthening the bond between herself and her child.

Mathews (1995) has indicated that parenting groups or child-centred individual counselling for men who batter incorporate goals that are similar to those for women, yet focus upon the issues that are specific to the male perpetrator. Consequently, this intervention modality should centre upon positive parenting techniques that include non-violent conflict management skills and an understanding of child development. This counselling, however, should also address characteristics of this population, such as resistance to counselling and shame for their violent behaviour (Busby & Inman, 1996). Additionally, the perpetrator's lack of empathy for the children in a violent home should also be addressed by educating the men about the impact of witnessing violence on children. This may help them to re-examine their behaviour and provide a foundation for supporting their children (Mathews, 1995).

Perpetrators and victims may lack role models for positive parenting as empirical research suggests that family violence often permeates their families of origin (Rosenbaum & O'Leary, 1981). The primary goals of a child-centred approach with perpetrators and victims of partner abuse are to provide guidance for developing healthy parenting skills, help parents understand the impact of violence on children, and lend

overall support. Additionally, educating parents about such issues may affect not only their ability to parent, but may also help some parents overcome their denial regarding the impact on children of witnessing violence, which may lead to a re-examination of their behaviour through the eyes of their children. Providing models for positive child rearing should help the caregiver support the child in reaching his or her developmental potential and should ultimately minimize the possibility of child abuse. Furthermore, learning how to use non-violent conflict resolution skills in the parent-child relationship may extend into the adult's intimate relationships. Despite some potential benefits, the manner in which child-centred work with caregivers is carried out must incorporate an understanding of the nature of the violent relationships. Thus, doing so within the context of couple therapy may be less advisable given the controlling patterns characteristic of abusive relationships. Safety concerns are therefore minimized within the less emotionally-charged environments of same sex groups and individual therapy.

- Parent-Child intervention

The literature fails to address the possibility of family or parent-child dyad work with this population. On the other hand, Rabenstein (1997) has discussed parent-child groups as another way to employ caregivers in the intervention process. This model is beneficial as it involves peer and family support for healing in the post-crisis and post-violence stage for families who encountered violence in the past. This work involves non-offending parents, commonly mothers who are heads of households in single-parent families, and children of various ages. Rabenstein (1997) has described one model for such an approach in which the group objectives include restructuring the family through

bolstering the mother's parenting capabilities, talking about abuse in safe ways, disclosing other secrets, debriefing traumatic stories, taking a family-wide stand against violence, searching for non-violent alternatives in the extended family and co-creating a non-violent future. She emphasizes the importance of the family's readiness to engage in this work. For example, the crises involving basic needs or safety should be resolved. Additionally,

> the majority of mothers who participate have received some support or therapy for themselves prior to or throughout the group. This can help them to focus on the children in group knowing that they have a place to go where they can attend to their own needs. (Rabenstein, 1997, p. 129)

The utility of this model stems from the concurrent usage of family systems work within a group model whereby the family can gain new insights into their strengths and limitations while drawing upon the power of peer support (Rabenstein, 1997).

- Groupwork with children

According to the literature, group therapy is a tempting intervention for use with this population as it serves a number of concurrent needs. It is educational, in that children learn how to cope with stressors, social, as children have the opportunity to relate with peers, and resource efficient, as one or two therapists can simultaneously intervene with a number of children. Peled and Edleson (1995) have noted that the short-term structured format of group intervention appears to effectively meet the basic cognitive and emotional needs of the children involved, while Jaffe, Wilson, et al. (1986) indicate that groups concurrently address attitudes and coping .

On average, group sessions incorporate a structured format, are 60-90 minutes in length and run from six to ten weeks (Jaffe, Wolfe, et al., 1990; Peled & Davis, 1995). They tend to be small, involving three to six children, with each incorporating children of

similar developmental levels (Hughes, 1982; Peled & Edleson, 1995). Every session is structured to accomplish specific goals through educational activities. Major group objectives include defining and attributing responsibility for the violence in one's family, learning self-protection, experiencing the group as a positive and safe environment and strengthening one's self-esteem (Peled & Davis, 1995; Peled & Edleson, 1995). A variety of educational and enjoyable activities such as role playing, discussions, art projects and homework assignments (Alessi & Hearn, 1984) can be used to achieve these goals.

Evaluations of group programs, however, have traditionally been few in number, small scale, lack the use of control groups and are largely inconclusive (Hughes, 1982; Peled & Davis, 1995; Peled & Edleson, 1995). Yet, a small pilot study evaluated by Jaffe, Wilson, et al. (1986) outlined positive changes regarding protection planning, self-esteem, attitudes about violence and gender roles. Furthermore, Sudermann (1997) reported a number of changes in attitudes. For instance, children gained a better understanding of what comprised abuse, and who was responsible for such acts and strategies for non-violent conflict resolution (Sudermann, 1997). Comprehensive results were also delineated in the analysis of Minneapolis' Domestic Abuse Project's (DAP) children's program (Peled & Davis, 1995). Specifically, their model for group counselling provided a safe environment which fostered education about abuse, emotional disclosure, the achievement of new and healthy attitudes and the promotion of protection and coping skills.

Despite the general acceptance of the group model, there is little discussion in the literature about the drawbacks of such work. One exception is the evaluation of the

DAP's children's program. It revealed, for instance, that while the group process facilitated disclosure, it also resulted in the removal of coping defenses which functioned to introduce new tensions for the child and family (Peled & Davis, 1995). Another consequence was that some children were directly critical of their parents' behaviour and manner of parenting. For parents who were not involved in an associated parenting group, this attitude could be threatening, stressful and may in fact lead to further violence (Peled & Edleson, 1995). The bounded and resource-efficient nature of the group model appeals to the mandate of agencies; however, the analysis of the model's drawbacks reveal the importance of employing caregivers, the family system and more intensive individual work with children to address the unique aspects of people within the contexts of their environments.

- Individual intervention with children

Current literature focusing upon children who have been exposed to violence in their homes rarely discusses individual counselling directly as a potential intervention. This may stem from the fact that much of the research has been carried out through shelters where the indefinite and often short-term nature of the child's stay, coupled with a lack of funds for resources, makes group counselling the intervention of choice. While shelter-based intervention is geared toward crisis, longer-term therapy on an individual level, also called play therapy, can address some of the deeper and more personal concerns of the child. This process may be further enriched through conjoint or separate participation in group therapy as well as parental and/or school-based intervention. As the literature offers few guidelines for play therapy with this specific population, by

conceptualizing the child who has witnessed parental violence to be emotionally abused and traumatized (Echlin & Marshall, 1995; Jaffe, Wolfe, et al., 1986), interventions which focus on physical abuse, neglect and general traumatization can be used as guidelines for therapy with this population.

In contrast to the group method which is structured in its time frame and objectives, play therapy with the child tends to be less directive with open-ended or less constricted time limitations. As a result, play therapy enables the therapist to "view each child's experience as unique" (Gil, 1991, p. 38). Furthermore, ongoing assessment is integral to play therapy (James, 1989; Silvern, Karyl & Landis, 1995) as it is likely that the child will change over the course of the sessions both in response to the intervention and developmental change. Therapists must therefore recognize such changes and adjust their methodology appropriately (Gil, 1991).

Play therapy can be directive whereby the therapist helps the child achieve a number of goals in a manner similar to that of the group. The therapist can thus use the group objectives outlined in the literature within the individual context. In doing so, however, the therapist must recognize that violent families often encompass multiple problems (Gil, 1991), and therefore a non-directive, or flexible therapeutic style, should also be employed in sessions to allow children to focus on the issues that are of primary concern to them. This method is especially useful for the initial assessment in order to gain an understanding of the child's unique situation (Gil, 1991; Guerney, 1983). As there are few concrete guidelines for play therapy with this population, the therapist must be

knowledgeable about a variety of modalities (Gil, 1991) and the impact of violence on children so as to tailor play therapy to their needs.

Play therapy can be short or long-term and sessions tend to be approximately one hour in duration, once or twice a week. The therapist's techniques can be relatively directive, unstructured or incorporate a balance between the two in order to accomplish similar goals to those previously outlined for groups. Play therapy should provide a safe environment with clear limits of confidentiality that encourages the conscious expression of the child's feelings through playing with toys, creating artwork and interacting with the therapist (McMahon, 1992). Gil (1991) refers to this as the corrective approach in which the positive and rewarding aspects of human interaction are demonstrated through the safety, trust and well-being of the therapeutic environment. Additionally, Gil notes that play therapy incorporates a reparative approach through which children can "process the traumatic event in such a way that it can be consciously understood and tolerated" (1991, p. 52).

The beginning of the therapeutic endeavour should be non-directive. This non-intrusive method enables free self-expression at a pace that is comfortable for the child (Arroyo & Eth, 1995; Gil, 1991). Furthermore, the therapist's use of reflective and validating remarks (McMahon, 1992) can encourage the child to explore the physical and emotional space of the playroom. While introducing the play therapy context to the child, the therapist should simultaneously assess what symptoms can be identified. Overall, the structure of therapy will follow this initial assessment.

Similar to the group objective, an important aspect in play therapy for this population is disclosure of the traumatic stressor, specifically, violence in the family (Silvern & Kaersvang, 1989). Some children may feel comfortable in therapy and possess the ability to communicate their feelings and experiences verbally through direct discussion or psychodrama, or non-verbally through such things as artwork or play. Conversely, other children may require more directive aid to facilitate this process. In particular, the child may feel threatened in the playroom (Jaffe et al., 1990), not know how to play due to early traumatization and/or may embody defenses such as denial or avoidance (Gil, 1991). Consequently, the therapist should use such modalities as art, music or play to help the child develop a vocabulary with which their thoughts can be communicated (James, 1989). Additionally, Silvern, Karyl, and Landis (1995) advocate the use of *straight talk*, direct and detailed therapeutic communication, to facilitate disclosure. While these authors recognize that some therapists may steer away from such an intrusive approach, they defend the use of this method as necessary to break the child's isolation and to elicit details. Overall, a non-directive approach provides children with the opportunity to reveal their unique characteristics and, unless they are forthcoming on their own, increasingly directive methods should be employed to facilitate disclosure.

Often disclosure is not complete as maladaptive defenses, such as avoidance and post-traumatic play, prevent children from re-experiencing distress associated with the trauma. It is difficult for children to break down these defenses as they were initially created and maintained to alleviate the distress of the trauma (Silvern & Kaersvang, 1989). The task of the therapist should therefore focus upon interrupting these defenses

to help children confront and understand the traumatic stimuli. This may involve desensitization, whereby children are exposed to "the trauma and surrounding details in a calm setting, without the recurrence of danger" (Silvern, et al., 1995, p. 54), and relaxation techniques or game formats that foster a non-threatening context. Additionally, children should be encouraged to achieve this objective by having the rationale of this goal explained to them. In addition to striving for disclosure, therefore, the therapist is further encouraging children to actively master their anxiety (Silvern, et al., 1995).

The resolution of trauma involves overcoming dissociation through the cognitive restructuring and ultimate coherence of the events (Silvern & Kaersvang, 1989). Following disclosure, therefore, the therapist and child should work together to make sense out of the traumatizing incidents. The therapist can directly and indirectly educate children about family violence by challenging children's "maladaptive beliefs about sex roles, violence, or their own helplessness and responsibility" (Silvern, et al., 1995, pp. 60-62). As a result, disclosure sets a foundation for addressing such issues as self-blame, learned helplessness and other types of misinformation.

The final part in this process involves the integration and full acceptance of the traumatizing events in the history of the child (James, 1989). To do so, the therapist helps the child understand not only the traumatic stressors, but also the relationship between them and the symptoms (Silvern, et al., 1995). By comprehending the events and their defensive responses, the children's experiences are normalized.

Like group counselling, individual play therapy should be an enjoyable experience that helps to bolster children's self-esteem. A snack should be offered to increase the

nurturing and positive experience, and the establishment of appropriate boundaries gives the play therapy context clarity and predictability (Peled & Edleson, 1995). At its minimum, play therapy should foster a positive client-therapist relationship so that children can experience the notion that intimacy does not always involve threat (Gil, 1991) and to show that "the therapist genuinely cares about him [or her], in spite of knowing all about the traumatic experience in the child's life" (James, 1989, p. 49). Additionally, validating remarks by the therapist serve to highlight children's accomplishments and increase their confidence in their ability to achieve. Overall, play therapy can be an oasis of trust and safety in which children can find temporary refuge from their world of fear, pain and disorganization.

The literature has demonstrated that children who have been exposed to partner abuse are influenced by a number variables. It is important, therefore, to employ an intervention modality that is able to assess and address the unique issues facing children in this population. While play therapy offers this flexibility and insight for work with children, the wider environmental context should not be ignored.

- Summary: Toward an ecosystemic model of intervention with children

Social work practice with children who have been exposed to partner abuse must go beyond an exclusive concentration on the individual child. Focusing upon such children in isolation from their environments can be pathologizing and may serve to reinforce the self-blame experienced by many children in this population. Assessment and intervention which concentrate solely upon individual symptoms tends to ignore the direct and indirect impacts of the environment on the person and are potentially ineffective

because the environmental stressors may continue to persist and could function to reverse individual gains. On the other hand, an ecosystemic framework provides a more comprehensive understanding of the issues and affords a greater range of avenues for intervention.

The ecosystemic perspective focuses upon people in the context of their environments. It postulates that in order to understand people it is necessary to comprehend the circular notion that individuals and their environments are both dynamic entities that are involved in ongoing transactions. Ecosystemic theory draws upon an ecological perspective, which explains human behaviour in terms of finding and maintaining a comfortable balance that benefits both people and their environments (Germain, 1991), and general systems theory, which postulates that a change in one member of the system affects the nature of the system as a whole and that a final goal can be achieved through a number of different ways (Nichols & Schwartz, 1995). By focusing upon behaviour within a transactional framework, the ecosystemic perspective thus curtails the possibility for pathologizing the individual while providing a number of avenues for intervention. Based on the notion that problematic behaviours stem from a mismatching of individual needs and environmental supports, assessment thus necessitates an understanding of the relationship between the person and environment (Allen-Meares & Lane, 1987), while intervention focuses upon improving their transactions in order to maximize the goodness of fit between the two (Germain, 1991).

While the literature does not overtly discuss an ecosystemic approach to practice, leading authors who have written about children exposed to partner abuse recognize the

importance of considering children as active players in the context of their environments for assessment and intervention. For instance, it has been noted that the effect of violence and manner of reaction is influenced by the age, gender and developmental level of children (Garbarino et al. 1992; Jaffe et al., 1990; McAlister Groves, 1991; Miedzian, 1995; Porter & O'Leary, 1980). Additionally, Garbarino et al. (1992) and Rutter (1983) connect individual personality traits, environmental resources and parental support as important factors in the development of resilience in children. Authors also emphasize that individual responses vary among children as a result of mediating factors such as access to community and environmental resources, quality of the parent-child relationship (Garbarino et al., 1992), availability of resources (McAlister Groves, 1991), and frequency of moves or separations (Jaffe et al., 1990). The literature thus recognizes the transactional interplay between children and their environments in the determination of the impact of partner abuse.

A number of avenues for intervention have been noted in the literature. For instance, work with caregivers (Busby & Inman, 1996; Bilinkoff, 1995; Hughes, 1982; Mathews, 1995) and parent-child groups (Rabenstein, 1997) employ environmental contexts to engage in child-focused interventions. Additionally, interventions can be geared toward work with children through their school environments (Hughes, 1982; Roy, 1988; Sudermann, Jaffe, & Hastings, 1995) and peer groups (Peled & Davis, 1995; Peled & Edleson, 1995; Sudermann, 1997). Thus, the literature recognizes that child-focused interventions can employ the individual children and/or their environments for healing. This mirrors the ecosystemic notions of *multifinality*, the concept which

states that one can enter a system at any given point to produce change, and *equifinality*, a goal can be achieved in a number of different ways. Overall, the literature has indirectly encouraged an ecosystemic approach to practice with children who have been exposed to partner abuse.

Employing an ecosystemic approach permits a more comprehensive assessment that can account for the direct and indirect influences of partner abuse, while recognizing that children 's individual and external resources lead to a variety of responses. A careful examination of children in the context of the world in which they live will help to understand their unique situations. Additionally, by identifying the significant systems in the lives of children, intervention can use them as partners in child-focused interventions. Intervention which focuses upon children, their environment and the interaction between the two can best promote the process of healing.

Conclusion

The nature of the family in which the father-figure abuses the mother can generate immediate and long-term effects on children. They may have watched, overheard or seen the aftermath of parental violence. Although parents may not realize or refuse to admit that their children are aware of the violence, the witnessing of these incidents are traumatic stressors for the children. The effects of woman abuse, however, can extend beyond the specific assaults and ultimately impact upon the family's organization. Both influence the children. In particular, the parents may model behaviour, such as conflict resolution through violence or acceptance of one's victimization as a function of one's gender, and may employ poor or inconsistent child management skills. The externalizing

and internalizing symptoms which children in this population often exhibit appear to reflect this lack of order and positive parental role models. Additionally, these maladaptive behaviours can influence the manner by which the child copes with the traumatic violent incidents and deals with daily pressures and interactions. While these behaviours may result in long-term problems for the child, their immediate implications can further compound the family's level of stress.

The primary goal for intervention is to stop the violence in order to establish a foundation of safety within which family members can begin to heal. Subsequent goals for intervention should emerge from an ecosystemic assessment. In particular, children who are living in a family in which violence has occurred are influenced by two major factors. Firstly, they can be affected by a family environment that can lack nurturing, consistency and positive adult role models. Secondly, they have been exposed to traumatic stressors, specifically violent incidents directed toward a primary caregiver. The research points to the fact that symptoms may arise in response to these two aspects of family violence. While the literature recognizes that partner abuse affects children, their environments and the interaction between the two, it does not discuss a model for intervention which would address such a comprehensive framework. Instead, play therapy from an ecosystemic perspective provides the flexibility and scope needed to adequately address the issues. Specifically, the play therapy model involves the therapist as an emotionally-available adult who can create a safe and predictable context in which the traumatic stressors and associated reactions can be addressed. Play therapy focuses upon children as unique individuals in helping to develop coherence about themselves and their environments, and

to provide a foundation for future coping skills. Additionally, employing an ecosystemic framework enables the therapist to go beyond the individual issues to engage the family context so as to address environmental stressors and use environmental strengths to bolster children's healing.

Current literature does not address the full range of intervention modalities available for work with children who have been exposed to partner abuse. Furthermore, the efficacy of many is largely unknown as there are few thoroughly researched evaluations, the majority of which focus upon children living in women's shelters. This sample, however, may bias the outcome as issues facing children who have accessed shelters may differ from those who have not done so. Consequently, the cited successes of shelter-based interventions may in fact reflect the needs of this specific population and may not be representative of other sub-populations. Evaluations should therefore consider the extent to which children and families are involved in social services to further discern the heterogeneity of the population.

Current research focuses upon this population's differing responses to family violence with regards to their age, developmental level and gender, but neglects to further categorize children in terms of other variables such as past or current attempts to access intervention. More research-based knowledge regarding the association between the child and these confounding environmental factors will produce more focused and effective modes of intervention for children in this population. Without a stronger empirical basis, however, it is difficult to create and implement effective programs. Present and future

behaviours exhibited by these children cannot hide the urgency for more research and widespread programs for this population.

DESCRIPTION OF THE PRACTICUM

Practicum Setting

All phases of the intervention took place at the Elizabeth Hill Counselling Centre (EHCC). The EHCC is located in Winnipeg's inner city and is a training centre for undergraduate and graduate students from the faculties of social work and psychology at the University of Manitoba.

Client contact began in mid-October, 1996 and terminated at the end of June, 1997. The process developed under the primary supervision of Diane Hiebert-Murphy, professor of Social Work at the University of Manitoba. Additional supervision was provided by the practicum committee. Specifically, Linda Perry, social worker at the EHCC, Barry Trute, professor of Social Work at the University of Manitoba and Kathy Levine, social worker at the Manitoba Adolescent Treatment Centre (MATC) and sessional lecturer for the department of Social Work at the University of Manitoba, provided guidance and feedback regarding written reports. Additionally, Linda Perry supplied direct clinical supervision for one case.

All sessions with child clients took place in one of the two playrooms at the EHCC. These rooms were equipped with a multitude of toys such as arts and crafts supplies, sandboxes, games and dollhouses. Sessions with parents or parent-child dyad sessions were held in the regular meeting rooms at the EHCC. On average, sessions took place once a week and were one hour in duration.

Videotaping was used to record all sessions. This facilitated the therapist's self-evaluation, recording and supervision of the therapist's skills and processes. Additionally, intake reports, case notes and termination reports were recorded according to the standards outlined in the EHCC Manual.

Criteria for Referral

The request for referrals was made to social service agencies. The therapist contacted social service agencies, schools and hospitals by telephone to introduce her service and to obtain correct mailing information. Flyers were then sent which outlined the general criteria for referral and the goals of therapy (see Appendixes A and B). Finally, the therapist presented this information to two social service agencies, Wahbung Abinoonjiiag and Ma Mawi Wi Chi Itata Centre, at their request.

The criteria for referral included girls or boys between the ages of four and twelve who had lived in a household in which violence between two primary caregivers had occurred. These children may or may not have been previously involved in counselling or other social services and may or may not have been presently living with the caregiver(s) who had been involved in the violence. Additionally, in accordance with the policy at the EHCC for students, cases in which legal charges or custody access issues were involved were excluded.[5] Children were not refused based upon their primary caregiver's sexual orientation; therefore, both heterosexual or homosexual violent relationships would have been considered. As safety is always a primary concern, however, children needed to be

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[5] The purpose of such a policy is to ensure that students are guaranteed the opportunity to engage in the therapeutic process without the threat of being subpoenaed.

in a non-violent environment with caregivers who were not abusing substances at the time of referral. It was also preferable for the perpetrator and victim to be or have been involved in individual, couple and/or group counselling either in the past or concurrent with the process of therapy for the child. It was expected that these criteria would help secure a safe and more healthy home environment for the child so as to extend the goals of healing beyond the boundaries of play therapy (Jaffe et al., 1990; Peled & Davis, 1995). In addition, a commitment to therapy by the primary caregiver(s) was required; this would send the message to the child regarding the importance of counselling and would lessen the chance of frequent cancellations of sessions and/or premature termination.

The screening process also focused upon past sexual and physical abuse directed at the child. Firstly, children who were known to have experienced sexual abuse were not included in this practicum as they may have required intervention focused principally upon the abuse rather than violence-related issues. It was decided that should sexual abuse disclosure occur during the course of intervention, however, therapy would not be terminated; instead, issues of importance would be addressed accordingly. On the other hand, children who experienced direct physical abuse were not excluded from this practicum. It would have been preferable to include clients who have not been physically abused so that intervention could focus upon the "indirect" influence of violence within the parental relationship upon the child. Research has indicated, however, that the prevalence of woman abuse in a family often overlaps with that of child abuse (Straus et

al., 1980). As a result, on a practical level, it was difficult to exclude children who had been physically abused by their primary caregivers from this sample.

Referrals were fielded from mothers and professionals from social service agencies such as Child and Family Services (CFS), Evolve, Child Guidance Clinic, Immigrant Women's Association of Manitoba, Marymound and the Native Women's Transition Centre. A number of referrals were also made internally from the EHCC staff and students or taken from the waiting list at the EHCC.

In total, approximately 30 referrals of 38 children were taken. This group was evenly split according to gender as 19 girls and 19 boys ranging from the ages of two to twelve were referred. Out of these, 10 children fit the practicum criteria and became clients of the EHCC for this practicum. The remaining referrals were encouraged to seek services elsewhere or through the general EHCC waitlist as they did not meet the inclusion criteria. In particular, six clients had legal charges or custody issues pending, two children had been sexually assaulted, one client was both sexually assaulted and was linked to ongoing legal issues, two children were not exposed to partner abuse, in five cases mothers were not motivated or interested, and five other referrals sought services at other agencies due to a variety of reasons such as acceptance from a waiting list elsewhere, over-involement in current social services or referral too late in the practicum process to be offered service. Throughout the course of the practicum and after its termination, the EHCC continued to receive inquires about this project.

The Clients

The original intent of this practicum was to focus upon 4-6 children. Ideally, this sample should have represented each age grouping: either ages 4-6, 7-9 and 10-12 or 4-8 and 9-12, with each incorporating an equal number of boys and girls. Such stipulations would have provided the opportunity to explore issues surrounding developmental levels and gender. Additionally, the initial goal was for each child to engage in therapy one hour per week for approximately eight months.

Less than one-third of the referrals screened by the therapist met the criteria for the practicum. In total, 10 children engaged in play therapy. The sample was comprised of four boys and six girls whose ages ranged from three to twelve years. The therapist engaged in play therapy with each child for approximately one hour per week for an average of four months. Within this sample, there were two groups of female siblings. One was comprised of a group of three sisters with whom the therapist engaged in concurrent play therapy. The other was two sisters, each of whom were seen separately for individual play therapy. The rest of the sample was seen as single individuals in the playroom. In addition, parent-child dyad work was incorporated into the therapeutic plan for one client and this work was completed as a compliment to the individual play therapy the child received.

Goals for Intervention

The literature outlines a number of different ways to conceptualize the impact of witnessing violence. The first is the effect of the violent incident as a traumatic stressor

(Arroyo & Eth, 1995; Eth & Pynoos, 1985). The second considers the influence of violence on the child's environment and impact of that context on the child (Jaffe et al., 1990; Straus et al., 1980). The therapist's conceptual framework will ultimately guide intervention. In particular, a focus upon traumatization concentrates largely upon individual trauma-related symptoms and defenses (Silvern, et al., 1995). On the other hand, consideration of the impact of violence on children and their environment provides the therapist with a broader range of choices for intervention as a variety of systems and subsystems can be targeted for change. Because this practicum incorporated an ecosystemic perspective, the therapist thus used the latter conceptual framework for assessment, intervention and evaluation.

The therapist's objectives were to help the child to:

- develop a positive self-concept.
- develop coping skills and a protection plan so as to deal effectively with current or future stressors or unsafe situations.
- address attitudes and misinformation associated with responsibility for the violence and gender roles.
- develop healthy relationship skills, such as non-violent conflict resolution.
- have an enjoyable experience.

Additionally, there were a number of broader objectives which centred upon environmental change. These included:

- strengthening the caregiver-child relationship.
- helping significant systems to understand the effect of partner abuse on children so as to foster empathy for the children's needs.

Overall, the intended outcome of this intervention was to affect changes in the child's attitudes, behaviour and self-perception while fostering change in the associated systems so as to improve the 'goodness of fit' between children and their environments.

Intervention Techniques

The primary intervention for this practicum was individual play therapy. Similar to the methodologies outlined in the previous literature review, the therapist used a balance of directive and non-directive play therapy techniques to achieve the objectives of this practicum. In particular, a non-directive approach required a flexible therapeutic style whereby the child guided playroom activities and discussions. This approach was especially useful during the initial sessions to establish the foundation for a comfortable relationship between the therapist and client. Unlike other structured contexts in the environment of children in which they are told what to do or say, free exploration of both the playroom and the relationship with the therapist empowers children by giving them the responsibility to make choices for themselves. An additional intent of such free expression was to help the therapist become familiar with the child's unique personality. Overall, the goal of non-directive play therapy was to enable the therapist to foster a respectful relationship with the client within which intervention could be tailored to address the unique concerns of each child.

As the child became comfortable with the space, process and therapeutic relationship of play therapy, the intent was for the counsellor to introduce structured activities in response to the child's unique needs. For this practicum, the aim was to use directive approaches to address many of the themes outlined in the literature related to group counselling. Depending upon the child's developmental level, personality and presenting issues, the therapist used tools such as art materials, books, puppets and role playing to facilitate discussions. The goal was to employ these materials to help the child

develop a vocabulary to talk about feelings and violence, create a plan for unsafe or emergency situations and practice non-violent conflict resolution techniques.

Ongoing contact with each child's primary caregivers was an integral component to the intervention. This was carried out through conversations over the telephone or in person prior to or after the play therapy sessions. (In one case, more intensive involvement of the mother through parent-child counselling sessions was also carried out.) The involvement of the caregivers was important for a number of reasons. Firstly, the caregivers were able to provide the therapist with information for initial and ongoing assessment and evaluation of the children. For instance, the caregivers gave insight about issues of concern and significant changes which may have arisen outside the playroom. Secondly, the therapist was able to discuss issues of concern and changes she identified in the play therapy sessions to keep the parent informed of the child's progress. Lastly, this ongoing contact provided caregivers with a link to supportive resources. In particular, the therapist was available to provide support or referrals should the caregivers' personal needs require attention.

Members of other significant systems, such as teachers and school counsellors, were also contacted (with written consent of the caregivers). Although the therapist's relationships with these individuals was less intensive that those between the therapist and caregivers, they nevertheless played important roles in the therapeutic process. For instance, their insight as non-family members commonly served to enrich the assessment because they were able to provide information about the children's functioning outside of the home, such as academic performance and relationships with peers. Additionally, by

having had contact with the children prior to and during the intervention, they were also able to indicate significant changes. The flow of information was reciprocal whereby the therapist attempted to educate them about the effects of partner abuse on children and the proposed path of intervention in order to foster understanding and empathy so that the needs of the children could be addressed in an appropriate manner.

Incorporating other systems into the therapeutic process is important. For assessment and evaluation purposes, members of a child's environment can offer insightful and useful data about the child in a number of different settings. In doing so, members of other systems can become partners in the intervention so as to maximize the child's process of healing.

The Screening and Assessment Process

- Telephone interview with parent/caregiver

All referrals were documented on the EHCC referral forms. Although some referrals were first documented by an intake worker at the centre, all referrals meeting the above criteria were screened for appropriateness by the therapist. The first contact occurred by telephone between the therapist and caregiver. Firstly, the therapist told the caregiver about the EHCC, the objectives and structure of the practicum, the process of intake and assessment, and the limits of confidentiality (which included information about the legal obligation to disclose information to the appropriate authorities regarding the threat of homicide, suicide, child abuse and other harmful acts). This conversation helped to develop a "working alliance with the parent" (Peled & Davis, 1995, p. 34) and elicited information about the presenting problems, the child's special needs and the current family

situation, such as the living arrangement of all members and whether violence continued to persist (Peled & Davis, 1995). A Phone Interview Form based upon the format outlined by Peled and Davis (1995) was used to guide and document this information.

At the end of this interview, the therapist determined whether to meet with the caregiver for an initial intake session or to refer the children elsewhere if they did not meet the practicum criteria. If an intake interview was scheduled, the therapist inquired about how the caregiver would tell the child about therapy. Should the caregiver have required such guidance, the therapist gave suggestions such as to use simple language relevant to the child's developmental age, to keep the issue family-focused instead of centred upon the problems of the child, to maintain a positive attitude, to avoid blaming the child for the abuse and to refrain from using the intake or therapy sessions as a threat or punishment (Peled & Davis, 1995). On the other hand, if the caregiver had discussed the possibility of counselling with the children, the therapist inquired about the manner in which this was done so as to gain insight into issues such as the caregiver-child relationship and the caregiver's attitude to the counselling process.

- Intake

(1) Caregiver and therapist

An intake session during which the therapist and caregiver were scheduled to meet at the EHCC was arranged during the telephone conversation. The therapist met with each caregiver for a number of sessions until the necessary data was gathered and rapport was established. On average, each session was one hour in duration for one to four sessions. This intake phase afforded the opportunity for the caregivers to become

more comfortable with the therapist, the agency and the process of play therapy. Furthermore, the therapist was able to gain a more accurate picture of the family's history and current situation, the motivation of the caregiver, and the background and needs of the child.

Prior to the first session, the caregivers were given the basic forms required to become a client at the EHCC (see Appendix C). In particular, they were asked to complete forms consenting to treat a minor, permission for observation and agreement to participate in the practicum process. If it was determined that the therapist needed to communicate with a third party, such as other family members, teachers or physicians, the caregivers were also asked to complete a form granting permission to obtain/release information. Furthermore, the therapist reviewed the limits of confidentiality as well as the objectives and process of intake and therapy sessions during each initial intake session.

The information gathered during the intake phase was both quantitative and qualitative in nature. The quantitative data was gathered by having the caregiver complete the Child Behaviour Checklist (CBCL) (Achenbach, 1991) and the Parenting Stress Index/Short Form (PSI/SF) (Abidin, 1990b). (These measures are described in greater detail below in the section on evaluation.) Three out of the seven caregivers completed these forms on their own while at the EHCC. They took approximately thirty minutes to do so. The remaining four caregivers preferred that the therapist read the questions out loud. This took considerably longer as some caregivers would verbalize their decision-making process or would attempt to justify their responses to the therapist.

Commonly, completing the quantitative measures for the latter group took approximately one hour.

The majority of the intake sessions were devoted to the completion of two qualitative assessment forms. These were conducted by the therapist in a semi-structured manner, who recorded the information in her personal notes, which were later transcribed onto the form. Firstly, the caregiver was asked questions from the Developmental Information Form based upon that outlined by Peled & Davis (1995). This information helped to give the therapist a better impression about the child's coping skills, academic level and exposure to traumatic events. Additionally, this form defined the child's special needs so as to tailor intervention accordingly. Secondly, questions from the Parent Interview Form (Peled & Davis, 1995) were asked. These responses yielded more detailed information about such things as family relationships, the child's behaviour, peer relationships, parenting, possible physical abuse of the child and types of violence witnessed by the child. When gathering this qualitative data, the therapist attempted to accurately document the caregivers' reports with minimal interpretation. Information from these sessions was integrated into the Intake Report and was ultimately used to structure appropriate intervention. In addition to gathering information and establishing a relationship, knowledge gained during the intake process with the caregiver was used to formulate a decision regarding whether to proceed further and invite the child to engage in the intake sessions or to refer the child to more appropriate services.

(2) Child and therapist

Prior to meeting with the child alone, the therapist met with the caregiver and child together in a regular meeting room for the first ten minutes of the session. The aim of including the caregiver in the initial child intake session was to convey the message that the caregiver was granting permission for the child to discuss issues related to violence in the home with the therapist. Additionally, this session provided the opportunity for the therapist to witness the interaction between the child and caregiver so as to gain greater insight into their relationship and the parenting abilities of the latter. The caregiver was also able to watch the interaction between the therapist and the child. To help comfort the child, a few toys that were developmentally appropriate, such as drawing utensils, paper and puppets were selected and placed in the intake room. In the first part of this session with the caregiver, the therapist introduced herself to the child, gave the child a tour of the agency and explained the process and objectives of both the intake and play therapy sessions in language appropriate to the child's developmental level. This discussion included defining limits of confidentiality, establishing a time frame, explaining the motives for videotaping and clarifying the notion of play therapy. Overall, the therapist attempted to foster a respectful and open relationship with the children and caregivers in order to create a comfortable and safe environment.

After this initial introduction, the therapist and child went into the playroom while the caregivers waited in the front of the agency. If the child was anxious about this situation, strategies to alleviate these fears and avoid a struggle would have been implemented, such as giving the child permission to leave the room when necessary,

validating the apparent anxieties (Peled & Davis, 1995) or allowing the caregiver to remain in the playroom during the session. None of the children in the practicum sample had difficulty entering and staying in the playroom for the first session.

The child intake interview was conducted in a playroom in a loosely structured manner. The priority was to establish a comfortable environment in order to encourage the child to explore the playroom and ask questions. Additionally, it was important for the therapist to review the limits of confidentiality in order to establish appropriate boundaries. Simultaneously, the therapist noted the child's reactions and behaviours in the playroom. For instance, the therapist paid particular attention to the manner in which the child explored the room as an indicator of how she or he generally approaches new experiences (Peled & Davis, 1995). Additionally, the therapist used the Child Intake Form (as outlined by Peled & Davis, 1995) as a general guide to ask questions about the child's perception about the counselling process, school, peers, family relationships, self-concept, awareness of feelings, physical abuse directed at them, violence witnessed by the child and goals. This questionnaire differs slightly for various age groupings. An age-appropriate questionnaire was consulted for each child.

The intake sessions were the first opportunity for the child to meet the therapist and explore the playroom. As a result, the therapist attempted to gather the intake information in a manner that minimized anxiety, while helping to form a positive therapeutic relationship. For instance, the use of arts and craft materials or games were useful tools to help the child communicate feelings and experiences. Each session was approximately one hour in duration and was comprised of a balance between structured

questioning by the therapist and unstructured free play to enable the child to investigate the playroom and become comfortable with the therapist. The last part of each session was devoted to "free play or nonintrusive activity to allow him or her to regain composure" (Peled & Davis, 1995, p.51), during which the therapist attempted to give positive feedback to the child to create a positive, accepting and comfortable environment to which the child would want to return. Furthermore, in line with an unstructured methodology, the therapist did not record answers during the sessions and instead completed the forms immediately after each session with the aid of the videotape. Similar to the prior intake session with the parent, this information was used to formulate the intake report and structure intervention strategies.

In addition to the qualitative information the therapist attempted to elicit using the Child Intake Form, quantitative information was also gathered using the Piers-Harris Children's Self-Concept Scale (Piers, 1984). This self-report questionnaire was employed to assess how children feel about themselves. This scale was administered in the pre-intervention phase, when appropriate, to the child clients.

The length of the Child Intake Form and the loosely structured manner in which it was administered would have necessitated many sessions to complete. Eliciting such information was further confounded by the length of time required by children to establish a trusting and comfortable therapeutic relationship. Consequently, the therapist highlighted significant areas such as family relationships and memories of the violence, to obtain an initial assessment of the child. However, assessment was an ongoing process throughout each therapeutic relationship.

Overall, the process of screening and intake provided a general foundation for intervention. In particular, the therapist attempted to gather information about the child's developmental level, behaviours, attitudes, interactions and experiences. This process was often confounded by issues such as heightened anxiety or inconsistent appointments. Using this information, the therapist created goals for intervention which were appropriate for the child as an unique individual. In addition, this process provided the opportunity for both the caregivers and children to become comfortable with the therapist, agency and counselling process.

(3) Therapist and caregiver: post-intake

Following the initial sessions with the child, the therapist met with the caregiver alone. Whether in person or by telephone, the therapist talked about her observations and suggestions. A contract for the therapeutic process was thus created in conjunction with the caregiver.

Assessment and Evaluation Measures

- Caregiver

(1) Qualitative:

• Pre-Test: The Parent Interview Form (Peled & Davis, 1995) was completed by the caregivers and therapist in a semi-structured manner. This form elicited information about family relationships, the child's behaviour, parenting and violence witnessed by and/or directed at the child. The goal was to obtain information about the child's context

in order to assess whether the child was appropriate for this practicum and, if so, what unique intervention strategies should be implemented.

• Post-Test: The therapist and caregivers maintained contact throughout the intervention and met for approximately 1 hour to discuss the intervention following termination with the child. One goal of this meeting was to outline whether the anticipated objectives had been achieved. A semi-structured interview was used to do so. Specifically, the therapist recorded the caregivers' responses to questions focusing upon issues such as the children's behaviour, levels of academic achievement and their relationships with peers, family members and other adults. Consequently, the therapist attempted to outline changes which occurred during the course of the intervention by comparing the post-test information with that received during the initial intake sessions.

A second goal of this session was to provide an opportunity for the caregivers to give feedback to the therapist. In particular, the caregivers were given an additional questionnaire on which to record their thoughts about the process, significant changes that occurred, additional areas which merit further change and other comments which may be important (see Appendix D). This open-ended format gave the caregivers the opportunity to reflect upon and share their perceived satisfaction with the intervention. The caregivers were asked to write their responses directly onto the questionnaire and were encouraged to seal the responses in an envelop and give it to the administrative assistant. This was done in an effort to provide anonymity so as to yield new insights which may have otherwise been influenced by the therapist's presence.

(2) Quantitative:

• Child Behaviour Checklist: The caregiver was asked to complete the Child Behaviour Checklist (CBCL) (Achenbach, 1991) at two points in time: once during the intake and again following termination. The CBCL is a standardized form on which the caregiver records the behaviour and social competence of the child (Achenbach, 1991). It is useful for small sample research as client data can be compared with the measure's well-established norms by age and gender categories. It has been replicated throughout the world and has also exhibited high inter-interviewer and test-retest reliabilities which "were supported by intra-class correlations in the .90s for the mean item scores obtained by different interviewers and for reports by parents on two occasions 7 days apart" (Achenbach, 1991, p. 81). Additionally, the manual demonstrates the content, construct and criterion-related validity of CBCL scores (Achenbach, 1991).

The caregiver was instructed to consider the past six months in rating 118 behaviour problem items using a three-point scale ranging from *"Not True"* to *"Very True or Often True"*. The CBCL is appropriate for this practicum as it has been used extensively for the age range of the focal population (Goldman, L'Engle-Stein & Guerry, 1983). Consistent with the CBCL format, separate profiles were used for boys and girls within the age groupings 2-3, 4-11 and 12-18. The CBCL scores for each child were compared with both a normative sample and its pre- or post-intervention equivalent. This measurement was an additional tool for assessment, to help better understand the child's behaviour outside the boundaries of play therapy, and for evaluation, to see if intervention affected behaviour.

This measure is supposed to take approximately 20 minutes to complete and requires a fifth-grade reading level (Achenbach, 1991). The CBCL was administered toward the end of the therapist-caregiver intake sessions or during the initial intake session between the therapist and child.[6] The post-intervention CBCL was completed during the termination session between child and therapist or at the post-intervention follow-up session between caregiver and therapist.

Although studies have consistently verified the utility of the CBCL (Wodrich & Kush, 1990), measures which rely upon the perspective of one caregiver have been criticized for the potential for bias (Porter & O'Leary, 1980). Consequently, this information was compared with the qualitative data gathered from the caregivers and children to verify the validity of these findings.

- Parenting Stress Index/Short Form: Caregivers also completed the Parenting Stress Index/Short Form [PSI/SF] at pre-test and post-test. This measure focuses upon the "relative magnitude of stress in the parent-child system" (Loyd & Abidin, 1985, p. 169). It was used as a pretreatment measure to assess stress associated with the parenting role and as a posttreatment measure to highlight change.

The PSI/SF is a shorter version of the original Parenting Stress Index [PSI]. It is accessible for completion by most English-speaking parents as the statements require a fifth-grade reading level and therefore should not exclude subjects with low literacy skills. The PSI/SF is a self-report measure which takes approximately ten minutes to complete. Additionally, the instructions are clearly outlined on the test sheet. Subjects were asked to

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[6] The timing of CBCL administration depended largely upon whether the caregiver was comfortable completing the measure with or without the aid of the therapist.

fill out basic demographic information and then respond to the 36 statements by choosing from a five-point Likert scale in which the possible responses are: *strongly agree, agree, not sure, disagree* or *strongly disagree*. Some items, however, follow a different format in that they are "preceded by a cue to use a different response format (e.g., "For the next statement, choose your response from the choices '1' to '5' below")" (Abidin 1995, p.54). The simplicity of wording ensures accessibility to the majority of parents regardless of their educational background.

A quick general interpretation was obtained based on the assumption that "the normal range for scores is within the 15th to 80th percentiles. High scores are considered to be scores at or above the 85th percentile" (Abidin, 1995, p. 55). On the other hand, a slightly more detailed interpretation was acquired from guidelines delineated in the manual. In particular, significant percentiles and raw scores for each subscale are outlined. For example, Abidin indicates that if Total Stress is at or above 90th percentile, the subjects "are experiencing clinically significant levels of stress. These individuals should be referred for closer diagnostic study and for professional assistance" (1995, p. 55). Furthermore, the manual notes the significance of the relationship between subscales. For instance, if Parental Distress is more that the 90th percentile and Difficult Child is below the 75th percentile, the parent may be "experiencing personal adjustment problems that are at least partially independent of the parent-child relationship" (Abidin, 1995, p. 56). The manual then goes on to suggest paths for intervention for these subjects, such as bolstering the parent's self esteem and sense of competence. Formal training is not

required to administer and score the PSI/SF, yet the manual suggests that for interpretation, graduate training in a related field is advised (Abidin, 1995).

The manual indicates that the PSI/SF is both reliable and valid; however, neither studies which have utilized the measure nor critiques have been published (Abidin, 1995). On the other hand, the short version is highly correlated with the original PSI, a measure which has been subjected to extensive research and development. Thus, research studies using the PSI and critiques pertaining to the long version can be loosely applied to the short form. This body of literature is extensive and indicates that the PSI demonstrates stability, validity, internal consistency, the capacity to measure change (Bendell, Stone, Field & Goldstein, 1989; Berry & Jones, 1995) and is "correlated to measures of theoretically related constructs" (Bigras, LaFreniere & Dumas, 1996, p. 168).

- Children

(1) Qualitative:

During the initial intake/assessment sessions the therapist asked children questions from the Child Intake Form (Peled & Davis, 1995) appropriate to their age in a semi-structured manner. The aim of these questions was to find out information from the child's perspective regarding relationships with peers and family, self-esteem, witnessing or physically experiencing violence and goals for future. Initially, the intent was to gather complete information prior to proceeding with the goal-setting and intervention phases. It was found, however, that all the children required a substantial amount of time to become comfortable with the playroom and therapist. The majority were anxious during this relationship building period. Consequently, it was found that asking lengthy and detailed

questions about personal and often previously "secret" issues tended to increase the level of anxiety for the child and reduced the likelihood of gaining such information for therapist. As a result, the therapist quickly learned to integrate a mix of questions regarding issues that were less emotionally-charged, such as school or peers, with questions regarding violence witnessed or directly experienced. The therapist modified the degree to which she would go into detail about the issues depending upon the reaction of the child. These reactions, however, became an important element of the assessment process. The length of time it took to elicit this general information depended upon each child's developmental level, degree of anxiety and relationship with the therapist. [7]

These answers were compared with the qualitative data elicited from the Parent Interview Form, a questionnaire with similar themes, so as to construct a more accurate multi-perspective understanding of the issues. While this helped to construct intervention strategies, a great deal of inconsistency between child and caregiver answers were also suggestive of problems within this relationship.

This questionnaire was not formally administered at the termination of play therapy. However, the process of termination included helping the child reflect upon similar themes, such as different living situations, while also reviewing changes in the child's behaviour, attitudes and self-concept. It was hoped that such reflection would help

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[7] An important factor which contributed to the child-therapist relationship was the consistancy in which the child attended the play therapy sessions. For at least two children, inconsistant attendance was a significant issue that clearly influenced their ability to establish a meaningful relationship with the therapist and affected the assessment process.

the child gain coherence about the therapeutic process in addition to gaining insight into past, current and future situations.

The termination process with the child also included an open-ended question feedback form written in simple language (see Appendix E). This form included questions related to what was learned, what was liked or disliked and other comments or suggestions. While it would have been preferable for the child to have completed this without the aid of the therapist, in the majority of cases, the child's developmental level or discomfort with reading and writing prevented independent completion of the form. For these children, the therapist read the questions out loud and directly recorded the child's answers without interpretation.

(2) Quantitative:

Children were asked to complete the Piers-Harris Children's Self-Concept Scale (Piers, 1984) at two points: once during the intake sessions and during termination. The goal of this self-report questionnaire is to assess how children feel about themselves (Piers, 1984) and should take about 25 minutes to complete (Epstein, 1994). The manual indicates its high reliability whereby "test-retest reliability coefficients range form .42 to .96 and internal consistency estimates for the total score range from .88 to .93" (Piers, 1984, p. 57). Additionally, Jeske (1994) has emphasized that "estimates of content, criterion-related, and construct validity from numerous empirical studies have generally been quite acceptable" (p. 345).

The questionnaire consists of 80 statements about oneself and the respondent is permitted to choose either *"yes"* or *"no"* as a response. This method is beneficial as it

focuses upon children's conscious perceptions of themselves and may indicate important internalizing and/or externalizing issues that may need to be addressed through intervention. Use of the Piers-Harris in this practicum was intended to help structure intervention strategies according to the needs of the children. Additionally, the post-test Piers-Harris was compared to that which was completed in the pre-test to assess for change in the children's sense of self.

One limitation of the Piers-Harris is that it is recommended for use with children between the ages of eight and eighteen; thus, almost half of the intended population for this practicum would have been excluded from its use. The scale has been used experimentally with children younger than eight years of age, however, the validity of its use with a young population has yet to be sufficiently proven (Piers, 1984). Thus, the measure was administered to the majority of the sample population, although time restrictions and developmental limitations sometimes prevented its use. Additionally, the authors indicate that children with low verbal ability and/or who are "overtly hostile, uncooperative, uncommunicative, prone to distortions, or so disorganized in their thinking that their responses do not accurately reflect their feelings and behaviours" (Piers, 1984, p. 3) may have difficulty completing the scale; this appeared to be an influencing factor with a number of children, yet its influence on test results was unclear. Another limitation was that its normative scores were standardized thirty years ago on 1,183 children in grades 4 through 12 in one school district in Pennsylvania. Thus, there are concerns about the generalizability of the results (Epstein, 1994).

Despite these limitations, the strengths of the Piers-Harris outweigh the criticisms. Additionally, this quantitative information was supplemented extensively with qualitative data gathered from caregivers and children and quantitative results from measures administered to caregivers. For this practicum, its utility stemmed from a comparison of pre-test and post-test scores to evaluate changes in self-perception.

PRACTICUM PROCESS

Overview of Clients

In total, ten children engaged in therapy. The sample was comprised of four boys and six girls whose ages ranged from three to twelve. The following is a general overview of clients subsequent to which four case studies will be expanded upon in greater detail.

- Crystal, April and Jasmine

Crystal (age 7), April (age 5) and Jasmine (age 3) were biological sisters who were referred to the EHCC by Child and Family Services. The sisters were Aboriginal and were from a Reserve in Manitoba. They had been placed in voluntarily foster care while their parents received services for substance abuse and family violence. The girls had been living with Caucasian foster parents in Winnipeg for approximately one month when they were referred. The girls were seen together at the EHCC for play therapy once a week for a total of five sessions. The first two were one hour in duration and the final three were one and one half hours long. In addition, the therapist met with the foster parents for two initial and one termination sessions that were approximately one and one half hours in duration. Telephone contact was maintained with the foster mother throughout the process. In total, the therapeutic relationship was approximately three months long. Therapy was terminated because the girls returned to live with their biological parents.

- Stephen

Stephen was a ten year old Caucasian boy who was referred to the EHCC by his mother. He attended a total of three one hour individual play therapy sessions. In

addition, the therapist met with his mother for four one hour sessions. The duration of this therapeutic relationship was approximately four months. The client terminated due to scheduling difficulties.

- Joey

Joey was a seven year old boy who was referred to the EHCC by his mother. Joey's mother was Caucasian and his father was African-American. Joey attended ten individual play therapy sessions which were each approximately one hour in duration. The therapist also met individually with Joey's mother for four sessions and maintained telephone contact throughout the process. The duration of the therapeutic relationship was approximately six months and was terminated unilaterally by the client.

- Sean

Sean was a seven year old boy who was referred by his mother on the advice of Evolve, a counselling program that specializes in partner abuse. Gina, his mother, had immigrated from a Northern Mediterranean country to Canada when she was pregnant with Sean. This therapeutic relationship spanned nearly eight months. The therapist met with Gina for four one hour individual sessions and one 45 minute termination session. As well, ongoing contact with Gina was maintained throughout the process. Sean attended 10 individual play therapy sessions which were on average approximately 45 minutes in duration, as they frequently arrived late. Additionally, Sean and Gina attended 4 sessions together which were between one hour to an hour and a half on average. Therapy was terminated due to the end of the practicum.

- Tracey

Tracey was a twelve year old Aboriginal girl who was referred to the EHCC by Child and Family Services. Tracey attended fourteen weekly individual play therapy sessions that were each approximately one hour in duration. Additionally, the therapist met with Tracey's mother for three initial sessions and one termination session. Telephone contact with the mother was ongoing throughout the process. The relationship developed over the course of five months. Therapy was terminated due to end of the practicum.

- Dustin

Dustin was an eight year old boy who was referred by his mother to the EHCC. His father was from the Caribbean and his mother was Caucasian. The relationship continued over a five month period during which Dustin attended eight individual play therapy sessions in an inconsistent manner. One average, these sessions were forty-five minutes in duration, as Dustin commonly arrived late. Additionally, his mother attended two individual intake sessions and one termination session. Therapy was terminated due to the end of the practicum.

- Kirsten and Lisa

Kirsten (age 8) and Lisa (age 6) were Caucasian half-sisters who were referred by their mother to the EHCC. The therapeutic relationship was about four months in duration. During this time, each girl attended individual play therapy for eleven sessions. The sessions were weekly and were approximately fifty minutes in duration. The therapist met with their mother twice to gather initial information and establish goals and once at termination. However, contact between the therapist and mother was maintained

throughout the therapeutic process. The therapy was terminated due to end of the practicum, yet, further therapy was not deemed to be necessary as many of the intervention objectives were met.

Case Studies

Four cases are expanded upon in greater detail below. These were chosen to provide a gender balance and to exhibit a fairly diverse range of assessments and interventions.

- Tracey

(1) Presenting problem

Tracey, a twelve year old Aboriginal girl, was referred by Winnipeg Child and Family Services (CFS). At the point of referral, her family was going through a number of changes as three of Tracey's five siblings were moving out of the home. Consequently, the CFS worker wanted to bolster the relationship between Tracey and her mother, Rose. An additional concern was Tracey's peer relationships in that she was becoming aggressive with other children at school and others were bullying her.

(2) History of violence

Tracey lived in a multi-problem family and was the youngest of six siblings (see Appendix F for genogram). She had two half-brothers, a half-sister and two brothers. The biological father of the three youngest children, Stan, had been physically, verbally and sexually abusive to Rose. Tracey had never directly witnessed this violence and had only vague recollections of overhearing it. While the abuse occurred when she was six years

old and younger, she may have been shielded from some of the violence because her preschool years were spent out of the house due to the fact that CFS had arranged for her to attend day care between the ages of two and five.

Stan had also been physically aggressive with all of the children except for Tracey, whom he had consciously protected. Tracey was able to recall detailed accounts of directly witnessing the abuse of her siblings. Sometimes they would bring her into the confrontation in an effort to protect themselves. In addition, she was aware of the indirect influence of the abuse in that she was able to conceptualize her father's cycle of tension building and violent eruptions.

Furthermore, there had been inter-sibling sexual, physical and verbal abuse of which Tracey had been a victim.[8] She did not remember the sexual abuse, as it occurred prior when she was two years old, and was not aware of the identity of the perpetrator. It was also revealed during the course of play therapy that Tracey had witnessed her mother physically abusing her sister.

Rose and Stan separated in 1992 when he publicly declared his homosexuality. Subsequent to this, Rose battled alcoholism for which she sought professional help after a number of months. Rose continued to attend Alcoholics Anonymous throughout the therapeutic process. Two years after the separation, Stan and Rose divorced. Rose was awarded sole custody of her children, which Stan has never contested. Despite this legal

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[8] Tracey had been accepted to participate in this practicum despite the fact that she had been sexually abused. Previous to her involvement in play therapy at the EHCC, she had attended a group run by CFS for girls who had been sexually abused. It was deemed that she should not continue with the group, however, as she had no memory of the abuse. For the purposes of the practicum, therefore, it appeared as if issues pertaining to the sexual abuse were not salient at the time of referral.

arrangement, most of the children maintained a relationship with Stan. Tracey used to visit him every weekend but stopped doing so when her fifteen year old brother, Bobbie, moved in with Stan.

During the course of Tracey's therapy, Rose was engaged to marry an Aboriginal man who had no history of abuse. Stan, on the other hand, was living with a Caucasian male partner and his partner's twelve-year old daughter. Apparently, he was no longer abusive to his children nor to his current partner. On the other hand, the inter-sibling abuse persisted and Tracey continued to be the focus of sibling aggression. This was especially true of her relationship with Bobbie, in that he was physically aggressive and verbally abusive to her. Bobbie and Ryan, Tracey's seventeen year old brother, were involved in Aboriginal street gangs. By the termination of Tracey's therapy, both brothers were incarcerated due to violence-related charges.

At the point of referral, Tracey was living with her mother, her eldest half-brother and his eighteen year old pregnant girlfriend. In contrast to the family context prior to her parents' separation, the violence in Tracey's home environment had diminished. Yet, unhealthy conflict resolution techniques such as verbal name calling and threats, and physical aggression such as punching and shoving continued in the inter-sibling relationships.

(3) Ecological assessment

Given the pervasive history of violence in Tracey's family, she appeared to be functioning relatively well. She was involved in community leadership roles, participated in competitive sports at school and was employed in the school computer lab. She

appeared to have a large number of friends and talked about goals for the future, such as becoming a police officer, for which she acknowledged that she needed to stay in school. Furthermore, Tracey was also able to articulate a number of good qualities about herself.

Rose had agreed to counselling for her daughter as she noticed a number of changes in her behaviour in the months prior to referral. According to Rose, Tracey was becoming "defiant" and "pushy". In response, Rose had established a number of rigid rules. For instance, she prohibited Tracey from dating, wearing make-up or cutting her hair, rules to which Tracey did not strictly adhere. Rose had been feeling guilty around not being able to prevent Bobbie from becoming violent, thus in an effort to protect Tracey from occupying a similar role, she became increasingly concerned about Tracey's "rebellious attitude". Additionally, Rose alluded to difficult issues during her own teenage years and thus the strict rules apparently were an effort to protect her daughter from the hurt she had experienced at that age. She admitted that she was not familiar with appropriate behaviour for a girl of this age and wanted her to stay young.

Despite Tracey's positive coping behaviours mentioned above, she was engaging in physical aggression with peers. She proudly recounted her involvement in these fights and stated that she may be expelled if they continued to be an issue at school. This aggressive pattern could be traced to a number of levels. Firstly, Tracey lived in the downtown core of Winnipeg. Largely an Aboriginal community, the area is characterized by poverty and a culture of violence. Secondly, this societal influence was further bolstered by the experience of violence in Tracey's family. Specifically, each family sub-system related to one another in an abusive manner. Violence was evident in the

couple subsystem, the parent-child subsystem and the sibling subsystem. Verbal and physical abuse was the mode of interaction between family members; thus, non-violent options for conflict resolution were not the norm. Lastly, on an individual level, Tracey believed that her use of physical aggression with peers was necessary. In particular, she would commonly justify her actions in therapy sessions by pointing to a younger child that was in need of protection. In the same way that she needed protection from the aggression directed toward her by her siblings, she was carrying out a "righteous act" by defending the more vulnerable and powerless children. Consequently, the social, family and personal reality of Tracey's life reinforced physical aggression as a method for relating with others.

Tracey also demonstrated internalizing behaviours. For instance, she had expressed self-blame for her father's violence and after the fifth session, she attempted to commit suicide. This may have set a dangerous precedent. It appeared to have been a rash decision which resulted in a great deal of "positive" attention. People were sympathetic to Tracey and treated her in a unique way that was nurturing and caring. Additionally, there had been a pattern of suicide attempts in her family. Throughout her childhood, Tracey had been present during a number of her mother's suicide attempts. In addition, her second eldest half-brother, Josh, had attempted suicide a number of times in the past. Her family experience had therefore exposed her to the possibility of suicide as a coping response. In addition, her personal experience with this attempt taught her that such an act of violence directed at herself could produce the nurturance, caring and support she

needed from the people in her life. For a short period, her family (and adult professionals in her life) pulled together to help Tracey, instead of victimizing her.

An additional internalizing issue pertained to Tracey's apparent divided loyalty to her father. On the one hand, he "protected" her from his direct abuse, but on the other hand, his actions made things more difficult for her among her siblings. Consequently, in an attempt to resolve these feelings, she may have felt the need to choose between loyalty to her father against her siblings and loyalty to her siblings against her father. Perhaps the immediate need to be protected from their aggression appeared to outweigh the close relationship with her father.

Overall, Tracey was attempting to deal with the onset of adolescence within a multi-problem family. She was engaging in the regular developmental concerns involving self-definition and sexuality within an environment that had demonstrated the devaluation of women, the use of interpersonal aggression to release anger and resolve conflict, and the application of unhealthy coping skills, such as attempting suicide and substance abuse. Although adolescence involves a move away from the family toward peers (Belsky, Lerner & Spanier, 1984), adolescents "need parents to model how responsible adults get their own needs met" (Fahlberg, 1991, p. 117). Despite her growing independence, therefore, Tracey required the guidance of her parents as role models in order to develop a corpus of values and skills so as to interact effectively in the adult world.

Tracey's parents were experiencing difficulty occupying an executive role. For instance, Rose appeared apprehensive regarding the challenges of Tracey's adolescence, despite her experience parenting five teenagers. One factor which appeared to have

contributed to this insecurity stemmed from Tracey's birth order. In particular, Rose expressed guilt regarding her perceived failure at not having prevented Bobbie and Ryan from engaging in violence. Another issue was related to Tracey's gender whereby Rose projected onto her daughter her own vulnerabilities at that age. Thus, Rose's uneasiness about Tracey's typical adolescent behaviour appeared to have stemmed from her experiences as a mother of teenagers and family of origin related issues. Rose recognized these vulnerabilities and attempted to employ external resources by engaging Stan as a co-parent, a role which she felt he did not willingly embrace.

From Tracey's perspective, her relationship with her father was inconsistent and confusing whereby she simultaneously needed to be close with him but feared retribution by her siblings. Stan did not understand this dilemma and instead believed that Tracey should value their relationship due to her favoured position among her siblings. In a developmentally appropriate manner, therefore, Tracey was beginning to perceive her father as an individual (Fahlberg, 1991). As she started to see beyond her idealizations of his past behaviour, her anger towards him grew. Thus, she needed him to take responsibility for his past actions so that their father-child relationship could be strengthened. Overall, Tracey began to challenge the "homeostasis" of her family system.

The three main system's in Tracey's life were school, peers and family. Her active involvement in leadership roles in school-related activities and peer interactions appeared to have provided Tracey with opportunities for success from which she developed a relatively strong self-concept. On the other hand, her family environment provided fewer opportunities for healthy development and instead encouraged the growth of unhealthy

behaviours and attitudes. Tracey was unique in her family by virtue of being the youngest female and having been the only member to be protected from her father's direct aggression. In order to feel acceptance within the system, she needed to employ the rules of interaction which were governed by verbal and physical aggression. She received little family recognition of her successes which stemmed from healthy behaviours, such as achievements at school. Consequently, in order to gain attention from her family. Tracey was beginning to recognize the value of employing extreme behaviours, such as attempting suicide. It was through such acts that she felt nurtured and valued by the fragmented parental, sibling and family systems. Tracey was increasingly adapting her behaviour and attitudes to fit into a family environment that encompassed unhealthy coping skills and whose transactions were characterized by aggression. As evidenced by her increasingly aggressive interactions with peers and her disregard for repercussions at school for such behaviour, the coping skills she was learning from her family were extending into her interactions with other significant persons in her environment.

Germain (1991) identified three areas of problems of living that arise from stressful person-environment relationships. The first encompasses life transitions or new developmentally imposed demands and roles. This was especially true in this case as Tracey and her parents were attempting to deal with the onset of her adolescence. In addition, a compounding life transition was Rose's engagement and planned move to a different town. For the first time, her parents would be living in different cities and the finalization of her mother's re-marriage would diminish any possibility for reconciliation between her parents. Secondly, environmental pressures, or difficulties in organization

and social network resources, is another stress producing area. This did not appear to be a significant issue for Tracey and her family as they were connected to a multitude of resources. The third life stressor is maladaptive interpersonal processes which include obstacles in communication or relationship patterns in one's family or other primary group. This was especially true in Tracey's family as communication occurred through verbal and physical aggression, thus, they had difficulty solving conflicts in a healthy and effective manner. As two life stressors were influencing the relationship between Tracey and her environment, intervention needed to be geared toward helping the person and the environment improve the "goodness of fit" (Germain, 1991), cope with changes and adapt accordingly.

(4) Intervention

• Duration: Tracey attended 14 weekly individual therapy sessions which were approximately one hour each in duration. In addition, the therapist met with her mother, Rose, for three initial sessions and one at the point of termination. During the course of Tracey's therapy, Rose and the therapist continued contact by telephone and at the EHCC. Therapy was terminated due to the end of the student's practicum placement.

• Goals:

Given the complex family history, Tracey's needs were often overlooked due to the competing demands of other family members. Thus, by focusing intervention primarily upon Tracey and her parents, the ultimate goal was to encourage Tracey's healthy attitudes, beliefs and coping skills through therapeutic and familial support.

There were a number of goals focused upon employing Rose as a therapeutic partner for intervention geared toward Tracey. The general objectives for Rose were to:

- understand Tracey's needs as an adolescent who has been exposed to violence and employ healthy parenting skills in order to address them.
- set an example for healthy coping skills and non-violent conflict resolution.
- employ resources to address personal needs.
- prioritize concerns about Tracey and make consistent rules when appropriate.
- bolster her relationship with her daughter as a unique individual.

Objectives for intervention with Tracey entailed the creation of a nurturing and supportive environment so as to:

- develop non-violent conflict resolution skills.
- talk about and understand the violence in her family.
- address and understand her defensive behaviour.
- explore developmental issues.
- experience positive encouragement from an adult role model in order to encourage her strengths and healthy coping skills.

Stan was involved to a lesser degree in the intervention. Nevertheless, objectives were geared toward strengthening his role as an active participant in Tracy's environment. The main therapeutic objectives for Stan were to:

- recognize his role as a parent to Tracey.
- understand the impact of violence on his daughter.
- develop empathy for Tracey due to her exposure to violence and her victimized familial role.
- take responsibility for having been a violent role model.
- strengthen the parent-child relationship between himself and his daughter.

Overall, intervention objectives were targeted toward improving Tracey's environment by focusing upon her parents' interactions with their daughter, while helping Tracey as an individual to interact with her environment in a healthy manner.

- Process: Throughout its history, this family had been involved in a multitude of interventions with a number of different agencies which focused primarily on subsystems and other individual family members. Previously, Tracey had been involved in family

counselling and a group that focused upon girls who had been sexually abused. Although she had a relationship with her school counsellor, her involvement at the EHCC was the first time she had engaged in individual counselling.

One primary goal for intervention was to bolster the relationship between Rose and Tracey. Intervention focused upon her mother's needs was clearly a priority even before Tracey's initial session. In particular, after the initial intake session, she missed two appointments in a row. In response to the therapist's inquiries, Rose was able to admit that she was feeling emotionally unstable. As a result, the therapist was able to arrange individual counselling for Rose at the EHCC which took place concurrently with Tracey's scheduled appointments. Until she was able to meet with her individual counsellor, however, Rose needed to discuss many of her personal issues regarding her current partner and relationships with her other children. It was difficult to focus these sessions on Tracey as Rose's needs outweighed those of her daughter. After beginning individual counselling, on the other hand, Rose's capability to focus upon Tracey grew immensely. She was able to articulate difficulties in their relationship and identify problematic behaviours Tracey was exhibiting. The goal of contact with Rose, therefore, was to help her understand Tracey's needs and come up with ways to address them better. One objective was for mother and daughter to spend time together engaging in a mutually enjoyable activity. Another aim was to help Rose prioritize her concerns about Tracey and make rules accordingly. For instance, it was decided that curfew rules should be of higher concern due to safety issues, as opposed to allowing her to cut her hair, which was

not permanent and healthy from a developmental standpoint. Overall, the therapist met with Rose for four sessions and maintained contact throughout the therapeutic process.

A large part of the intervention was focused upon Tracey as an individual. In the playroom, she rarely engaged with the toys even when invited. Yet, on three separate occasions she responded to the therapist's invitations to do so and played Trouble, Monopoly and with the cash register and food in a structured manner which included the therapist. For the majority of the sessions, however, Tracey enjoyed sitting in a chair or on the couch and talking with the therapist about issues she believed to be significant.

Tracey responded more positively to non-directive therapy and tended to avoid engaging in directive tasks. Within this unstructured context, the therapist attempted to address the intervention objectives within the context of Tracey's agenda for the week. The therapist-guided topics of discussion focused upon peer, intimate and family relationships, self-esteem, protection planning, sexuality, healthy relationships and anger. She was familiar with many of these issues as she had discussed them previously in family counselling, with her school counsellor and through school prevention programs. Yet, Tracey was more responsive when the issues were contextualized within her own life. In the first few sessions, for instance, when the therapist attempted to engage in a discussion focusing upon healthy relationships, Tracey's responses seemed mechanical and appeared to reflect lists of information she heard at school. In later sessions, the therapist addressed the topic again in the context of Tracey's proclaimed crush on a male teacher. The contextualization of this topic yielded more genuine responses as Tracey was able to use her concrete life experience to discuss abstract notions pertaining to gender relationships

and sexuality. Thus, despite Tracey's verbal ability, her developmental capabilities demanded the use of concrete examples to understand abstract notions.

The therapist introduced a number of directive tasks which often provided a foundation for less structured discussion. For instance, in the first session, Tracey reluctantly agreed to draw a picture of her family from which an initial discussion of family relationships ensued. In the tenth session, after the argument with Stan, the therapist employed written visual representations to explore her relationship with her father and the anger she felt toward him and other family members. For instance, the therapist drew an "anger meter" on which she was invited to detail the level of anger she felt toward individuals on a scale of zero to ten, with the latter representing the most angry. She indicated that her anger towards her father and Bobbie were the strongest as both were at ten, Ryan was nine, Chris was three, Josh was two, Janice was one and she equated both her mother and Chris' girlfriend with zero. This exercise was useful for a number of reasons. Firstly, it reflected Tracey's feelings back to her in a visual manner in order to foster a new understanding of her relationships and emotions. Secondly, it enriched the assessment. By providing more detailed information about Tracey's relationships with her family members, the therapist was able to recognize varying degrees of conflict between herself and members of her environment. Additionally, by noting that her anger appeared to be correlated with violence and gender, the therapist used the scale to address responsibility for violence and gender stereotypes. This opportunity was thus used to challenge her "maladaptive beliefs about sex roles, violence, [and her] own helplessness and responsibility" (Silvern, et al., 1995, p. 60-62) so as to

help her understand the traumatizing stressors and educate about partner abuse (Silvern & Kaersvang, 1989). Furthermore, the identification of a range of emotion was also used to discuss anger management and non-violent conflict resolution techniques, important skills for the establishment and maintenance of peer, intimate and family relationships (Peled & Davis, 1995). Consequently, the anger scale provided a concrete representation of Tracey's relationships with family members and the emotions she experienced in these transactions. This exercise thus extended beyond the discussion of acute violent incidents to explore associated emotions, internalized attitudes, beliefs and coping skills.

An important part of the counselling process was the therapeutic relationship. In particular, the therapist attempted to provide support and nurturance while emphasizing Tracey's uniqueness and bolstering her self-esteem. Tracey appeared to enjoy this support and tended to respond positively to encouraging comments. By emphasizing her strengths and accomplishments through validating remarks, the therapist encouraged Tracey's self-confidence in her ability to achieve. Additionally, Tracey was able to experience that intimacy does not need to involve threat (Gil, 1991) and that despite knowing about the traumatic stressors in Tracey's life, the therapist would continue to care about her (James, 1989). The therapist's function as a non-judgemental person who listened was an important objective for a girl whose emotional needs were sometimes less of a priority than other parental and family concerns.

A final level of intervention was directed toward Tracey's father. While this contact was considerably less intensive than that directed at Rose and Tracey, it became necessary to include Stan in the therapeutic process due to the ongoing argument

between him and his daughter. He became involved after the twelfth session in response to the therapist's request to meet with him to discuss current relations with his daughter. Although Tracey was invited, she refused to attend, but insisted that the therapist tell her everything her father had said. Stan expressed hurt regarding the argument and indicated that he missed the special relationship he previously enjoyed with Tracey. The goals of this meeting were for the therapist to gain a better understanding of Stan's perspective, to act as an advocate for Tracey's needs and to bolster Stan's role as the adult to take responsibility for working out this issue. Prior to the termination session, he was able to initiate a discussion with his daughter. He apologized to her for the violence he perpetrated and in the end, they resolved the immediate conflict.

- Themes: Within the relatively unstructured sessions, a number of themes emerged. Firstly, Tracey's discourse exhibited relatively strong self-esteem. She talked fondly about leadership roles she occupied, and noted a number of positive qualities about herself. Tracey agreed with the therapist's assertion that her self-esteem was linked with extra-familial systems and interactions. For instance, she distinguished between family and other systems by indicating that she was proud of her accomplishments outside her home, but disliked the activities she carried out within her home.

Another theme was peer relationships. Tracey indicated that she had a number of friends, however, her relationship with one female friend in particular changed from one extreme to the next. One week they would be best friends and the next they would be enemies. While fluctuating peer relationships are common during adolescence, there was also a noted increase in physical aggression toward peers. Within the regular peer

conflicts many adolescents experience at this age, Tracey began to employ the externalizing conflict resolution skills she learned from familial interactions.

- Turning points: The first significant event occurred during the fourth session. She was less talkative than usual, yet, Tracey disclosed traumatic stressors and associated emotions while expressing her need to be protected and nurtured. In particular, she expressed internalized notions whereby she regretted having been protected from her father's abuse and voiced self-blame pertaining to her victimized role among her siblings. In addition, she was able to express anger towards Bobbie and her father for the violence they perpetrated. She also disclosed details regarding her mother's past alcoholism and noted fearful emotions regarding an incident she witnessed when she was about six years old during which her mother physically abused her half-sister, who in turn protected Tracey by warning her not to enter the room. Her discourse reflected also themes of loyalty and protection whereby she felt that she needed to be faithful to her eldest siblings so that they would protect her from Bobbie and Ryan. Additionally, she chose to stand in solidarity with her siblings against her father by opting not to live with him after the divorce. Finally, Tracey expressed subtle themes of escape and the need for nurturance. In particular, she wondered what it would be like to drop out of school, yet was able to identify advantages and drawbacks to such action. More concerning, however, was her lack of desire to attend school in the days prior to the fifth session. She clearly identified that she used to love school, but did not want to attend recently because it was the only time that she and her mother could spend time together alone. The nurturance theme also emerged in the playroom as she excitedly noted a baby bottle. When the therapist

proposed that she bring Tracey her own baby bottle for the next session, Tracey replied enthusiastically. In response, she noted that if her mother saw her with a baby bottle, she would grab it out of her mouth; perhaps a subtle indication of her perception that her mother was depriving her of the nurturance she desired. Overall, her defenses were reduced as Tracey felt sufficiently comfortable and safe in the session to begin to address the past issues of physical and substance abuse, her present victimized role and associated emotions of fear and anger.

Later that evening, she attempted to commit suicide. Although it was not clear what contributed to this, it could be hypothesized that without an alternative corpus of healthy coping skills, Tracey drew upon unhealthy role models to enact violence upon her own body in an effort to gain the nurturance and compassion she needed from her family Ultimately, this act served to focus the attention of Tracey's environment upon herself. Not only did her parents care for her throughout the night, but they worked together as a co-parenting subsystem. Additionally, her siblings were responsive toward her and temporarily suspended their aggressive interactions to be compassionate. She specifically noted that even Bobbie was nice to her. Furthermore, adults and eventually peers from school were told about the incident, all of whom were sympathetic and granted special attention to Tracey.

Noting the secondary gains Tracey achieved by committing a harmful act, the therapist emphasized a focus upon healthy environmental support. One focus of this objective was Tracey's parents. In particular, the therapist encouraged both Rose and Stan to highlight Tracey's healthy achievements and qualities on a daily basis in an effort

to prevent the use of such extreme measures to get her needs met. Additionally, both were encouraged to model healthy coping skills and talk with Tracey about employing them. The events preceding and subsequent to this crisis provided opportunities to address the traumatic stressors, defenses and associated emotions on an individual level, while facilitating change on a transactional level whereby Tracey's environment was encouraged to alter their patterns of interacting.

This objective was also emphasized on the individual level whereby Tracey was encouraged to spend time outside of the house with friends and at extra-curricular activities. Tracey was able to link her improved mood to such interactions and also noted that she would not attempt suicide again because she promised a lot of people she would not do so. Thus, Tracey recognized the importance of interaction with extra-familial systems and the support of external resources. Despite the uncontrollable stressors which persisted within her household, Tracey was able to connect with and engage other systems that were supportive and healthy.

A second turning point occurred after the ninth session during which Rose disclosed the ongoing argument between Tracey and Stan. Tracey became angry at her father for not intervening on her behalf when Bobbie hit her[9]. During the argument, Tracey blamed her father for being a violent role model. In response, Stan forced her to leave. Ultimately, Tracey refused to talk with him for over a month until Stan initiated a discussion during which he took responsibility for the violence. During Stan's session, the

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[9] The therapist attempted to contact CFS about the inter-sibling violence. After a number of unsuccessful telephone attempts, the therapist notified the family's CFS worker of such by written correspondance. Ultimately, the risk of violence diminished as Bobbie and Ryan were incarcerated soon thereafter.

therapist attempted to differentiate this argument from others. Stan indicated that he was affected by Tracey's accusation so that unlike other arguments in which he would pursue Tracey, this hurt prolonged the resolution of issues. In the past, Tracey denied the impact of her father's behaviour on the family. However, with maturity and insight gained from counselling sessions, Tracey's defensive denial was beginning to erode as she began to express her previously suppressed anger toward her father. This change, however, appeared to catch Stan off guard. In the session, he revealed that while he knew the accusation was true, the anger from Tracey was unexpected as she was favoured among the siblings. From a logical perspective, he understood that he needed to embrace a paternal guiding role to address his daughter's anger, yet, he was simultaneously hurt by her disloyalty. Thus, it took some self-reflection and encouragement from the therapist for Stan to address the emotional needs of his daughter. Ultimately, he was able to discuss the situation with Tracey and was proactive in renewing their relationship.

This argument was one significant turning point during Tracey's intervention for a number of reasons. Firstly, by bringing the argument to the therapist's attention, it was revealed that Rose was beginning to consider the needs of her daughter. While she expressed concern for Tracey, she also recognized the limits of her own boundaries. In particular, she acknowledged that the issue was primarily between Tracey and her father and thus declined to be triangulated between the two. Instead, she drew the therapist's attention, as an objective extra-familial helper, to the need for strengthening the father-child relationship. Secondly, by expressing anger towards her father, Tracey was beginning to confront the violence to which she had been and continued to be exposed.

Her previous defensive behaviour had diminished as she directed her anger to the source of the violence, her father. By doing so, she demanded that he take responsibility for his past behaviour so as to facilitate healing from past wounds, while simultaneously requesting that her father take parental responsibility to protect her from her sibling's aggression. Finally, the argument forced Stan to recognize that the impact of his past violent behaviour extended throughout the family; thus, despite her special status, Tracey needed him to embrace a parental role to foster coherence about the past and model healthy coping skills. With the aid of the therapist, Stan was able to begin this process. Thus, by changing as an individual due to developmental and therapy-related issues, Tracey demanded changes in her transactions with her environment. In response, Stan was forced to confront the reality of Tracey's past and present family environments so that the relationship between him and his daughter could be improved.

A third significant event occurred that was triggered by her environment. In particular, the family was freed from the remaining violent stressors in the latter sessions as Bobbie and Ryan were incarcerated by the ninth and tenth sessions respectively. Previous to this, both had maintained contact with the family, but the living arrangements of each boy were inconsistent and unstable. This unpredictability and their violent behaviour contributed significant stress to the family; thus, there were notable changes during their absence. In particular, Rose expressed relief when the boys were incarcerated as she knew that they were safe, yet the stress of her parental responsibilities was removed. She expressed to the therapist that neither she nor Tracey needed to "walk on eggshells" as they no longer were confronted by Bobbie and Ryan's violent outbursts.

This affected Rose's maternal role because without the boys as a focal concern, she was able to be more available to her daughter. The environmental changes also affected Tracey. In particular, she expressed that she felt more safe with her brothers in prison as the security guards did not allow them to "bug" her. She also reflected fondly upon the last time Bobbie was incarcerated, during which he covertly expressed his feelings toward her by making her a box of origami. Thus, Tracey was able to enjoy a safe and caring relationship with Bobbie and Ryan only within the secure confines of their incarceration. Additionally, at termination, Rose noted a number of healthy changes in Tracey's behaviour. In particular, Rose expressed that Tracey was managing her anger better and was less aggressive toward herself. She linked both of these changes to the absence of the violent boys. Overall, the change in the environment affected Tracey, Rose and the relationship between the two.

From these turning points, the circular influences of the person and the environment can be clearly seen. In particular, two turning points were initiated by Tracey due to individual change that appeared to have emerged from her developmental level and ongoing counselling. With the therapist as ally, Tracey felt sufficiently safe to challenge her environment in order to get her needs met. Additionally, her environment, specifically, her mother and father, required support in order to adapt to their daughter's requirements. The therapist offered guidance to each party to facilitate the goodness of fit between parents and child.

• Evaluation: (a) quantitative data - mother: The PSI/SF scores for Rose differed significantly between the pre-test and post-test (see Appendix G for chart of quantitative

scores). Previous to intervention, her Total Stress Score ranked at the 99+ percentile. The pre-test score indicated that she was experiencing clinically significant levels of stress. At the post-test, her score fell to the 85th percentile. As scores which are above the 90th percentile are considered clinically significant, following intervention, Rose's parental stress decreased significantly from a clinical range to one that was less worrisome. Additionally, each subscale score had been clinically significant at pre-test, but had decreased to an acceptable range at post-test.

This change in parental stress may have been linked to a number of things. Firstly, in the initial intake sessions, Rose missed a number of appointments as she was feeling depressed. Since then, she began to engage in individual counselling and a women's group. Secondly, she was getting to know her daughter better as she brought Tracey consistently and on time for her appointments. Tracey and Rose were able to spend time together prior and subsequent to each play therapy session; on separate occasions, they each expressed their enjoyment of this mother-daughter time. The solidified connection between mother and daughter may have also been a contributing factor to Rose's lower parental stress. Lastly, at the point of termination, Bobbie and Ryan were both incarcerated at the Manitoba Youth Centre. Despite the seriousness of their offenses, their absence appeared to lessen the tension in the family. For instance, Tracey was protected from their aggression while Rose did not have to worry about them being on the street as they were living in a "safe" environment.

The Total Score for Tracey's CBCL completed by her mother declined at post-test from a t-score of 75 to a t-score of 61 (see Appendix G). The Internalizing

t-score changed from 76 to 60, while the Externalizing t-scores were 75 at pre-test and 64 at post-test. At pre-test, all items except for Somatic Complaints were in the borderline or clinical range. At post-test, all items were well below the clinical range.

(b) quantitative data - child: Tracey's Youth Self-Report [YSR] score indicated a different trend than the results of the CBCL completed by her mother. At pre-test, her Total Score was a t-score of 64, which increased at post-test to a t-score of 69. Additionally, the Internalizing t-score was 64 at pre-test and 75 at post-test, while the Externalizing t-scores were 67 at pre-test and 70 at post-test. Although the changes between pre-test and post-test were not large, the scores increased slightly at post-test.

The discrepancy between Tracey's CBCL and the YSR may be linked to a number of things. Firstly, one limitation of the CBCL is its reliance upon the parent's perspective and therefore may not be an accurate reflection of the child's behaviour. As Rose's mental health stabilized and her parental stress decreased, her perception of Tracey's problems may have also subsided.[10] Rose's perception of Tracey's behaviour, therefore, may have been influenced by her own situation.

Secondly, the difference between the two results may have also been linked with social desirability. While Rose completed all forms on her own, Tracey completed the measures with the therapist. In particular, the therapist read the questions and circled the answers as indicated by Tracey. It can be hypothesized, therefore, that unlike the measures completed by Rose confidentially, Tracey's YSR may have been influenced by her relationship with the therapist. During the pre-test, for instance, she may have been

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[10] Achenbach (1991) has noted that "studies have shown...that CBCL problem scores are correlated with maternal depression"(p. 227).

reluctant to give truly accurate answers as the therapeutic relationship was not yet established. During post-test, however, the need for social desirability most likely decreased as a trusting relationship with the therapist was developed. Therefore, the post-test YSR is probably more reflective of Tracey's behaviour as it incorporated her perspective and can be assumed to be more accurate than the pre-test.

Tracey's Total Scores on the Piers-Harris Children's Self-Concept Scale increased from a t-score of 56 at pre-test to 62 at post-test. Both scores indicated a favourable self-concept. The cluster scale scores fluctuated little from pre-test to post-test. T-scores of 50 and 52 respectively on the Intellectual and School Status cluster scale indicated a healthy self-perception of her ability to perform "intellectual and academic tasks, including general satisfaction with school and future expectations" (Piers, 1984, p.38). Regarding the Physical Appearance and Attributes cluster scale, her t-scores were 69 and 60 respectively, indicating a positive attitude about her physical characteristics, "as well as attributes such as leadership and the ability to express ideas" (Piers, 1984, p. 39). Her t-scores were 47 on the Anxiety cluster scale at both pre- and post-tests. This was in the normal range for a cluster scale that "reflects general emotional disturbance and dysphoric mood" (Piers, 1984, p. 39). Her t-scores decreased from 55 to 47 in the Popularity cluster scale, which reflects the child's perception of "his or her popularity with classmates, being chosen for games, and ability to make friends" (Piers, 1984, p. 39). Although her post-test score for this cluster scale remained in the normal range, it may have decreased in response to her expressed anxiety about moving to a new town and to a different school. In the Happiness and Satisfaction cluster scales, her t-scores were 63

both times, the highest possible score, thus indicating a strong "feeling of being a happy person and easy to get a long with, and feeling generally satisfied with life" (Piers, 1984, p. 39). The most substantive change between pre-test and post-test scores, however, was within the Behaviour cluster scale. The t-scores were 71 and 46 respectively, and both were in the normal range. This cluster scale

> reflects the extent to which the child admits or denies problematic behaviours....how the child views his or her problems, where they occur, and whether or not the child assumes responsibility for these problems or externalizes blame for them onto others. A low or moderately low score on the Behaviour scale suggests acknowledged behaviour difficulties. High scores are more difficult to interpret. They may reflect either a lack of behavioural problems or an attempt to deny such problems. (Piers, 1984, p. 38).

The significance of these scores wasn't clear, yet, it could be hypothesized that the pre-test high score was an attempt to deny the issues, while at post-test, Tracey began to acknowledge her problems.

(c) qualitative data: Data gathered through an unstructured interview in the termination session with Rose revealed that intervention addressed two of the initial presenting problems. Firstly, Rose and Tracey's relationship was strengthened. They had been able to spend more time together as a result of their attendance at the EHCC and the absence of the demanding boys from the home. Rose's increased closeness with Tracey was demonstrated by her ability to consider her daughter's needs. For instance, during the intake sessions, she had difficulty talking about Tracey and tended to steer the interview toward Bobbie. During the termination session, however, Bobbie was mentioned only in passing and Rose was able to focus upon perceived changes in her daughter, while also demonstrating empathy for her daughter's current and future needs. Secondly, Rose noticed that Tracey had been consciously attempting to control her anger and had been

noticeably less aggressive to her mother. She attributed this to a change in the family environment in that Bobbie and Ryan were no longer living in the household.

One issue that remained, however, was the struggle between Rose and Tracey pertaining to developmental changes. Rose indicated that Tracey had "grown up" a lot during the intervention as she was increasingly interested in the opposite sex and wanted to wear make-up and revealing clothes. Rose was able to recognize her discomfort with these developmental challenges and understood that she was trying to keep her as a little girl by making rigid rules about hair, clothes and make-up. Tracey's narrative during the course of her sessions also pointed to the persistence of this struggle.

Tracey's peer relationships was another issue that was not resolved at termination. Rose continued to express concern about some of Tracey's peers that "bully" her and are known to participate in gangs. This issue of aggression with other children also emerged during Tracey's individual sessions. While Tracey never admitted to being victimized or "bullied" in peer relationships, she continued to get into fist fights with children at her school.

Another area of change emerged regarding Tracey's relationship with her father. Apparently, they had been close, but the relationship became conflictual toward the end of the therapeutic endeavour. Close to termination, they resolved the argument, yet, it was difficult to judge Tracey's reaction to this renewed contact.

Rose completed the consumer feedback form on her own, while Tracey did so with the aid of the therapist. This feedback revealed that Rose was satisfied with the counselling process. In particular, she noted that seeing the change in her daughter was

the most helpful thing about coming for services. Additionally, she indicated that what she liked about coming for counselling was that the therapist was easy to talk to and was understanding. She also indicated that she could tell the therapist anything "without being scared what would happen". Rose emphasized that the therapist was helpful as she enabled her to understand Tracey and encouraged her to "try different things". Tracey's feedback, on the other hand, was more concise. In particular, she noted that missing school was both "good" and "not so good". Yet, she also indicated that what was "good" about coming for counselling was that she could talk a lot "without people telling [her] to be quiet".

(5) Conclusion

For Tracey, the therapy experience provided the opportunity for her to be unique in a multi-problem family. Tracey was the youngest and the least aggressive in a family that had experienced many levels of abuse. It was important for her to feel valued without having to compete with her siblings in controlling and violent games. Over the course of the therapy process, Rose's parental stress had decreased and her mental health had stabilized. These factors, combined with the removal of the stressors of Bobbie and Ryan, served to focus healthy attention onto Tracey.

There was little behavioural change based upon the therapist's observations and the YSR. On the other hand, the significant behaviour changes exhibited by the CBCL were suspect as her mother's pre-test perception may have been skewed due to high parental stress and personal mental health issues. Additionally, there was little significant changes in self-concept as exhibited by the Piers-Harris Children's Self-Concept Scale.

Instead, the value of therapy stemmed from its ability to provide support for Tracey. In particular, Tracey indicated in her feedback form at termination that the one good thing about counselling was that she was afforded the opportunity to express herself freely. She was able to address and gain coherence regarding past and present stressors while her supportive network was bolstered. In particular, Tracey's relationship with her mother improved and she was able to re-establish a relationship with her father. Overall, intervention was able to enact change in the person, environment and the transactions between the two.

- Kirsten

(1) Presenting problems

Kirsten was an eight year old Caucasian girl who was referred to the EHCC by her mother. Her six year old half-sister, Lisa, was also referred and was also seen by the therapist as part of the practicum (see Appendix H for genogram).

The presenting problems were initially difficult to clearly define. One main issue, however, was Kirsten's fear of men and of places such as downtown or her basement. Another issue was sibling aggression in that Kirsten and Lisa called each other names and sometimes hit one another. Overall, Kirsten's mother, Cathy, wanted Kirsten to have the opportunity to work out confusing feelings she may have had regarding George, her stepfather, and Lisa's biological father.

(2) History of violence

Based upon information gathered from Cathy, Kirsten was both a victim of child abuse and had been exposed to partner abuse. When Kirsten was a preschooler, Cathy

worked at night and George was in charge of evening child care. In one incident, George admitted to shaking Kirsten after Cathy came home from work at three o'clock in the morning to find the then two year old awake with a bleeding nose. This was not reported to Child and Family Services and George promised never to hit Kirsten again. Nevertheless, Cathy did find bruises on both girls' rib cages; she took pictures of the injuries, but the photographs eventually disappeared. There has never been evidence of sexual abuse. After she separated from George, Cathy took the girls to the local children's hospital to be assessed for the impact of abuse. Sexual abuse was not detected but the assessment team highlighted the impact of emotional and verbal abuse directed at both girls.

George was also verbally and physically abusive to Cathy in that he called her names and pushed her. Kirsten and Lisa witnessed him throwing Cathy against a wall. The police were called and he was charged with assault. He was ordered to take anger management courses for one year. Cathy said that it worked for a while, but he then reverted back to the same abusive patterns. Cathy discussed a second violent incident which occurred after their separation during which he tried to choke her. The police were called and Cathy was unsure if the children were aware of the incident as both were supposed to be asleep in their rooms. Neither Kirsten nor Lisa disclosed knowledge of these incidents during their sessions.

George and Cathy separated in 1991 and were officially divorced in 1995. During the divorce proceedings, George admitted to the child abuse in court; in response, he was ordered to take three parenting classes. He did so, but Cathy indicated that they were

ineffective. The custody arrangement permitted him supervised visits with Kirsten and Lisa, with the possibility of future renegotiation of these terms. He refused to see Kirsten and eventually declined to pay for a facilitator in order to see Lisa. Lisa last visited him six months prior to the time of referral and although she had maintained telephone contact with him during this period, she had begun to refuse to speak with him as she found it frustrating to talk with him but not see him. During most of the therapeutic contact, Lisa had no contact with her father. At the point of referral, Cathy continued to maintain a restraining order against George for her personal safety.

Kirsten's perspective about the violence she had experienced and witnessed was somewhat different from her mother's perspective. In particular, she had few recollections of violence between her mother and father. She was able to recount two instances during which George compromised the safety of their home. Firstly, George had broken into their home in the middle of the night and threw her mother against a wall. While this was corroborated by her mother, Kirsten also added that he wanted to take Lisa with him, but did not succeed in doing so. Another frightening incident occurred when George came to their house the day before they were going to move. Cathy saw his car in the driveway and warned the girls to be quiet. As a result, Cathy, Kirsten and Lisa hid in a bedroom for two hours until he left. Kirsten articulated that she was scared that he was going to take away her sister. In both instances, her family was vulnerable to George's behaviour and Kirsten feared that her sister may be harmed.

(3) Ecological assessment

Kirsten witnessed only one direct incident of violence and experienced the threat of another, yet, her fear and insecurity persisted even in the absence of the perpetrator. Kirsten was thus vulnerable to the indirect effects of George's violent behaviour. Consequently, she feared men who resembled George and was scared of going to places, such as downtown, where he may be. She was in need of protection from the threat of harm he presented to herself and her family. Kirsten needed to know that her mother would be able to protect her even though Cathy was unable to do so in the past.

Kirsten's aggression toward her sister appeared to have been linked to anger which stemmed from a number of sources. Firstly, Kirsten was hurt by George's rejection. His acceptance of Lisa appeared to have contributed to feelings of jealousy toward her sister. Not only was Lisa accepted, but she had the opportunity to spend time with her biological father, an experience she could not have. Secondly, Kirsten was extremely angry at George, but was unable to express it directly to him due to the fear of being hurt. On the other hand, in Kirsten's eyes, Lisa was aligned with George by virtue of being his biological daughter and by the fact that she maintained contact with him. Thus, it was easier for her to direct her angry feelings toward her sister, who posed little danger, yet was connected with George. Kirsten's anger towards George was thus diverted to her less threatening and present younger sister. Lastly, she may have also been angry at her mother for not being able to protect herself, her children and the family in general from George; yet, she could not permit herself to express these feelings for fear of further parental rejection. In reaction to Lisa's perceived alignment with George, it seems that

Kirsten unsuccessfully tried to align with her mother against the parent-child subsystem comprised of her sister and George. Kirsten may have also been frustrated with her mother's inability to side against Lisa in the same way that George had sided against her. The covert anger toward her mother may have further fueled the aggression toward her powerless and present sister. Consequently, Kirsten was dealing with feelings of rejection, fear, jealousy, vulnerability and revenge which were being expressed through externalizing behaviours directed toward Lisa.

Despite this aggression, however, Kirsten insisted that Lisa sleep with her at night. In the past, Kirsten would sleep with her mother due to fears. This stopped, however, when Cathy began to place limits on this behaviour. As a result, Kirsten employed Lisa as a substitute family member to ensure protection while engaged in the vulnerable state of sleep.

Kirsten had been coping relatively well despite the issue of fear and the sibling issue of aggression. Kirsten had no academic problems, had a number of close peer relationships, which she discussed often, and was able to express and exhibit self-confidence. It appeared that her mother had played a significant role in Kirsten's adjustment. For instance, Cathy was able to recognize Kirsten's needs and would plan a special activity for her when Lisa visited with her father. Additionally, Cathy had made a conscious effort to secure Kirsten's safety by explaining their family's legal protection from him and emphasizing that their new house is unlike the old one in that it is safe from George. Furthermore, Cathy resisted Kirsten's attempts to triangulate her into the conflictual sibling relationship by attempting to employ consistent parenting techniques,

such as time-outs, for both daughters. Cathy also cultivated a close relationship with her brother and his family. Thus, the support of extended family provided playmates for the girls and respite for Cathy as a single parent.

From an ecosystemic perspective, Kirsten was an individual who encountered difficulty adapting to her familial environment context. Her transactions with other systems appeared to be healthy as she enjoyed a number of close friendships, academic success and close relationships with extended family which included cousins her own age. Within the relatively new post-violence family form, however, Kirsten was attempting to deal with a number of unresolved issues. Firstly, George continued to be a threat to Kirsten and her family. Additionally, she experienced mixed emotions about George as she hated and feared him while simultaneously wanting to be accepted by him. Even in his absence, George continued to impact upon Kirsten. A second concern pertained to the transactions between Kirsten and her mother. While this relationship was healthy and supportive, Kirsten's confidence in her mother's ability to provide safety and protection was weakened due to exposure to violence during which Cathy was unable to protect herself or her children from George. A final issue focused upon Kirsten's relationship with Lisa. In particular, she "hated" Lisa during the day, but relied upon her for protection at night. Thus, Kirsten projected her anger toward George and the need for her mother's protection onto the most available and least threatening family member, her sister. Overall, Kirsten expressed the unresolved anger and vulnerability related to George and the need for her mother's assurance of safety within transactions with her sister. It was necessary, therefore, for Kirsten to work individually to understand her emotions and

redirect them to the appropriate sources. Additionally, her environment needed to be targeted so as to remove the threat of harm and emphasize safety and acceptance.

(4) Intervention

• Duration: Kirsten participated in eleven weekly sessions of individual play therapy which were approximately fifty minutes each in duration. She always appeared happy and excited to be at the EHCC and although she was relatively quiet at the beginning of each session, Kirsten always grew more talkative and animated as the session progressed. The therapist met with Cathy twice at intake and once at termination, and had ongoing contact throughout the therapeutic process. Therapy was terminated due to the end of the practicum, but further therapy was not deemed to be necessary.

• Goals: The majority of the intervention objectives focused upon Kirsten, but, Cathy was also employed as a therapeutic partner to achieve child-focused goals. The goals for individual counselling with Kirsten were to:

- sort out possible confusing feelings about George, the violence and her past or current family form.
- address fears and bolster a sense of security.
- address feelings of anger and direct to appropriate source.
- develop non-violent conflict resolution skills.

In an effort to bolster her role as parent and the parent-child relationship, Cathy was encouraged to accomplish a number of child-centred objectives. In particular, the aim was to:

- emphasize the safety of the family's current situation.
- reassure Kirsten through words and actions that she is able to protect her and Lisa from harm.
- encourage the uniqueness of both her daughters.

• Process: The above mentioned goals were defined in association with Kirsten's mother. Without prompting, Cathy was able to express that Kirsten needed her mother to bolster her sense of security and expressed appropriate methods of doing so. Cathy also recognized the importance of valuing Kirsten as a unique individual and gave examples of doing so, such as planning a special activity for Kirsten to coincide with her sister's visits with George. Because Cathy was able to clearly identify and articulate Kirsten's needs, it was assumed that she was working toward solidifying her protective role in the mother-child relationship throughout the course of Kirsten's therapy. Although the parent-focused intervention was less intensive than that which was directed to the individual child, the objectives for Cathy were important. Thus, the therapist maintained ongoing telephone and in-person contact with Cathy to continually monitor changes and address issues as they arose.

The majority of the intervention was directed toward Kirsten as an individual and was comprised of a combination of directive and non-directive play therapy techniques. Half of each session was devoted to structured therapist-directed activities, such as art projects focusing upon feelings, puppet play re-enacting the sibling relationship and a workbook that focused upon abuse and safety planning. While Kirsten engaged in these, she preferred "free play" to such directive tasks.

Kirsten chose to play with games such as Operation, Knockout, the fishing game and Memory, the majority of which she had not played previously. She always engaged the therapist in play and never repeated play with one game twice. Kirsten played with each game in a developmentally appropriate manner whereby instructions were consulted

and the play was structured. Kirsten's favorite activities, however, involved the use of arts and crafts materials, especially coloured glue, sparkles, bingo markers and paints; thus, much of her undirected play was creative.

Kirsten was shy and giggled a lot during the initial sessions, but quickly became increasingly comfortable later in the process. She always engaged the therapist during the course of both structured and unstructured activities. She appeared more comfortable when the therapist was participating in parallel play and would ask why the therapist was not doing the same activity if she was not already doing so. Kirsten engaged in many creative activities, such as drawing or painting, about which she was able to give contextual details. She was also able to express details about the therapist's parallel creations. By tailoring the parallel play to Kirsten's directive discourse, the therapist acted as a non-threatening medium through which Kirsten was able to communicate her thoughts. It appeared as if it was safer for Kirsten to employ such a distancing strategy than to expose her feelings or thoughts directly.

One main intervention objective for Kirsten was to focus upon emotion definition and expression. Over the course of therapy, she developed an extensive feeling vocabulary. In the initial sessions, she used the feeling faces poster to define her feelings. For instance, in the second session, she referred to the poster without prompting and noted that she felt sad when a boy at school pushed her and broke her arm. In later sessions, Kirsten began to internalize a feeling vocabulary and became increasingly comfortable expressing her feelings verbally, symbolically using arts and crafts materials and physically through actions. For example, in the third session, she was able to act out

angry and sad faces and articulated how others know when she is feeling these emotions. During the same session, she began to expand her feeling vocabulary. For instance, she used the feeling faces poster to define "confused" and was able to link this emotion to her personal experience, specifically, the death of her maternal grandfather. Toward the end of the therapeutic process, however, Kirsten began to address more complex emotional issues. For instance, in the eighth session, she drew a figure and instructed the therapist to do the same. She then placed two feeling faces stickers on the noses of each of the figures, the outside border of one just barely showing under the other. On her figure, she placed what she referred to as a "mad" face on the bottom and a "happy" face on top. On the therapist's figure, she placed an "angry" face under a "worried" face. It was not clear what the significance of such actions were. It could be hypothesized, however, that Kirsten could have been attempting to sort out confusing emotions that were sometimes conflicting. Additionally, by differentiating "mad" and "angry", she may have been demonstrating her increasing familiarity with different levels of anger. Simultaneously or alternatively, she could have been communicating coping or defensive behaviour whereby difficult feelings are suppressed and less threatening feelings are expressed.

A second important therapeutic objective focused upon addressing the past violence, feelings pertaining to George and her current family form. Kirsten appeared to encounter little difficulty in disclosing exposure to violence; however, the therapist attempted to elicit such information only after it appeared that Kirsten was sufficiently comfortable with the therapist and the playroom. In the third session, for instance, Kirsten appeared at ease talking about George's abuse directed at her. She did not remember him

hurting her and only recalled one incident during which he bent her ankle while they were wrestling. She noted that he was not nice, after which she repeatedly asked the therapist how come he hurt her. The therapist attempted to foster coherence about George's rejection of Kirsten by pointing out that he was not her biological father and emphasized the uniqueness of her relationship with her mother. She was able to distance herself from the connection to George by discussing what she knows about her biological father and by expressing fantasies about meeting him and his new family. Additionally, she recognized the importance of her relationship with her mother and noted that while George took Lisa to a "fun place" during their visits, her mother made a point of taking Kirsten to that same place during their special times.

A further therapeutic objective was to help Kirsten develop non-violent conflict resolution skills. This was done through discourse, symbolic play and interactions with the therapist. For instance, in the third session, Kirsten talked about a girl in her class who was a bully. The therapist directed the conversation whereby Kirsten was able to empathize with the bully's victims while also discussing non-violent alternatives to hitting and kicking. In the fifth session, the therapist directed Kirsten to employ puppets to demonstrate her relationship with Lisa. She chose and controlled two identical birds that differed from one another only in colour with which she acted out an aggressive incident. The therapist verbally reflected this and used the opportunity to explore other ways to resolve the issue. Kirsten was able to reenact the scene and instead of hitting, she told Lisa's puppet to "get lost" and walked away. Finally, non-violent conflict resolution was covertly demonstrated through the therapist-child relationship. For instance, in the ninth

session, Kirsten threw a ball at the therapist twice. Instead of becoming angry and retaliating physically, the therapist responded by expressing that she did not like to be hit and suggested an alternative whereby she could continue to throw the ball hard, but the target needed to be an object that did not have feelings. She agreed to this suggestion and enjoyed doing so.

• Themes: A prevalent theme was sibling rivalry. In particular, Kirsten's discourse commonly involved a comparison between herself and Lisa. In the sixth session, for instance, Kirsten talked about getting many playground injuries. She noted that while such things never happen to Lisa, their mother used to get injured a lot while riding her bike as a young girl. This example demonstrated Kirsten's attempt to align herself with her mother and distance herself from her sister.

Sibling rivalry was also demonstrated through play, such as when Kirsten used puppets to represent herself and Lisa in the fifth session. This directive task showed how conflicts evolve between Kirsten and Lisa and how they get resolved. Additionally, the "anger-meter" exercise was useful for helping Kirsten to explore the manner in which she dealt with anger.

Peer relationships was a third theme prevalent throughout Kirsten's sessions. She talked fondly of spending time with one female classmate in particular. For example, one of her three wishes during the third session was to have another slumber party with her friend. Overall, Kirsten appeared to enjoy a number of close relationships with female friends with whom she described as "different" and "fun".

A more covert theme in Kirsten's play was fear. In particular, she expressed that she was scared of certain television shows and of trees in a park. Additionally, she was able to articulate that in order to prevent the fear associated with these experiences, she could avoid such places and situations. The therapist validated this planning, but noted that some things cannot be avoided, as she also expressed fear pertaining to George. Over the course of the therapeutic process, however, Kirsten's narrative indicated a growing belief in her mother's ability to protect her from George. In addition, during later sessions, Kirsten was able to differentiate the past violence from the present safety of their new house.

- Turning points: The course of the therapeutic process was gradual, yet there were two significant events that occurred during the fifth session; both functioned to address Kirsten's underlying emotions regarding the violence and her present family form. Firstly, it had been hypothesized that Kirsten was directing her anger at her sister instead of toward the absent and threatening George. This notion was verified in directive tasks which focused on anger. Specifically, the therapist used a written "anger-meter", a scale which indicated levels of the emotion, to differentiate the extent to which she was angry with different people. On a scale of 1-10 (with 10 being the most angry), her mother was at 1, Lisa was 4, a bully in her class was 5 and George was 8. The second part of the task involved using a ball to act out the different levels of anger. Looking in the playroom mirror, she was able to tense her body, make sounds and throw the ball in different ways for each type of anger except for George. She was physically unable to do so and instead stood quietly with the ball in her hand until she meekly said that she could not do it. This

provided the therapist with more information for assessment, as it was revealed that she felt a great deal of anger toward George, but had difficulty expressing it. In contrast, in her daily life, she expressed a lot of anger toward her sister, who, according to the scale, was associated with a significantly lower level of anger. Thus, it was hypothesized that the expression of anger toward George was being misdirected toward her sister. Furthermore, the task created a framework to address these concerns with Kirsten. For instance, it provided an opportunity to talk about how it cannot feel safe to express anger at some people. Consequently, subsequent sessions were based upon this information as they were geared toward the healthy and safe expression of anger toward George, while helping Kirsten to sort out confusing emotions stemming from his roles as a violent perpetrator and father-figure. This was important for a number of reasons as it provided the opportunity for her to understand that anger can be experienced and expressed in different intensities.

Secondly, the puppet play during this same session also provided greater depth of assessment for the therapist in order to emphasize parent-child intervention objectives. In particular, the puppet play demonstrated Kirsten's mother's significant role in the context of sibling rivalry. Specifically, Kirsten chose a tiger puppet to represent her mother. She noted that the tiger was significantly smaller than the girls' puppets, perhaps a reflection of a balance of power in which the girls had equal or more power than their mother. The therapist employed the tiger puppet but encouraged Kirsten to direct its behaviour. The interaction between the three puppets provided the opportunity for Kirsten to demonstrate and explain feelings regarding her mother. Her perception was that her

mother always sided with her sister and she felt powerless to get attention. Despite this emotional disclosure, Kirsten quickly omitted the mother puppet from the story and again focused the play upon the conflictual relationship between the sisters.

This puppet play again displayed Kirsten's difficulty in directing her emotions to their source, her mother, and instead redirected them into anger toward her sister. While she was able to briefly express the need to feel valued by her parent, the quick change of the puppet play's focus appeared to have been indicative of the difficult nature of this issue for Kirsten. As the individual intervention objectives were geared primarily toward dealing with the exposure to violence and loss of a father-figure, the therapist noted this information and chose to target the issue through environmental change. In particular, her mother was encouraged to emphasize the uniqueness and individuality of both of her children. Within the playroom, additionally, the therapist highlighted Kirsten's strengths and accomplishments in order to further bolster her self-esteem and address her need to be valued. Thus, the symbolic play provided a forum for Kristen to express her needs within the parent-child relationship which the therapist used to further emphasize environmental change through the solidification of the parent-child relationship.

• Evaluation: (a) quantitative data - mother: Cathy's parenting stress decreased after intervention (see Appendix G for a summary of quantitative data). At the time of pre-test, Cathy's parental stress was clinically significant as her Total Stress Score was at the 95th percentile. Additionally, the subscale percentile scores for Parent-Child Dysfunctional Interaction and Difficult Child were each at the 91st percentile, both falling into the lower part of the clinical range. On the other hand, the percentile score of 86 for

the Parental Distress subscale was at the higher end of the normal range. Consequently, Cathy was comfortable in her role as parent, yet was confronted with difficulties in the parent-child bond and child behaviour. At post-test, all scores decreased and were no longer in the clinical range. The Total Stress Score was at the 81st percentile, and the Parental Distress, Parent-Child Dysfunctional Interaction and Difficult Child subscale percentile scores were 65, 70 and 81 respectively.

The CBCL demonstrated a change in Cathy's perception of Kirsten's behaviour over the course of intervention. At pre-test, the Total Score t-score was 66 with an Internalizing t-score of 71 and an Externalizing t-score of 58. Kirsten was in the clinical range for the Withdrawn subscale with a t-score of 73. She was also in the borderline clinical range on Anxious/Depressed, Thought Problems and Attention Problems subscales with t-scores of 69, 67 and 67 respectively. At post-test, the Total Score t-score was 55 and the Internalizing and Externalizing t-scores were 59 and 52 respectively. All of the subscale scores were in the normal range.

(b) quantitative data - child: Kirsten's self-concept varied little over the course of intervention and generally indicated a healthy level of self-esteem. Her Total Score t-scores on the Piers-Harris Children's Self-Concept Scale were 56 for both pre- and post-tests. In the pre-test, all scores were in the normal range, although the cluster scale t-score of 42 for Intellectual and School Status was in the borderline range. Nevertheless, the score did indicate a satisfactory "self-assessment of ... her abilities with respect to intellectual and academic tasks, including general satisfaction with school and future expectations" (Piers, 1984, p. 39).

Her pre-test and post-test scores varied little. The cluster scale t-scores changed in the following manner during the course of intervention. Behaviour t-scores changed from 54 to 59, the pre-test t-score of 42 for Intellectual and School Status increased to 48, t-scores for Physical Appearance and Attributes changed from 53 to 64, cluster scale t-scores for Anxiety decreased from 69 to 59, Popularity -scores decreased from 61 to 51 and Happiness and Satisfaction t-scores increased slightly from 56 to 63. Thus, her perception of her own behavioural problems varied little, in that a high score indicates either denial or lack of behavioural issues. Kirsten's attitudes about her appearance and attributes such as leadership and her ability to express ideas (Piers, 1984) strengthened. It is not clear what the change in the Anxiety cluster scores indicated, although they remained high, and therefore did not point to emotional disturbance and dysphoric mood (Piers, 1984). The Popularity scores continued to remain in the normal range during both measurement points, thus indicating her perceived popularity with peers in her class. However, the post-test decrease may be linked to a recent change in her best friend. Lastly, Kirsten's scores for the cluster scale entitled Happiness and Satisfaction indicated "a general feeling of being a happy person and easy to get along with, and feeling generally satisfied with life" (Piers, 1984, p. 39).

(c) qualitative: Cathy noticed a number of significant changes in Kirsten's behaviour. Most notably, her fears diminished in that she was no longer afraid of going downtown or to the basement. Additionally, as evidenced by her comfort around men at a recent family party, she was becoming less fearful of males. Finally, Cathy noticed that Kirsten and her sister Lisa had begun to talk about the violence, George and their current

family form in a clearer and more comfortable manner. Cathy was comfortable with such discussions and encouraged her children to discuss the issues both within the family and with friends.

The child and caregiver consumer feedback forms indicated positive responses. In particular, Kirsten noted that it was "fun" to come to the EHCC and that she would not change anything about the experience. Cathy indicated that counselling was helpful. She liked the fact that it "helped the children" and found it beneficial to meet with the therapist to discuss issues to "work together on". She also found the way the children related with the therapist to be helpful. The thing she liked least was "the drive"; a point that was not expanded upon nor previously expressed to the therapist.

(5) Conclusions

Over the course of therapy, Kirsten's feelings of security increased. As evidenced by the differences in the pre-test and post-test CBCL scores, her mother's perception of her behaviour changed for the better or stayed the same in all areas. Most notable, however, were the subscale scores which decreased from the clinical to normal range. According to the post-test CBCL, she was less withdrawn, anxious or depressed, and was experiencing fewer thought and attention problems. In addition, Cathy's parental stress decreased to the normal range and Kirsten's self-concept increased slightly.

Kirsten demonstrated a number of personal gains during her therapy. For instance, she talked about the incidents of violence she had witnessed between George and her mother, was able to assign blame to the perpetrator and expressed what she understood, but often did not directly remember, about the violence directed at herself. Furthermore,

she was able to express feelings around the custody arrangement with George and questioned why he did not want to see her. In addition, Kirsten's sense of security was demonstrated during play therapy sessions as she was able to differentiate between her previous house that was unsafe and her current home that was secure. Kirsten emphasized her mother's important role as a protector a number of times during the sessions; specifically, she was reassured by her mother's comments when she felt scared. Kirsten thus developed trust in her mother's ability to provide a safe environment. Finally, through a structured activity using a workbook, she had little difficulty discussing safety planning and was able to feel confident in her ability to secure protection should it be needed.

These changes, however, may not have been solely attributable to the relationship with the therapist or Cathy's consistency and support. In particular, the original stressor, George, did not have any contact with family during the therapeutic process and did not have physical contact with any member for approximately six months prior to the referral. Consequently, Kirsten's changes in behaviour may have been linked to the combination of play therapy, a safe and supportive home environment and the absence of the stressor.

- Sean

(1) Presenting problems

Sean was a seven year old boy who was referred to the EHCC by his thirty-seven year old mother, Gina. There was only one presenting problem, which was Sean's physically aggressive behaviour toward his mother at home.

(2) History of violence

Sean had been exposed to violence directed toward his mother by his father, Jose (see Appendix I for genogram). The relationship was sexually, verbally, emotionally and physically abusive. His father also used physical force and verbal threats to discipline Sean.

Jose and Gina were both from a Mediterranean European country. Jose was Gina's first intimate male partner and they had been in a relationship since she was seventeen years old. They eventually married, but Gina separated from him a number of times as he was abusive. During their first separation, Gina's parents helped her to emigrate to Canada to live with relatives. Jose soon found out where she lived and vowed he would change. She returned to her country of origin and they resumed the relationship.

Jose did not permit Gina to use birth control. When she became pregnant, Jose was physically abusive toward her. She soon moved back to Canada and they married by proxy. Jose emigrated seven months after Sean was born. When Sean was two years old, Gina sought refuge at a women's shelter in Winnipeg, after which Jose and Gina separated. The divorce was finalized five years later, in 1995, a year before the referral. Sean has had no contact with his father since the separation. Soon after their separation, Jose was deported to his country of origin due to criminal charges. Gina did not know why he was arrested.

(3) Ecological assessment

Gina bore bruises and scratches attesting to Sean's aggression toward her. This externalizing behaviour was a significant problem and Gina discussed it with fervor during

every conversation between herself and the therapist. He was not aggressive with his peers nor with other adults; the issue was solely between himself and his mother. The questions for assessment thus focused upon what the aggression was attempting to communicate and what the significance was of Gina's role in this interaction.

Individual play therapy yielded little insight into the presenting problem. In the presence of the therapist, Sean was quiet, calm and respectful. On the other hand, observations of parent-child sessions yielded more data regarding the issue. In particular, it appeared that both parent and child were attempting to express personal needs that were not being addressed. On the one hand, Gina needed Sean to "behave" and "respect" her so that she could deal with the daily tasks of work and running a household. On the other hand, Sean needed the protection, guidance and emotional availability of his mother to confront the secrets of his past and present family environments. The relationship between parent and child, therefore, was strained whereby they were engaged in a power struggle in order to express and address their personal needs.

Gina presented as having many unmet needs. She had minimal social supports and a multitude of stresses. For instance, she brought her son at least fifteen minutes late to every session, yet demanded to speak with the therapist without him for at least half of the remaining time. She did not have a social support network outside of her extended family. The relationship with her cousins, however, was strained as they were not supportive of her decision to live free from abuse through separation. They frowned upon divorce for cultural and religious reasons and encouraged Gina to reconnect with her ex-husband.

Gina was employed full-time in the public education system. Her employment demands and the challenges of single-parent child-rearing provided little time for herself or for pleasurable activities. She indicated that she could not remember a time during which she enjoyed engaging in activity with Sean and emphasized that she did not have time to do so. Without positive social supports, Gina was lacking outlets through which she could cope with and address her stress in a healthy way. Without such respite, she thus encountered difficulties coping with daily and trauma-related parenting issues.

In contrast to his mother's social isolation, Sean was involved with a number of systems. In particular, he enjoyed healthy interactions with peers at school and through sports, was academically successful and retained a close relationship with extended family members that included adult and young cousins. In addition, assessment revealed that Sean possessed a fairly positive self-concept and confidence in his abilities. Given the assumption that Gina encountered difficulties addressing the emotional needs of her son, it was hypothesized that Sean's transactions with external resources such as peers, school and extended family contributed to the development of his internal resources. Regardless, such transactions could not adequately address his need for coherence regarding the past violence and his current family form. Due to the intimate nature of the issues and the important role of the parent in processing trauma (Jaffe et al., 1990), Sean required Gina's help to address and overcome the violence and loss of a father-figure.

Gina had yet to confront and deal with personal issues, such as minimization, denial and shame, which stemmed from the experience of victimization and associated cultural expectations. Without this preliminary groundwork, she was not able to be

available to her son to address his associated concerns. Consequently, the secretive nature of these issues prevented few opportunities for Sean to discuss, comprehend and integrate the violence and divorce.

Observations of parent-child interactions revealed that Gina was less responsive to her child's non-verbal cues and was only able to communicate with Sean through concrete and direct language. However, Sean was not given the skills to verbalize his thoughts. Without an appropriate vocabulary or outlet for doing so, he continued to harbour a number of intense feelings and maladaptive beliefs. As a result, Sean used physical aggression as a non-verbal way to express emotion to which Gina was responsive. However, Sean's aggressiveness compounded Gina's stress, which, in turn, contributed to her son's assaultive behaviour. Consequently, intervention needed to be geared toward interrupting the circular nature of these transactions.

Gina requested that the therapist change the manner in which her son interacted in the relationship. However, ecosystemic assessment revealed that the issues went beyond the individual child. Instead, it was noted that Sean was attempting to cope with his immediate family environment in which secrets were perpetuated and emotional expression was suppressed. On the other hand, Gina was struggling to maintain the homeostasis of her family environment by avoiding addressing the violence and current family form. Their conflicting needs contributed to and perpetuated the stress which resulted in a bad fit in the parent-child transactions. Intervention was thus geared toward diffusing the stress by giving the parent and child tools to deal with personal issues while concurrently solidifying their relationship.

(4) Intervention

• Duration: Since the initial referral, the therapeutic relationship lasted approximately eight months in total. In the beginning, Gina was unsure about counselling and thus the therapist talked with her by telephone for a number of weeks. The therapist then met with Gina for four weekly one hour sessions. Subsequently, Sean engaged in ten weekly individual play therapy sessions that were approximately forty minutes each in duration. During four of these sessions, Gina's need to converse with the therapist without Sean lasted for approximately half of Sean's scheduled time. Gina and Sean also engaged in four parent-child dyad sessions. They were about one and a half hours in duration and took place between the seventh and eighth play therapy sessions. During two of the dyad sessions, Gina also requested to speak with the therapist alone.

• Goals: The core objective was to break the secret of the violence. In doing so, the aim was to address Sean's current family form, the past family violence and the process and reasons for the separation through individual and dyad work.

Specific goals for individual play therapy with Sean were to:

- talk about the violence, the divorce and the loss of his father.
- develop a feeling vocabulary.
- address anger management and non-violent conflict resolution techniques.
- discuss different family forms and normalize separation and divorce.

Therapeutic work with Gina focused on personal and interactional issues with Sean. In particular, goals were focused upon helping her to:

- develop a healthy social support system within which her personal stresses could be expressed and diffused.
- employ resources to address personal needs.
- discuss the violence and divorce with Sean.
- recognize her son's strengths and ultimately develop empathy for his needs.
- develop and reinforce her capacity to be an emotionally available mother.

- understand Sean's needs as a child who has been exposed to violence and employ healthy parenting skills in order to address them.

• Process: Initially, intervention was to focus mainly upon individual play therapy for Sean. During the therapist's initial meetings with Gina, however, it was difficult to focus upon child-centred issues as she demanded a great deal of attention for her own needs. Initially, she declined individual counselling for herself, but after the fourth session with the therapist, she agreed to such. Subsequently, she participated in approximately six sessions with a student therapist at the EHCC. When this process terminated due to the end of the student's school term, Gina continued to engage in individual counselling with a full-time social worker at the EHCC. During the course of her involvement with her own counsellor, it became easier for her to focus upon child-centred issues.

During the initial six play therapy sessions, the therapist employed non-directive play therapy tasks. While Sean explored the playroom, the therapist attempted to verbally address the issues of feelings, violence, divorce and his family form. Sean talked quietly and appeared slightly apprehensive during the initial sessions. However, he quickly became comfortable with the playroom and the therapist. He eagerly explored games such as Trouble, Snakes and Ladders, and Knockout, which he played with the therapist in a structured and engaging manner. Without prompting, he enjoyed telling the therapist stories about school, friends, extra-curricular activities and extended family. On the other hand, he exhibited avoidance when the therapist attempted to address topics such as his aggression toward his mother, his father, the divorce or the violence perpetrated by his father. For instance, he would ignore the topic of conversation by focusing upon a toy,

changing the subject to one that was less emotionally-charged, avoiding further discussion by exclaiming that the therapist already knew about the topic of conversation or covering his ears. Yet, in the fifth session, he was able to express that he hated his father because he was a "rattlesnake", "evil" and "a bug". He did not know what "divorce" meant, but was able to express that he hated it. He exhibited his most drastic avoidance behaviour, covering his ears, when the therapist explained that his parents were divorced because his father hit his mother. It was clear that although five years had passed since his parents' separation, Gina and Sean had never discussed the topic. He was angry about the situation and little had been done to validate his feelings or to facilitate his adjustment to separation.

Sean's attitude regarding divorce was played out a number of times in the play therapy sessions. For instance, he included both his extended and nuclear family into his definition of membership in his family. His cultural and religious background was revealed when he was appalled in response to the therapist's inquiry about his grandparents' marital status; he indicated that there is no alternative to marriage. Furthermore, while completing a rough genogram in the fifth session, he noted that all of the adults in his family were married, only his mother was divorced. None of his friends' parents were divorced and thus his immediate family was different.

Sean played with games, figurines and sand in a developmentally appropriate and structured manner. His avoidance behaviours, however, created a defense against confronting emotionally-charged topics. Additionally, his relaxed and engaging manner with the therapist revealed little about his apparently aggressive tendencies. It soon

became clear, therefore, that assessment of the parent-child interaction would be helpful. In particular, it was hoped that his mother could be employed as a therapeutic partner to help diminish his avoidance by breaking the secrets surrounding his father, the divorce and the violence. Additionally, such dyad assessment provided the opportunity to observe and address interactional issues between Sean and Gina.

The decision to pursue dyad counselling was based upon two reasons. Firstly, it was hoped that Gina would be able to provide a safe and reassuring context in which the violence could be addressed. A second reason stemmed from Gina's needs in that she pressured the therapist to address the issue of Sean's aggression every session. However, Sean avoided this issue during individual play therapy. As it was largely an interactional concern, it appeared that it could be best addressed in a setting which focused upon their relationship.

During the dyad sessions, the therapist employed a number of structured and unstructured techniques. While Gina was more comfortable with the former, Sean was more responsive to the latter. In an effort to involve both mother and son, therefore, a balance of such activities was important. Some directive activities included having Gina read a children's book on stress and another on divorce, using figurines to discuss family forms, drawing a kinetic family picture and an "anger-meter" on which levels of anger were rated and discussed. On the other hand, Sean was permitted to bring some toys from the playroom into the dyad sessions. He brought games such as Snakes and Ladders and Guess Who into the session. Before the second dyad session, he attempted to engage his mother by inviting her to choose toys; she haphazardly chose a toy and impatiently

demanded that Sean leave the playroom. During the sessions, Gina was never able to engage in play with him, thus serving to heighten both of their levels of anxiety. Consequently, structured activities were more effective methods of addressing the issues.

The parent-child dyad sessions revealed a great deal about Sean and Gina's relationship. Both were extremely anxious most notably at the beginning and end of each session. Throughout, their manner of interaction exhibited a struggle for power and control as each attempted to express personal needs. For instance, Gina needed to discuss her dissatisfaction with her son's behaviour during every session, regardless of the therapist's proposed agenda. On the other hand, Sean focused upon his toys or drawing and exhibited behaviours such as hiding under chairs, whereby he avoided adult discussions and attempted to focus attention on his play. Gina wanted to address the presenting problem in a direct manner that involved adult conversation, while Sean was more responsive to indirect symbolic play that focused upon significant issues, such as anger and divorce. However, Gina grew increasingly impatient when Sean was unable to answer direct questions relating to topics such as his aggression or the divorce. Gina appeared to have little understanding of Sean's developmental needs and had difficulty engaging in play with him. Her discomfort was displayed, for instance, when the therapist requested that they draw a family picture together. While Sean started to draw immediately and began to direct his mother, Gina did not consult with her son and instead, looked to the therapist for guidance. This exercise demonstrated their difficulty working co-operatively to complete a task.

During the first dyad session, Sean expressed that his mother didn't listen. When the therapist attempted to probe this response, he quickly refuted it and would not expand upon his perspective. Gina's inability to "listen" to Sean and be aware of his needs soon became apparent through the interactions in session. For instance. during the first dyad session, she discussed Sean's aggressive behaviour at length. In the meantime, he took out a game, started playing and put it away, played with his leggo motorcycle by the window and hid under his mother's chair. She did not respond to any of his actions until the therapist noted them. She demonstrated little ability to understand the indirect expression of his feelings. Unless his feelings were directly expressed in a verbal manner, Gina was unable to recognize and address them.

Gina's busy and pressured personal life appeared to influence her son's behaviour. For instance, the therapist attempted to explore a possible connection between Sean's aggressive behaviour and the family's weekend schedule. In particular, during one busy weekend, Sean went to bed late and attended a number of activities. He became aggressive with her on Sunday afternoon when, after attending a birthday party, she took him grocery shopping. Subsequently, she sent him to his room as a punishment. He slept for eleven hours. This example demonstrated her inability to focus upon her son's needs so as to prevent the escalation of his behaviour. In her busy and stressful schedule, she had little time to employ a patient and empathetic approach to parenting. Instead, she favoured a quicker punitive parenting style, which denied opportunities for Sean to express his needs while contributing to his anger and frustration. It could be hypothesized that she was not capable of recognizing his indirect expression of needs and in his

frustration, Sean could only elicit a reaction from his mother by using physical aggression. Thus, the cycle of aggression and punishment between mother and child exacerbated the stress in their relationship, leading Gina to feel overwhelmed and perceive her son as a burden.

After the four dyad sessions, the therapist engaged Sean in three more play therapy sessions to debrief the issues which arose during the dyad sessions and to begin to introduce termination. Additionally, ongoing contact was maintained with Gina, who continued to pursue concurrent individual counselling.

- Themes: A number of themes emerged in the play therapy and dyad sessions. Firstly, the theme of "ghosts" and "aliens" permeated play therapy and dyad sessions. For instance, when drawing a kinetic family drawing with his mother during the third dyad session, Sean included a bodiless figure outside the boundaries of their family home, which he referred to as a "ghost" or "alien". Sean indicated that he hated the alien and that he and his mother were running away from it. He indicated that the alien loved Gina but warned that he was evil. The alien's head was perched on a sign with a large arrow pointing away from the family. The alien was pointing one way, but Sean warned that it was a trap. He continued so say that his mother won't go out because the alien will put her back into the apartment. He said that no one could help his mother. Later, Sean wanted to erase the alien from the picture or cut it out stating that "he" was not part of their family. It seemed that the ominous presence symbolized his father, who, despite his physical absence, was continuing to exert his power on the members of the family. He was threatening, deceptive and controlling. The family needed protection from this force.

but none was available. Sean's desire to remove the alien from the family picture was indicative of his need to confront the issue and separate from it. Interestingly, Gina drew a small flower next to the alien, perhaps symbolizing her need to make the alien's context bearable without confronting it or making it leave. Thus, Jose's power and control continued to be exerted on the family in his absence, five years after the separation.

The theme of escape was also exhibited in the sessions. For instance, in the second dyad session, Sean expressed his desire to go to an island in the flood near Grand Forks. Additionally, when the discussion was emotionally-charged, Sean would hide behind or under a chair. The wish to escape was therefore linked with his desire to avoid discussion of previously secretive topics.

- Turning points: The first significant event pertained to Gina. In particular, there was a noticeable difference in Gina's concerns while she was seeing her own therapist. Specifically, by having her own needs met by a separate counsellor, she able to focus more clearly upon child-centred interventions.

Secondly, parent-child dyad sessions yielded a lot of information for assessment and provided more opportunities to address the violence, the divorce and their current family form. In particular, the third dyad session was especially significant as these issues began to be discussed through directive tasks such as drawing a kinetic family picture, creating different family forms using human figure paper cut-outs and the use of a written anger scale. In contrast to the previous individual and dyad sessions, the third dyad session revealed a reduction of defensive behaviours. For instance, in the first and second dyad sessions, Gina centred her discourse upon Sean's aggressive behaviour. During the

third session, however, she put aside this concern and was able to engage in conversations about Sean's father, violence, anger and divorce. By doing so, Gina gave Sean permission to discuss the previously taboo topics and was able to dispel myths that arose. Additionally, Sean began to express his emotions regarding these issues in a direct manner, using the feeling vocabulary he had learned in the playroom, and indirectly, through symbolic play for which the therapist acted as an interpreter in order for Gina to understand.

• Evaluation: (a) quantitative data - mother: According to the PSI/SF, Gina's levels of parental stress increased at post-test (see Appendix G for quantitative scores). Her Total Stress Score increased from the 90th percentile prior to intervention to 97th percentile at post-test. Both levels were clinically significant. The scores from all the subscales also increased. Parental Distress changed from the 75th percentile to the 83rd percentile, both of which were at the higher end of the normal range. Subscale scores for Parent-Child Dysfunctional Interaction were both in the clinical range and increased from 91 to 96 percentiles. Finally, the scores for the Difficult Child subscale moved from the 83rd percentile, in the higher end of the normal range, to the 97th percentile, considered an "extreme case" in the PSI/SF manual.

Thus, Gina's normal Parental Distress score indicated that she was not experiencing distress in her role as a parent. On the other hand, high scores in the Parent-Child Dysfunctional Interaction subscale suggest "that either the parent-child bond is threatened or has never been adequately established (Abidin, 1990, p. 20). In particular, this subscale centres upon

> the parent's perception that his/her child does not measure up to the parent's expectations and that the interactions with their child are not reinforcing to him/her as a parent. These parents project the feeling that their child is a negative element in their life. Commonly, their description of the parent-child relationship suggests that either they see themselves as abused by or rejected by their child, or they are disappointed in and feel alienated from their child. (Abidin, 1990, p.20)

This data is supported by clinical observations which highlighted the significance of interactional issues between parent and child. Specifically, Gina regarded her son's behaviour toward herself as abuse and perceived him as a negative element in her life. The Difficult Child scale moved from the higher end of the normal range at pre-test to beyond the 95th percentile at post-test. "In these families the parents are typically experiencing difficulty in managing the child's behaviour in terms of setting limits and gaining the child's cooperation" (Abidin, 1990, p. 21). Overall, the latter two subscale scores provide evidence for the presenting problem, specifically aggression toward Gina within the parent-child relationship.

Despite the extremely high scores pertaining to parent-child interaction and child behaviour from the PSI/SF, Sean's CBCL scores were in the lower end of the normal range at both pre- and post-test. "Extremely low scores...reflect the absence of reported problems" (Achenbach, 1991, p. 234). However, there was a slight change in the clinical direction between the two. In particular, the Total Score t-scores increased from 49 to 54, Internalizing t-scores increased from 43 to 53 and Externalizing t-scores increased from 56 to 63. However, the post-test scores were not reliable as Gina failed to answer five statements and for six statements, she circled both "0" and "1". The manual indicates that problem scale scores or total scores should not be completed when there are more than eight items missing. Additionally, it states that if a "1" and "2" are both circled, than

the "1" should be used for computation; it does not give direction for computation when the "0" and "1" are circled. Thus, it became necessary to include them into the missing answers category. Given this issue, there were eleven invalid answers, thus making the post-test CBCL invalid. While the therapist helped her to complete the pre-test CBCL, Gina filled out the post-test measure on her own.[11] Thus, limited conclusions can be made based on a comparison of pre-test and post-test scores. Interestingly, the extremely low scores in the pre-test CBCL do not coincide with Gina's verbalized concerns for Sean's behaviour.

(b) quantitative data - child: The Piers-Harris Children's Self-Concept Scale indicated that Sean possessed a positive self-concept. The pre-test Total Score t-score of 62 increased slightly to 63 at post-test. The Behaviour cluster scale t-scores increased from 48 to 55, possibly indicating an increased absence or denial of behavioural problems. The scores from the Intellectual and School Status cluster scale t-scores decreased slightly from 63 to 60, indicating a perception that he can complete intellectual and academic tasks well and he possessed "general satisfaction with school and future expectations" (Piers, 1984, p. 38). A t-score increase from 53 to 64 was exhibited within the cluster scale of Physical Appearance and Attributes. These high scores reflect a high opinion about his physical characteristics in addition to "attributes such as leadership and the ability to express ideas" (Piers, 1984, p. 39). For the Anxiety cluster scale, the

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[11] It is not clear why she completed the post-test CBCL in this manner. While it may be possible that she may not have understood the wording of the questions, given her educational background, she should have encountered few difficulties with the fifth grade reading level of the measure. Other hypotheses may have been that her own anxiety prevented a focused approach to the questions or she may have had difficulty answering the questions due to the fact that she was unaware of her son's behaviour.

t-scores increased from 59 to 69, indicating a move away from "emotional disturbance and dysphoric mood" (Piers, 1984, p. 39). The t-scores for the Popularity cluster scale climbed from 51 to 69, suggesting a more favourable self-perception of his ability to make friends and general popularity among his classmates. For the cluster scale, Happiness and Satisfaction, his t-scores were 63, the highest possible number at both pre-test and post-test.

(c) qualitative: On an individual level, Sean developed a more extensive feeling vocabulary. During play therapy sessions, he would refer to the feeling faces poster or use feeling faces stickers when discussing events, such as his grandfather's anticipated visit. Additionally, he was able to draw a detailed angry face during the discussion of anger in the dyad session. During the termination session with Gina, the therapist probed for changes. Gina reluctantly identified that Sean was employing more feeling words and explanations in his daily interactions with her.

Overt the course of the therapeutic process, Gina became slightly more emotionally available to her son. She slowly started to move away from pathologizing Sean and began to empathize with his confusion around separation and divorce. For instance, Gina became interested in the books and was able to take some books and videos out of the library to facilitate such a discussion at home. In turn, this affected Sean as he became slightly less defensive about the issue of divorce.

At termination, Gina expressed that getting new ideas, the therapist's support and helping to understand the "problem" were most helpful about the process. On the other hand, she felt discouraged that it was a long process and there was insufficient time to

improve. It was more difficult for Sean to reflect upon the process of therapy as he attempted to avoid discussion of termination. With some prompting by the therapist, however, he noted that he liked the snacks and toys at the EHCC. He also said that he learned about feeling faces and divorce. On the other hand, he indicated that one thing that was not so good about coming to the EHCC was that there were "too many questions about hard things".

(5) Conclusions

The PSI/SF and qualitative data gathered from Gina indicate a high level of parental stress associated with Sean's difficult behaviour and problems in the interaction between parent and child. Yet, the pre-test CBCL and individual play therapy assessment indicated few child behaviour problems. On the other hand, parent-child dyad assessment depicted a relationship in which the participants were disconnected from one another possibly due to issues pertaining to impaired attachment. Both parent and child exhibited needs that were not being met by the other, thus the relationship was characterized by a power struggle that was exacerbated by ineffective conflict resolution skills.

During the course of the play therapy sessions, the therapist attempted to address Sean's needs by acting as a supportive and emotionally available adult. Additionally, having Gina engage in individual counselling was an attempt to address her personal need for the same. During the dyad sessions, the goal was to attempt to bolster the parent and child relationship, however, insufficient time was available to do so. Instead, the majority of the sessions were devoted to assessment and building a therapeutic relationship. It appeared as if Gina and Sean gained a sufficient foundation from which they were

prepared to move toward achieving therapeutic goals at the point of termination. This was reflected in Gina's qualitative and quantitative measures in that there was an increased sense of urgency regarding the presenting problem. While Sean made a number of personal gains as evidenced through qualitative evaluation and the Piers-Harris Children's Self-Concept Scale, the interactional issues remained at termination as they had not been sufficiently addressed. Thus, Gina and Sean were referred within the EHCC for further dyad work.

- Joey

(1) Presenting problems

Joey was a seven year old boy whose mother was Caucasian and father was African-American. He was referred to the EHCC by his mother, Stephanie. One presenting problem was Joey's short attention span at school. Other issues were his victimization by school "bullies" and sleeping with his mother.

(2) History of violence

Stephanie was physically and verbally abused by Joey's father, Vince (see Appendix J for genogram). Vince spent a lot of time out of town due to employment; the abuse would occur during the few weeks he was at home. Vince was verbally abusive to Stephanie during her pregnancy and physically abusive to her from the time Joey was about four weeks old. Stephanie was also using cocaine, alcohol and marijuana prior to and during the first trimester of her pregnancy. She was in rehabilitation during the pregnancy and did not use substances again until Joey was two years old - at which point she used for about six months and then stopped.

When Joey was two years old, he witnessed his father choking his mother. Vince was charged for the incident and deported to the United States, his country of origin. Subsequent to this, Vince and Stephanie divorced. One year later, however, they remarried and lived in the United States with Joey and David, Vince's teenage son from his first marriage. After the initial "honeymoon period", the abuse directed toward Stephanie resumed. Additionally, Vince acted in a physically aggressive and verbally abusive manner toward Joey. Stephanie left Vince in 1993, approximately three years prior to the referral, and their divorce was finalized during the intake procedure. Stephanie retained sole custody of Joey, which Vince did not contest.

It was not clear what Joey remembered witnessing. In the initial intake session with him and his mother, Joey asked a multitude of questions regarding the attempted choking, apparently in an attempt to verify the "facts" of the incident. Consequently, his memories of the violence may have been heavily influenced by Stephanie and he wanted to ensure that he knew all the correct details.

(3) Ecological assessment

Assessing Joey from an ecosystemic viewpoint was a difficult task as his inconsistent attendance, high anxiety and early termination left a lot of questions unanswered. Regardless, assessment revealed that Joey's relationship with his environment was strained. In particular, interactions with peer and school systems were for the most part negative and unsuccessful and the relationships with his parents were inconsistent and confusing.

Firstly, Joey did not have access to a positive peer support system. During play therapy sessions, he only recounted stories about children who had moved away, were mean or with whom he fought. Additionally, he fantasized about moving to the United States to live with his father where he would be given the opportunity to meet new friends.

Secondly, Joey encountered few successes in school; not only did he lack healthy contact with peers, but he also encountered academic difficulties. Joey recognized the issue and verbalized to the therapist that he thought the classroom material was too difficult. This was verified by the school psychologist who, through telephone discussions with the therapist, indicated that Joey was experiencing academic problems in his grade two class. In particular, his teacher observed gaps in his learning and despite receiving academic assistance from a resource teacher and a teaching assistant, she noted that Joey made no academic progress. Additionally, according to the school psychologist's classroom observations, Joey continued to be inattentive, unfocused and easily distracted. The school wanted to put him back into grade one, a recommendation Stephanie resisted as she feared he would be stigmatized by his peers. Based on classroom observations and a checklist, the psychologist diagnosed Joey as having Attention Deficit Disorder (ADD). Stephanie refused the recommendation to medicate him with Ritalin, pointing to her own drug abuse issues. As a result, the school attempted to implement a number of alternative strategies focused upon behaviour modification in the classroom and more structured parenting at home. Neither yielded successful results. Stephanie was critical of these interventions, but was not forthcoming with other suggestions in which she was willing to

participate. Joey's difficulties in school were therefore compounded by the conflictual relationship between his home environment and the school system.

Stephanie was engaged in a power struggle with the school. She continued to insist that they should be more understanding about Joey and his history of exposure to violence, despite their apparent efforts to implement other interventions as alternatives to medication. While it may be true that Vince's abusive behaviour influenced Joey's development and the overworked teacher may have demonstrated limited patience with Joey's demanding behaviour, nonetheless, Stephanie was not able to sufficiently consider Joey's needs in order to adequately weigh the benefits and drawbacks of the consequences of present decisions on his later life. For instance, her fear of transferring Joey to a lower grade was linked to a large extent with concerns stemming from her own childhood memories, as she too had been placed in a younger class while in elementary school after which she was teased by peers. Stephanie's difficulties in working cooperatively with the school for the benefit of her child perpetuated the "bad fit" between Joey and the school. Specifically, the conflictual relationship communicated a negative message to Joey about school whereby, in an effort to be loyal to his mother, teachers and the importance of education were devalued. Furthermore, Stephanie's own needs prevented her from engaging in a cooperative partnership with the school to work toward improving her son's situation. Without the support of his family environment, therefore, Joey continued to encounter difficulties within the school system.

A third significant transaction was between Joey and Vince. In particular, his relationship with his father was unclear as Joey simultaneously wanted to be with him, but

was aware of the potential for uncertainty and violence. His play exemplified this confusion and anxiety. For instance, Joey would express a fantasy about going to live with his father, and at the next moment would refuse to talk about it further. This ambiguity was further reinforced by mixed messages from his mother. For instance, despite her efforts to end the relationship with her ex-husband and her apparent relief regarding the recently finalized divorce, Stephanie re-connected with Vince by telephone soon after beginning the therapeutic process. It was unclear what her intentions were in doing so, but, the resulting unpredictable contact with his father exacerbated Joey's confusion.

Finally, there were issues pertaining to the relationship between Stephanie and Joey. In particular, the boundary between mother and child was not clear. For instance, Stephanie equated their relationship to "roommates", whereby they were best friends, but sometimes fought. Yet, she expressed concern that he ruled the house. This information was also noted by the psychologist as an area of concern. Additionally, Stephanie was working through a number of family of origin issues with an individual therapist at another counselling agency prior to and concurrent with the child-centred therapy. Given her emotional needs and the blurred boundaries between her and her son, it appeared as if Joey was inevitably affected by her personal issues. During his individual play therapy sessions, Joey further verified his mother's inability to address his developmental needs by expressing regret that she did not play and indicated that they don't "do much" together. Thus, instead of embracing an hierarchically-appropriate role as a parent who provides guidance and support to her child, it appeared as if Stephanie projected her own fears and

anxieties upon her son, thereby relying upon him to function as a friend and ally to her own personal and adult needs.

Joey's in-utero exposure to substance abuse[12] and early experience of violence may have contributed to the possibility of cognitive and learning problems. Additionally, such an environment functioned as a barrier to the development of healthy parent-child attachment. While the violence ceased when Joey was four years old, the characteristics of his post-violence and post-separation environment were not conducive to providing the guidance, predictability and stability necessary for fostering healing from trauma or for contributing to the development of healthy internal resources in a child. Specifically, the boundaries within his family continued to be unclear. The mother-child relationship lacked an appropriate hierarchy, the relationship between mother and father was unpredictable and the transactions between father and son were confusing and subject to the control of the mother. Nichols and Schwartz (1995) note that when boundaries in families are excessively weak and ineffective, "younger members...may find themselves unprotected because of a lack of guidance" (p. 219). Instead of providing a supportive foundation from which Joey could develop internal skills and explore external resources, Joey experienced an unpredictable and ambiguous family environment. Without adult role models to provide leadership and a supportive environment in which he could feel safe, Joey had limited access to internal and external resources. Consequently, Joey had few

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[12] Archie (1992) noted that studies focusing upon the use of marijuana in pregnancy have been inconclusive, while studies focusing upon cocaine have exposed the risk of pregnancy complications, embryo-fetal and neonatal adverse outcomes and congenital problems. In addition, "postnatal problems have also been associated with cocaine use in pregnancy....Early neurobehavioural studies have suggested depression of interactive behaviour and poor organizational response to environmental stimuli" (Archie, 1992, p. 194).

resources on which he could rely. He lacked peer support, school was a negative context, his mother was focused on her own needs, he was confused about his father and overall, his environmental context was unstable and thus, anxiety-provoking. Joey's behaviour, therefore, reflected the uncertainty of his surroundings.

(4) Intervention

• Duration: Joey attended a total of ten play therapy sessions over the course of four months. The weekly sessions were approximately one hour in duration. The therapist also met with Stephanie for four one-hour sessions and conversed with her by telephone at least six times. Each conversation was approximately one hour in duration and focused upon her concerns, behavioural changes at home and school, and feedback about the therapeutic process. The therapist also established telephone contact with the school and spoke with the psychologist approximately three times. Joey refused to return to the EHCC after the tenth session. After four canceled appointments, therapy was terminated without closure.

• Goals: Intervention objectives focused upon Joey, Stephanie, the interactions between the two and the relationship between the school and the family.

The primary goal of Joey's intervention was to establish a therapeutic relationship as a foundation for counselling. In order to do so, Stephanie was employed as a partner for child-centred therapy. Objectives for therapeutic work with Stephanie were to:

- foster predictability in their family by developing a pattern of consistency in which Joey would be brought to play therapy every week at the same time.
- diminish her focus upon discipline and punishment in parenting.
- spend time engaging in enjoyable activities with her son.
- receive parenting support to help with the decision making processes relating to her son.

- receive support regarding her relationship with Joey's school.

The objectives of this work were to lessen Stephanie's feeling of parental stress and bolster Joey's feelings of self-worth. Overall, it was important to employ Stephanie as a therapeutic partner to reinforce her relationship with Joey and subvert the possibility of her depending upon the therapist to address Joey's full range of emotional needs. It was hoped that helping Stephanie to understand and address Joey's needs would serve to further reinforce the individual-focused play therapy objective.

The objectives for play therapy with Joey were contingent upon establishing a therapeutic relationship. He needed to experience a consistent and trusting relationship with a counsellor in order to diminish his anxiety and create a safe and relaxing environment in which sometimes difficult topics could be addressed. It was hoped that this relationship could also be utilized to model non-aggressive social skills and to create a foundation of social support to minimize his apparent sense of isolation.

With the therapeutic relationship as a foundation, there were a number of goals for intervention. Objectives for individual therapeutic work with Joey were to:

- develop a feeling vocabulary in an effort to express himself in a focused manner so as to lessen his sense of confusion and anxiety.
- lessen social isolation by identifying barriers to healthy peer relationships and addressing them accordingly.
- discuss the past family violence, his parents' separation, his current family form and the recent contact with his father.
- diminish the possibility of self-blame and maximize coherence by focusing upon aggression and control in interpersonal relationships, gender roles and different family forms.
- develop safety planning skills to cope with the possibility of future unsafe situations.

Finally, the family's relationship with the school was also targeted during intervention. In addition to work with Joey's mother, the therapist:

- facilitated communication between the school and parent.

- acted as an advocate for Joey's needs as a child who has been exposed to partner abuse.
- helped to communicate Joey's school-based needs in an effort for Stephanie to make informed decisions about her son.

- Process: In order to employ Stephanie as a therapeutic partner, the therapist took great care to develop a trusting and respectful relationship with her. It soon became apparent, however, that firm limits regarding Joey's appointments were necessary in order to create consistency in her schedule. By doing so, the therapist encouraged her to consider Joey's needs. The therapist attempted to maintain the collaborative relationship with Stephanie, which developed during the four initial sessions, by scheduling a number of separate child-focused individual sessions. While Stephanie initially agreed to these, as each approached, she commonly expressed her preference for telephone contact. Regardless, the therapist maintained correspondence with Stephanie on a relatively regular basis to encourage a focus upon Joey's needs and to support her in her daily parenting struggles. Additionally, throughout the therapeutic process, Stephanie was engaged in weekly individual counselling at another counselling agency.

In an effort to solidify the parent-child relationship, the therapist encouraged Stephanie to spend time engaging in an enjoyable activity with her son for fifteen minutes every day. There were a number of objectives for the task. Firstly, it would provide the opportunity for her to establish a consistent and predictable pattern of interaction within her family. Secondly, she would be able to get to know her son as a person and by being aware of his thoughts and feelings, it was hoped that she could become better acquainted with his needs. Thirdly, by having the chance to spend time engaging in an activity that was mutually enjoyable, it was hoped that her level of stress would be lessened. A final

objective was for Stephanie to take responsibility for the needs of her son by adopting an active role to carry out such an activity. In the end, however, Stephanie had difficulty defining a mutually enjoyable activity and finding time to do so. This exercise was therefore strained and carried out in an inconsistent manner.

Initially, Stephanie presented as a strong, articulate and motivated woman. During the course of Joey's therapy, however, her fragility soon became apparent. She appeared to be overwhelmed by her own needs, such as emotional issues related to her family of origin, and financial uncertainty. It appeared that she lacked the foundation on which to develop the capacity to be emotionally available to Joey as a result of the physical, sexual, verbal and substance abuse in her family of origin. For instance, she expressed that she was parentified as a child and thus found it difficult to play with her son. Additionally, her financial and employment concerns limited the amount of time she was able to spend with Joey. Overall, she may have recognized her son's needs but may have been unable to attend to them. Thus, she appeared to have been employing third parties to focus upon these issues. For instance, she relied upon the teacher to employ discipline and chastised the school for not doing so. Secondly, she appeared to rely upon the therapist to provide for Joey's emotional needs which would explain her anxiety around termination. Lastly, Stephanie's contact with Vince may have been linked with an effort to employ him as a co-parent. Consequently, it could be hypothesized that she was attempting to use her external resources to satisfy the needs of her son as she was unable to attend to them on her own. Thus, as an alternative to taking responsibility to feeling blame or guilt when Joey's needs were not met, she could criticize the third parties.

During the relationship building phase of play therapy with Joey, the sessions were devoted mainly to non-directive play therapy. The aim during this period was for Joey to explore the playroom and become comfortable with the therapist. Once such a relationship was created, a predictable routine consisting of a mix of directive and non-directive play was established.

During and subsequent to the seventh session, therefore, the first part of each session was devoted to a therapist-directed structured activity and the second part was "free play". Some directive activities included puppet play and story telling to explore family and peer relationships, employing a calendar to encourage mastery and predictability, and acting out feeling faces to encourage emotional expression. Despite the range of structured activities the therapist attempted to employ, many of the above mentioned goals were addressed within the context of Joey's self-directed play.

In the initial sessions, Joey played with trucks, police cars, stoplights and barriers in the sand table. He made a racetrack and verbalized the actions of the cars and objects. The use of toys in the sandbox waned in later sessions. Instead, he used the sand in a manner that was less structured and more aggressive. Specifically, he tried to climb into the sandbox, hit the sand with his hand to create dust and dipped the foam racquet into the sand and hit the ball, which would cause sand to fly at the therapist and around the room. Additionally, Joey played with games in a structured manner, but commonly would not complete the tasks. He often verbalized his curiousity about other games, yet, he would give an excuse for not trying them by indicating that they would take too long to

play or that he did not know how to play. On the other hand, the foam racquets were the one toy with which he played in a consistent, structured and engaging manner.

For the first five sessions, the establishment of consistent attendance was a problematic issue. As a result, it was difficult for Joey to create a meaningful relationship with the therapist. Despite the increasing consistency of attendance in later sessions, however, Joey grew increasingly anxious. For instance, during at least three sessions, he avoided entering the regular playroom. Additionally, he had difficulty staying in the playroom and would find excuses to leave, such as going to the bathroom or having a stomach-ache.

Over the course of therapy, the manner in which Joey interacted with and related to his therapist changed. In the first few sessions, Joey was quiet, timid and wanted the therapist to complete tasks for him. As therapy progressed, however, Joey grew more aggressive and frustrated with the therapist. As his anxiety mounted, his attempts to avoid interacting with the therapist increased. Ultimately, his anxiety peaked in the final session as evidenced by extreme frustration with the therapist. Furthermore, by refusing to return to the EHCC, his attempts to avoid the therapist were successful. Such a pattern of behaviour appeared to point toward impaired attachment issues. Specifically, it reflected what James (1989) refers to as "distancing", whereby a "child rebuffs attempts at emotional closeness due to distrust and a felt need to protect [one]self" (p. 39). Joey thus sought to "precipiate a crisis and break the tension" (James, 1989, p. 129) as his experiences had taught him that reciprocal attachment inevitably leads to disappointment and abandonment.

School was a stressful environment for Joey throughout the therapeutic process. In response to the decision to keep Joey in grade two, he continued to have difficulties which extended beyond academic demands. For instance, after the fourth session, Joey was reluctant to go to school. When he did attend, he tried to avoid being in the classroom and started causing mischief, such as stealing another child's toy, in an effort to leave the classroom. He encountered few classroom successes, the results of which began to permeate his behaviour. This was evident in the playroom. For instance, the themes of low self-esteem, fear of failure, anxiety and avoidance were repeatedly exhibited in Joey's play. For instance, during the sessions, he would rely upon the therapist to read the titles of games and engaged mainly in activities with which he was previously familiar. These issues were problematic. Not only was he lacking the foundation for learning he would need for healthy functioning in later years, but he was also developing negative coping skills to deal with the difficulties he was encountering in school.

Through telephone contact, the therapist attempted to mediate between the school and Joey's mother by communicating the needs of each to one another. Previously, the teacher, psychologist and Stephanie had met approximately every two months. During a telephone conversation with the psychologist prior to Joey's fourth session, it was revealed that school officials continued to be concerned with Joey's low skill development and inability to focus or concentrate. He expressed concern about Stephanie's parenting abilities, describing her as "chaotic" and pointed to the time she forgot to pick her son up from school during an early dismissal. He continued to maintain Joey's diagnosis of ADD and emphasized the need for medication. The therapist was invited to the next meeting

with the teacher, Stephanie and the psychologist. The therapist accepted. Subsequently, the therapist discussed this with Stephanie who was told about the meeting by the teacher. In a later telephone session with Stephanie, the therapist attempted to prepare her for the meeting by encouraging her to consider all options and discussing the definition of ADD. Stephanie was nervous about this meeting, but expressed relief that the therapist would be present. Unfortunately, the therapist was unable to attend due to illness and as the teacher was unable to reschedule, the meeting went ahead as planned. Ultimately, parenting and classroom-based objectives were decided upon, but the psychologist insisted upon medication as intervention should these objectives have failed to have been successful.

Approximately one and a half months later, after Joey's tenth session at the EHCC, Stephanie was called to a meeting at the school. She was unaware that unlike previous meetings that involved only the teacher and psychologist, Joey's pediatrician and the principal would be present. The therapist was not notified of the meeting. The physician insisted that Joey be put on a trial run of Ritalin that was to be used during school hours and at the discretion of his mother. Stephanie felt defeated and scared. Joey did not return to play therapy after this decision was made. Thus, it could be hypothesized that play therapy was linked with Stephanie's resistance to the medication. In particular, Stephanie involved Joey in play therapy in an effort to help Joey change and thus resist the prescription; upon initiation of drug therapy, however, this need was no longer required.

• Themes: Joey presented as an anxious boy who was easily confused and frustrated. He was often unfocused and had difficulty completing tasks. Joey's play commonly reflected his low self-esteem. In particular, he was never able to outline one good thing about himself, he would disagree with the therapist when she would highlight his positive qualities and he would avoid engaging in tasks because he believed that he would fail. For instance, in the third session, Joey did not want to write his name on his picture because he was afraid that he would do it wrong. Additionally, in the first few sessions, he did not want to pursue games about which he was curious as he said that they were too hard.

The theme of loneliness was also enacted in his play. This was most overtly expressed in his artwork, as all of his drawings were of single figures. For instance, he drew a picture of a dolphin with a frown in the middle of the white page. Joey also alluded to this theme in the context of his family. In particular, he would discuss his cousins and point to the fact that they all had siblings, in contrast to himself who was an only child. Finally, Joey never discussed positive peer relationships. Instead, he fantasized about meeting new friends and only recounted stories about interactions with children in which he had experienced loss or conflict.

• Turning points: There were few distinct turning points during the course of the therapeutic process. Instead, a number of ongoing overlapping issues intensified, which impacted upon Joey and his family environment. The main issues pertained to the relationships between Joey, his father and his mother.

Firstly, changes in Joey's behaviour appeared to reflect the renewed telephone contact with his father. Stephanie initiated contact with Vince around the time of the initial parent-therapist sessions. Despite the effort of leaving him and the relief she expressed when their divorce was finalized, it was not completely clear what her intent was in initiating this contact. Stephanie expressed that she felt Joey had a right to continue a relationship with his father even though he had been abusive to her. She wanted to prevent the possibility that when Joey got older, he would blame her for not cultivating a relationship between himself and his father. This contact, however, was inconsistent and was subject to Stephanie's control. Ultimately, it served to heighten Joey's anxiety and confusion about his parents relationship.

This telephone contact appeared to serve a number of purposes for Stephanie. Firstly, she was able to exert control over her previously abusive ex-husband; she made the calls, the rules and monitored the conversation by listening on another telephone extension. She was powerful in the relationship with her ex-husband as she regulated the timing and content of his contact with Joey. It may have also been a way to seek revenge as she was exerting her power in a relationship in which she was previously the victim. Secondly, she may have been setting Vince up for failure. Although she indicated that he was being "co-operative", she most likely knew that he would not be able to maintain such consistency. Like many children who deal with divorce, Joey idealized his father and fantasized about living with him. Thus, the intent of the phone contact may have been to prove to Joey that his father could not "abide by the rules" and did not care about him. Regardless of the reason, Joey's behaviour was exacerbated in relation to this contact.

While the therapist attempted to outline this connection, Stephanie had difficulty recognizing it.

Joey's play clearly exemplified his confusion and heightened anxiety around his father. For instance, he idealized his father's house as being his "real, real, real home", as opposed to his Winnipeg home, which was merely his "real home". On the other hand, Joey witnessed his mother and father arguing on the phone, which may have induced memories of the abuse. Lastly, the contact may have jeopardized his relationship with the therapist, the relationship within which he would have been able to sort out confusing feelings, as his father sent him negative messages about the value of therapy. Stephanie indicated that Joey expressed relief when the divorce was finalized, however, the hope for a stable, predictable and safe environment which the divorce may have provided diminished with renewed contact.

A final issue that influenced Joey was his relationship with his mother. In particular, Joey's environment was unstable in that his schedule appeared to change in response his mother's needs. For instance, a consistent appointment time was only successfully scheduled after the fifth session. Additionally, Joey commonly confused days and could not remember when he had come to the EHCC or when he had talked with the therapist by telephone, even if it was the day before. His family environment was chaotic as there was little structure or predictability.

Stemming from the blurred hierarchical parent-child boundary, Joey was given the freedom to make decisions in his life with little guidance. In addition to the lack of structure, his choices were limited whereby he covertly was required to adjust to his

mother's needs. For example, in an effort to reinforce predictability, the therapist gave Joey a calendar during the eighth session. Each future session was noted and the proposed termination date, which was three months away, was discussed. At the time, Joey's calm reaction appeared to indicate acceptance of the notion of termination. Although he did not mark the date on the calendar, he did not avoid discussion of the topic. After this session, the therapist reminded Stephanie about the termination date during a telephone conversation. Although the scheduled termination date was still three months away, in response, Stephanie panicked and expressed anxiety. In the ninth session, Joey indicated that his mother had been pressuring him to tell her about what they did in sessions, but he did not want to do so; the therapist reassured his right to choose. During the tenth session, Joey exhibited extreme anxiety and confusion. He refused to return after this session. He discussed the matter with the therapist by telephone. Joey blamed the therapist for asking questions that were too hard and confusing to which he did not know the answers. The cause of his sudden increased anxiety and proclaimed confusion was difficult to pinpoint at the time. While it may have been linked to the difficult nature of the material being addressed in the sessions, refusing to return revealed his regular coping behaviour whereby he would quit rather than try to succeed. Stephanie was unable to sufficiently consider her son's needs and thus was unable to provide support and guidance for Joey to overcome this defensive behaviour. His usual coping mechanisms were thus reinforced by his family environment whereby the unclear parent-child boundary allowed Joey to make important decisions from an immature perspective.

An additional factor stemmed from Stephanie's anxiety pertaining to the "impending" termination. This appeared to have influenced Joey's perspective of therapy as he reacted only after the therapist had reminded Stephanie of the termination. Consequently, it was probably easier for him to stop coming to the EHCC than to face the anxiety of continuing to do so. His actions were thus guided by his mother's needs[13]. As a result, the lack of hierarchy was demonstrated by the fact that Stephanie let her son make a major decision from an uninformed and immature standpoint with little guidance nor concern about future implications.

• Evaluation: Due to the nature of Joey's termination, post-test results were not gathered. Consequently, only pre-test measures were available for analysis.

(a) quantitative data - mother: On the PSI/SF, Stephanie scored in the 96th percentile for parental stress (see Appendix G for quantitative scores). However, the percentile score of 80 on the Parental Distress subscale was in the normal range, while the scores of the other two subscales were in the clinical range. In particular, Parent-Child Dysfunctional Interaction exhibited a percentile score of 92 while the Difficult Child score was 96. Consequently, she did not experience distress in her role as parent, while the other subscale scores pointed to the child as the focus of the problem. Specifically, the Parent-Child Dysfunctional Interaction score pointed to the fact that she saw Joey as not measuring up to her expectations "and that the interactions with [her son] are not reinforcing [her] as a parent....either the parent-child bond is threatened or has never been adequately established" (Abidin, 1990, p. 20). Furthermore, according to the manual, the

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[13] James (1989) notes that the expectation for children to meet parents' needs is a characteristic of substance abusing families.

Difficult Child score was "extreme". This suggested that Stephanie was probably having difficulty "in managing [her son's] behaviour in terms of setting limits and gaining the child's cooperation" (Abidin, 1990, p. 20).

The CBCL for Joey exhibited a Total Score t-score of 71 and the Internalizing and Externalizing t-scores were 71 and 65 respectively. Joey's subscale t-scores for Withdrawn, Delinquent Behaviour and Aggressive behaviour were in the normal range. His t-scores were in the borderline clinical range for Somatic Complaints and Thought Problems. His t-scores for the remaining subscales, Anxious/Depressed, Social Problems and Attention Problems, were in the clinical range.

(b) quantitative data - child: Joey's self-concept was extremely low as evidenced by the Piers-Harris Children's Self-Concept Scale. All of his scores were in the clinical range. His total t-score was 38, thus indicating a low self-concept. His t-score was 39 in the Behaviour cluster scale, thus suggesting acknowledged behavioural problems. For the Intellectual and School Status cluster scale, his t-score was 39, pointing to "difficulties with school-related tasks" (Piers, 1984, p. 39). His attitudes regarding his physical characteristics and his self-assessment of leadership qualities and the ability to express ideas were low in that his t-score was 24 on the Physical Appearance and Attributes cluster scale. The lowest score on the chart was that for the Anxiety cluster scale. His t-score of 34 on this scale pointed to

> a variety of specific emotions including worry, nervousness, shyness, sadness, fear, and a general feeling of being left out of things. More than the other cluster scales, this scale contains items which may suggest the need for further psychological evaluation or referral. (Piers, 1984, p. 39)

Joey did not see himself as popular among his peers as reflected in the low t-score of 39 on the Popularity cluster scale. "Low scores on this scale may reflect shyness, lack of interpersonal skills, or personality traits which tend to isolate the child from others" (Piers, 1984, p. 39). Finally, Joey's low t-score of 36 on the Happiness and Satisfaction cluster scale reflected a "general dissatisfaction, feelings of negative self-worth, and a longing for things to be different" (Piers, 1984, p. 39).

The authors of the measure warn of a potential limitation in that the responses may not accurately reflect the feelings and behaviours of children with low verbal ability and/or who are "overtly hostile, uncooperative, uncommunicative, prone to distortions, or...disorganized in their thinking" (Piers, 1984, p. 3). Although the therapist read the questions to him, it was possible that Joey could have been categorized in a such a way; therefore, the results of the test may not in fact have accurately reflected his true self-concept. Nonetheless, the interpretations of many of Joey's scores on this quantitative measure are supported by data gathered from his mother and observations of him in the playroom.

(c) qualitative: In the previously mentioned case studies, the therapist met with the mothers at termination to discuss the process of therapy, significant changes and plans for the future. Due to the abruptness of Joey's termination and Stephanie's lack of commitment to attend such a session, such qualitative feedback was not available. Yet, some changes were noted during the ongoing communication with Stephanie and through the therapist's observations of play therapy.

One of Stephanie's concerns during intake was Joey's insistence on sleeping with her every night. After Joey's second play therapy session, however, he began to sleep in his own bed. It was not clear why this change occurred, yet it persisted throughout the counselling process.

One goal of therapy was focused upon helping Stephanie develop consistency in her daily schedule. This was especially important for Joey's play therapy experience. It took at least five sessions to establish a predictable appointment time; this corresponded with the slow development of a trusting relationship between Joey and the therapist. Soon after this relationship was established, however, counselling was terminated.

Throughout the sessions, Joey was anxious, avoidant and unfocused. Without a sufficient level of comfort with the therapist and playroom, it was hard to address emotionally difficult themes such as violence and the relationship with his father. On the other hand, Joey did demonstrate a number of gains over the course of therapy. Firstly, Joey started to become accustomed to the predictable structure of session. For instance, this was played out in the racquet game in that he ensured that each had the same colour racquets as usual and that he and the therapist stood in the same places in the playroom. Secondly, Joey showed improvements in his social interactions. For instance, he hit the therapist with the ball a number of times. In latter sessions, however, he began to hit the foam ball lightly and when he wanted to hit it hard, he would do so on the floor or wall. There were signs, therefore, that Joey was beginning to become less aggressive. Finally, Joey became increasingly comfortable with expressing feelings and started to develop a feeling vocabulary. For instance, in the seventh and ninth sessions, he asked the therapist

about specific feeling faces on the poster. Additionally, in the ninth session, Joey was comfortable acting out different feelings, such as frustrated, surprised, anxious and enraged. He was also able to give examples of being jealous and mischievous. In the final session, he was able to draw a picture of "mixed up", what he was feeling at the time; he drew three faces to symbolize this one feeling. Furthermore, this trend extended beyond the playroom to his home environment as Stephanie expressed that Joey increasingly employed feeling words at home.

Prior to termination, Joey became more comfortable with the structure and consistency of the sessions, developed a trusting relationship with the therapist and began to make a number of gains. He was poised to start working on more complex and emotionally-charged issues, such as those related to his father. Yet, the removal of his coping mechanisms was too difficult for a boy who lived in a family environment that was unpredictable and lacked structure. He terminated therapy, therefore, at a critical phase.

(5) Conclusions

The quantitative and qualitative data pointed to Joey's significant behavioural issues, which contributed to the presenting problems of his short attention span at school and poor peer relationships. Most notably, low self-concept, anxiety, and social and attention problems contributed to his behaviour, yet, his past and present family environments did little to minimize the severity of these issues. For instance, his early childhood was characterized by exposure to physical and emotional violence directed at his mother, inconsistent contact with his father and his mother's substance abuse. Consequently, the parent-child attachment and Joey's early development were threatened.

Although his present family context was free from abusive behaviour, the instability persisted. Specifically, his mother's needs superseded his. She had difficulty creating a stable emotionally supportive environment in which she could provide the parental guidance Joey would need for healing and growing. Termination exemplified their relationship in that his anxiety heightened only in response to her perspective about ending therapy. She was limited in her ability to provide safe and supportive guidance to help him heal. Thus, Joey lacked a consistent supportive environment in which his developmental, learning and emotional needs could be met.

THEMES

Assessment and intervention in this practicum focused upon children and their environments within a ecosystemic framework that considered past exposure to partner abuse. Despite the range of cases involved in this practicum, a number of common issues arose pertaining to the structure of therapy, the benefits of an ecosystemic approach for assessment and intervention, themes in children's play and presenting problems. It is hoped that an understanding of these common themes will help to create models for practice with children who have been exposed to partner abuse.

Challenges in engaging families

This practicum focused upon a population that is rarely addressed in the literature. In particular, the majority had no previous contact with women's shelters and were voluntary clients who had been living free from violence for a number of years. The distinctive characteristics of this population thus presented unique challenges to engaging them in the therapeutic process.

- Scheduling

Arranging appointments for families to attend sessions at the EHCC was often challenging as it entailed the co-ordination of the family, therapist and agency space. For instance, parents' work schedules and child care arrangements needed to be considered for both the parent intake and play therapy sessions. Many of the families referred to the EHCC are low income, thus they commonly have little flexibility in their work schedules

and often have limited resources for child care either for the referred child client during parent intake sessions or for siblings. On the other hand, some parents were reluctant to come to the EHCC in the evenings due to safety concerns related to being downtown after sunset. Secondly, the child's schedule also needed to be considered when planning sessions in that the majority needed to be scheduled after school. While the possibility of coming to the EHCC during the day was offered, many of the referred children were experiencing difficulties in school and thus missing classroom time would not have been in their favour. An additional consideration was the child's daily needs in that sessions could not occur too late in the evening due to meal and bedtime constraints. Lastly, the agency's hours of operation and the availability of the playrooms needed to be considered for scheduling. Thus, despite the fact that there were two playrooms, competition for them was intense between the hours of four and six on the days during which the agency was open in the evenings. Lastly, the therapist's schedule needed to be considered. Although she attempted to maximize flexibility by spending weekdays at the EHCC, the commitment of nine hours of classes per week sometimes posed a barrier to scheduling. Overall, it took some organization to co-ordinate the participants.

- Referral information as a barrier

The quality of referral information influenced the ease and speed of engagement with families. In particular, ecosystemic assessment and intervention objectives were constructed more quickly and accurately when the referral information was detailed and complete. For referrals by parents, the therapist was able ask pointed questions about the

family's past history and current context for which the majority were able to give detailed information. On the other hand, many of the referrals for this practicum came from professionals at social service agencies and the information was sometimes vague. Although initial telephone interviews and in-person intake sessions tended to complete the picture, incomplete data continued to be an issue when the parents were not accessible. For instance, obtaining referral information from one agency was extremely frustrating as the referred clients were living with foster parents. It was assumed that a child welfare worker may not be aware of developmental information, however, she was also unable to give details about the family's history and the extent of violence witnessed by the children. The worker was not even aware that the foster children had other biological siblings who were in the care of extended family. This lack of information prevented the therapist from assessing the clients properly and thus, there were difficulties in establishing appropriate therapeutic objectives. More importantly, the foster parents' ability to care for the emotional needs of these children were constrained due to this lack of information.

- High needs of parents

The literature recognizes that mothers who have been victims of partner abuse may have overwhelming personal needs which can affect their ability to be physically and emotionally available to their children (Jaffe et al., 1990). Consequently, authors such as Bilinkoff (1995) and Rabenstein (1997) note that securing safety, attending to basic needs and mourning of the end of the intimate relationship with the perpetrator should take precedence to child-centred counselling. The practicum experience supported this notion

as the personal needs of previously victimized women often needed to be addressed as a precursor to work focusing upon children.

Out of the seven family systems that were engaged in this practicum, three of the mothers required individual counselling focused upon their personal needs prior to proceeding with child-focused intervention. They were all referred to therapists at the EHCC and each was able to schedule her individual sessions to coincide with the play therapy sessions. In addition to these women, one mother was engaged with an individual therapist at the EHCC prior to the child's referral. She too arranged for concurrent sessions until the contact was terminated due to the end of her counsellor's student placement. One other mother was involved in individual counselling at another agency which continued throughout the course of her child's therapy. Only one mother and the set of foster parents were not involved in concurrent individual counselling. However, the former had received services in the past pertaining to parenting and family issues.

The involvement of the mothers in personal counselling was extremely helpful in the process of engaging with the families. Prior to connecting with individual counsellors, it was difficult for some women to focus exclusively upon their children. On the other hand, there were some drawbacks to the concurrent parent and child therapy sessions. For instance, involving another therapist tended to increase the previously mentioned complexity of scheduling. In practice, however, all parties tended to be motivated when scheduling difficulties did arise and therefore, it did not ultimately create barriers for engaging with families. Secondly, such concurrent sessions presented a potential barrier to working with the child; specifically, parents who may not be comfortable with their

individual therapy may simultaneously jeopardize their children's therapy by not coming. Although this was always a hypothesis, the therapist did not have clear evidence to support such an occurrence. Overall, the gains achieved by connecting mothers with individual counsellors outweighed the potential disadvantages.

Significance of working from an ecosystemic perspective

For this practicum, understanding the past and current transactions between children and their environments provided for a more comprehensive assessment while suggesting further avenues for intervention. Additionally, by affecting change in both the person and environment, it was hoped that each could be reinforcing to one another outside the boundaries of therapy and in the future following the cessation of the therapeutic endeavour.

In Kirsten's case, for instance, the presenting problems emerged and were perpetuated by a combination of personal and environmental issues. In particular, she expressed a fear of men and was aggressive to her sister. Without considering her environmental context, these two issues appear to be distinct from one another. Employing an ecosystemic perspective, however, provided a more comprehensive understanding of the issues. In particular, her fear of men stemmed from the victimization and rejection by the most significant adult man in her life, George. While she was afraid of interacting with other men for fear of being hurt again in such a manner, he had taught her that violence was an effective way to express needs and maintain power. Consequently, she expressed her need for mastery and power through aggression toward

her sister. Thus, an ecosystemic assessment contributed greater depth of understanding into the issues presented by Kirsten.

An ecosystemic approach also provided a number of avenues for intervention. In Kirsten's case, for instance, play therapy was employed to focus upon individual issues such as demystifying her feelings, anger management and non-violent conflict resolution skills. However, her mother was an important part of the intervention as the therapist worked with her to foster empathy for Kirsten's needs. As Cathy was able to do so, she was employed as a therapeutic partner to encourage Kirsten's expression of feelings, while emphasizing her uniqueness and solidifying the family's safety.

Ultimately, many of the goals for Kirsten's therapy were achieved due to the involvement of both the child and her family context. Her fear of men diminished as she began to sort out confusing feelings about George, while her own uniqueness and sense of safety was bolstered by her family context. Although the sibling rivalry persisted, it can be argued that it is a common issue in all families regardless of a history a violence. Overall, the combination of professional therapy and a family that supported the therapeutic objectives outside of the physical boundaries of therapy helped Kirsten achieve her goals.

While Kirsten was experiencing mainly personal difficulties within a supportive environment, the situation was different for Joey. In particular, an ecosystemic assessment revealed significant issues pertaining to Joey, his family context and the interaction between the two. For instance, one of his presenting problems was his short attention span at school. A psychological perspective would most likely assume a diagnosis of

ADD and thus treat it using medication. An ecosystemic understanding, however, also pointed to his past and present family contexts as factors that contributed to and maintained the problem. In particular, while living with partner abuse, he experienced an unstable and unpredictable family environment that was also characterized by substance abuse. These traumatizing experiences may have contributed to an attachment disorder which can result in learning difficulties (James, 1989). Although the violence ended approximately four years prior to the referral, the attachment issues were reinforced as the pattern of inconsistency continued to characterize their family.

Play therapy attempted to address Joey's emotional and informational needs; however, the one hour session per week could not contend with his chaotic home environment. In therapy and at home, Joey's needs were competing with those of his mother. Additionally, Joey's school environment was somewhat hostile. While he was exhibiting externalizing behaviour, the school was frustrated by Stephanie's differing opinion regarding etiology and the proposed intervention. It soon became clear, therefore, that intervention needed to go beyond the individual level to affect environmental change.

Firstly, the therapist attempted to occupy a mediating role between the school and family. Thus, the school was encouraged to employ an ecosystemic perspective that incorporated an understanding of the past and present family environments. Conversely, the therapist attempted to help Stephanie understand the concerns of the school and their proposed interventions in a manner that was less threatening. It was hoped that by

facilitating a working relationship between the family and school, the classroom would become a more positive and encouraging environment for Joey.

Furthermore, the therapist attempted to stabilize Joey's home environment by encouraging Stephanie to establish a predictable schedule during which she would set aside time for play therapy and special time to engage in enjoyable activities with her son. Eventually, she began to exhibit some consistency with Joey whereby she brought him to play therapy at a regular appointment time. However, pointing to family of origin issues that prevented her from being comfortable with play, she continued to encounter difficulty engaging with her son in enjoyable tasks. Ultimately, therapy was terminated prematurely. In hindsight, despite the achievements of individual play therapy, it could be hypothesized that more intensive work with Stephanie focusing upon therapeutic parenting may have produced more successful results. For instance, in line with parent-focused intervention for children dealing with impaired attachment, the therapist could have offered Stephanie greater "support, skill-training, patience, and a determination not to give up on [her]" (James, 1989, p. 129), in an effort that she would ultimately be able to offer her son the same.

Engaging in play therapy without considering the past and present environmental contexts of the child is potentially pathologizing and may serve to reinforce self-blame. Ecosystemic play therapy provides a more comprehensive understanding of the presenting issues while supplying a range of options for intervention. In particular, despite the fact that the experience of family violence was common to all the children in the practicum, the issue was not always the most pressing factor influencing current concerns. This is an

issue that is commonly overlooked in the literature. In contrast to the shelter-based populations used in the majority of studies in this area, the post-crisis, post-separation family who had previously experienced partner abuse envelops a number of concerns which tend to go beyond the issue of exposure to violence. Some authors, on the other hand, do allude to such systemic issues. For instance, Garbarino et al. (1992) recognize the impact of community violence on children and Jaffe et al. (1990) discuss associated literature which focuses upon separation and divorce, parental substance abuse and parental mental health issues. However, adequate research focusing upon environmental variables within the post-violence family has yet to be published. This practicum has demonstrated that despite the fact that the violence ceased prior to referral for all clients, significant stressors continued to persist in the child's environment. For instance, Kirsten continued to be affected by the perceived lack of family safety and Joey was influenced by his mother's inconsistency and attachment issues. The existence and impact of such stressors could only be identified and addressed through assessment of and intervention with the children's environments.

The literature has also indicated the importance of the environment in buffering children's stress and contributing to resiliency (Garbarino et al., 1992; Rutter, 1983). Through an ecosystemic assessment, therefore, the strengths of the child's environmental context can be harnessed and employed in the therapeutic endeavour. For example, intervention objectives for Kirsten included employing her mother in the process. As Cathy had strong parenting skills, her involvement in her daughter's therapy was beneficial for reinforcing therapeutic objectives outside of the agency. It can be

hypothesized that this positive environmental context contributed to Kirsten's achievement of the therapeutic goals. Conversely, the limitations of the environmental context can be identified and targeted for intervention. For example, Joey's environmental context appeared to reinforce his personal issues while minimizing his ability to heal through therapy. Overall, employing the child's environment in therapy can be a helpful tool to achieving objectives and the nature of this context may determine the successes children will encounter through intervention.

Themes in play with children exposed to partner abuse

There were a number of similar themes which permeated the play of children in this practicum. The main themes which emerged virtually every session for the case study clients were family relationships, escape or avoidance and protection or safety.

- Family relationships

As was noted in the literature, immediate and extended family systems are significant external resources for the development of resiliency in children (Hawley & DeHann, 1996) and for contributing to a child's sense of security and confidence (Garbarino et al., 1992). For each child, the topic of extended family was a significant issue. Tracey defined her family as including her mother, father, siblings and herself. She also talked fondly about her relationships with younger cousins. Kirsten's reflections on happy times in the past and wishes for the future included special times spent with her mother and sister, but, she also included her first cousins in many of her family-based discussions. Additionally, Sean defined his family as including his mother, grandparents, aunts, uncles and cousins. According to him, his nuclear and extended families were

differentiated only by separate physical homes. While the previous three children perceived their extended families to be positive and supportive, Joey's perception was different. For instance, he was hesitant to write his name on one of drawings for fear that a cousin his age would see it, as he too had been a client of the EHCC in the past. In contrast to the others who referred to their extended families without prompting in a positive manner, Joey viewed his extended family with suspicion and mistrust. While Tracey, Kirsten and Sean were able to access extended family resources, Joey's inability to do so further compounded his issues.

Three out of the four children in these case studies did not include the male perpetrators into their definitions of their family and all expressed negative attitudes of differing degrees toward these men. For instance, Kirsten expressed her anger toward George and questioned why he had hurt her. She was able to attribute responsibility to him for his violence toward her and her mother and expressed the desire for him to be punished for doing so. Secondly, Sean had some difficulty directly discussing his father and attempted to avoid doing so. On occasion, however, he expressed intense feelings of hatred for his father and labeled him as "evil". Lastly, Joey's play reflected his feelings of confusion about what type of person his father was and whether he wanted to be connected with him. Unlike Kirsten and Sean, he did not express anger toward his father. Rather, he idealized his father's home, but simultaneously exhibited heightened anxiety around the issue. He was able to agree with the therapist's suggestion, however, that divorce was confusing to children. On the other hand, Tracey included her father in her family drawing yet, would often discuss their relationship as separate from the

relationship between herself, her siblings and her mother. The ambivalent relationship between herself and her father was reflected in the sessions, as she would sometimes talk fondly about him and other times would grow quiet and attempt to avoid such discussion by changing the subject. Overall, Kirsten and Sean, the children who had minimal or no contact with the perpetrators, expressed extreme and definite emotions regarding the relationship. On the other hand, Tracey's and Joey's relationships with their fathers were inconsistent and subject to the whims of adults; thus, the expression of their feelings reflected the nature of this confusing and ambivalent relationship.

- Avoidance/escape

Escape and avoidance were also prevalent themes in the play therapy sessions. These were commonly enacted directly when the therapist attempted to address emotionally-charged issues pertaining to violence, divorce and the perpetrators. For instance, Tracey would often change the subject to one that was banal, such as roller-blading or rock stars, when the therapist would attempt to address issues pertaining to the argument with her father. Secondly, Sean exhibited a number of avoidance behaviours, such as changing the subject or covering his ears, when the topic of conversation focused upon divorce or his father. Finally, Joey would request to go to the washroom or pretended he had a stomach-ache in order to leave the playroom and avoid discussing his father.

The theme of escape was also projected in a less direct manner through play. For instance, Kirsten pretended to be in Mexico and Disney World by dressing up herself and the therapist and communicated her intentions using toy cellular telephones. She also

discussed her fantasy of meeting her biological father and his other children. Additionally, Joey indicated his desire to move to the United States to live with his father so as to meet new friends. Thus, he also expressed fantasies of escape through his play.

The topics focusing upon the violence, separation and perpetrators were confusing, anxiety provoking and emotionally-charged. The avoidance behaviours were understandable and provided a window into each child's coping skills. Yet, in an effort to confront the stressors, intervention necessitated addressing avoidance. The manner of doing so depended upon the stage of the therapeutic relationship. For instance, during the initial stages, the therapist would verbally reflect such behaviour and would mentally note the significant response to a specific issue in order to address it again at a later date. As the relationship with the therapist grew stronger and children felt safer in the playroom, the therapist attempted to address the issue using a directive task. If the avoidance persisted, the therapist again verbally reflected the behaviour and attempted to place limits, such as not leaving the playroom. Whether the therapist pursued the issue at that moment depended upon the intensity of this behaviour and the therapist-child relationship. If it appeared as if the defensive behaviour was strong and the child did not feel sufficiently safe to stop employing it, the therapist would attempt to minimize anxiety by covertly attempting to address the stressors during indirect play. The literature indicates that disclosure of the traumatic stressor (Silvern & Kaersvang, 1989) and interrupting associated defenses, such as avoidance (Silvern, et al., 1995) are integral tasks to facilitate healing with children in this population. Thus, an important objective was to help children to address and understand the traumatic stressors by slowly

eliminating their need to hide behind the defensive behaviour. By doing so, it was hope that they could gain coherence regarding both the stressors and the defenses.

- Protection/safety

Safety and protection were commonly occurring themes which tended to be less directly expressed than those previously mentioned. For instance, within her family's culture of "bugging", Tracey would physically retaliate against her siblings and then hide behind her mother for protection. The value of her mother's protection was a common theme for Tracey, as she would sleep with her mother almost every night due to nightmares and pointed to her mother's role in protecting her siblings from her father's abuse. Additionally, the theme of protection also emerged in association with her recognized victim role in her family. In particular, she expressed anger at her mother's powerlessness and her father's unwillingness to protect her from her siblings' aggression. Thus, by fighting on behalf of younger children, she appeared to be acting out her own need for protection from older children.

Themes of safety and protection were also prevalent in Kirsten's play. For instance, she recalled being lost and scared in a play structure but was reassured by her mother's voice who guided her out. This need for protection was also played out with the therapist, in that she requested that the therapist ensure that no one else touch a drawing she put on the wall. Lastly, Kirsten also relied upon her sister for safety, whereby, despite her anger toward Lisa, she demanded they sleep together every night.

Unlike the other children, the theme of protection was less common in Sean's play. During the parent-child dyad sessions, Gina revealed that he sometimes came to her bed at night due to nightmares. He immediately denied this, however, and appeared

embarrassed. In the final few sessions, on the other hand, the theme of protection began to be incorporated into his play. In particular, he placed soldiers in the dollhouse and used rocks, tanks, barbed wire and fences to protect his soldiers from the opposite "team".

Lastly, protection and safety were common themes in Joey's play. Sometimes, the themes were symbolically communicated, such as when he used a tiger to protect the castle and noted the weapons inside. Other times, he directly communicated his ability to protect others. For instance, he displayed his knowledge of karate which, he proudly exclaimed, his father and half-brother taught him when he was a baby; he indicated that he would be able to use his knowledge of karate should his half-brother get "captured". In practice, however, he demonstrated his dependence upon others for protection. For instance, when he got into a fight at school, he wanted to call his mother. Additionally, he requested that the therapist stand in the doorway of the washroom at the EHCC to protect him from the mice he believed to be living in the walls. Although he idealized his ability to protect, in reality, he lacked the confidence to do so and instead depended upon others for safety.

Whether directly or indirectly expressed, protection and safety were important concerns of these children. Commonly, the notion of protection was associated with the family or home context and more specifically, was associated with every child's mother. Overall, the importance of family relationships as the core foundation for security was demonstrated to be a salient issue for these children. Their need to avoid confronting issues pertaining to the perceived negative elements of their family histories, specifically the acts and perpetrators of violence, was indicative of the way such children cope with

emotionally difficult issues. Their play demonstrated their need for a secure and protective family context that is reliable and consistent. Ultimately, the children who gained the most from the counselling process were the ones, such as Kirsten and Tracey, who had relatively more confidence in their family's trust and ability to secure their safety.

Understanding the role of violence in the presenting problem/issues

All clients for this practicum were referred to the EHCC because they had been exposed to partner abuse. Despite this similarity, the presenting problems and issues varied among them. The question raised is the role the common experience of exposure to partner abuse played in creating or maintaining the issues seen among these children.

The literature commonly highlights the "traumatizing" effects of exposure to incidents of violence, however, it appears that the indirect consequences of partner abuse are also pervasive and damaging. While the notion of direct traumatization focuses upon psychological reactions, the indirect effects of partner abuse deals with attitudes and behaviours of both the individual and the people with whom that person engages in transactions. Traumatization implies a linear effect on the child, while a focus on the indirect effects of such violence provides the opportunity to conceptualize the transactional and circular impact of violence. The child is affected not only by the perpetrator's actions but also by the reactions of the associated sibling, parent and family systems.

All four children in the previously mentioned case studies had been referred to the EHCC with presenting problems that included aggression in interpersonal relationships.

Tracey was the victim and aggressor with peers, Kirsten fought with her sister, Sean was physically aggressive with his mother and Joey's referral information indicated that he was the victim of bullies, although his play suggested that he also was an initiator of such aggression. Thus, it could be hypothesized that these children learned that physical control can be employed as a means of expressing feelings and solving problems. Their life experiences taught them few alternatives to doing so.

It could be argued that exposure to a violent role model, such as a violent father-figure, may have taught them such aggressive techniques. Yet, for some of the children, the violence was either acute or ceased when they were very young. For instance, Tracey had been exposed to her father's violence toward her siblings and her mother prior to their separation, six years before the referral, when she was six years old. What Kirsten witnessed was more acute than the others in that she witnessed only one or two acts of violence against her mother. Additionally, the violence stopped five years prior to the referral as George and her mother separated when she was three years old. Furthermore, both Sean and Joey had been exposed to more chronic abusive incidents. Their parents separated approximately five years before the referral and thus had not been exposed to a violent perpetrator since the age of two. It can be questioned that direct exposure to violence is the sole stressor which contributes to later aggressive behaviour.

Children were also influenced by the after effects of aggression by a violent father-figure. For instance, Tracey was victimized by her siblings' reactions to her father's violence. Despite the fact that the violence between her parents had stopped years before, Tracey continued to be exposed violent role models by witnessing and being a victim of

inter-sibling aggression. Additionally, for Kirsten, the threat of harm persisted as she continued to be victimized by George through his rejection of her. Thus, both Tracey and Kirsten had the experiences of being victims in addition to being witnesses of violence. Consequently, their aggression may have been a response to gain some mastery over their previously powerless victim roles.

Violence-related gender roles may have also contributed to aggressive behaviour among these children. For instance, Tracey and Kirsten were both victims of abuse and had been exposed to their mother's victimization. As their experiences of being female may have been equated with powerlessness, their aggression may have been linked with the need to embody the "powerful" role of aggressor in order to empower themselves as females. "Children who assault others often do so by engaging in behaviours they know to be powerful as an attempt to escape their own state of helplessness and terror" (James, 1989, p. 83). Interestingly, the externalizing behaviour exhibited by these two girls counters the literature's assertion that girls tend to display mainly internalizing behaviours. Again, such assertions may reflect shelter-based populations and may not be indicative of post-crisis long term gender-specific behaviours.

There was also a link between gender and aggression pertaining to Joey and Sean. In particular, the mothers of both boys expressed their fears that their sons would become abusers when they grew older. Specifically, Gina had verbalized this fear directly to Sean during their arguments. Even at the age of seven, these boys were labeled as abusers, which offered few alternatives to this destiny. The literature has identified the connection between gender and the cycle of violence whereby boys identify with and emulate the

perpetrator (see Jaffe, Wilson et al., 1986; Porter & O'Leary, 1980; Straus, 1990). The case studies postulate, furthermore, that through labeling behaviour, boys may be socialized by their families toward occupying abusive gender roles in future intimate relationships. As a result, this label can became a barrier for mothers to teach their sons options to becoming perpetrators.

Lastly, the aggression of these children may have also been linked to a punitive style of parenting. In particular, the narratives of Tracey, Sean, Kirsten and Joey and their mothers indicated the use of rules, threats and punishments. As is noted in the literature (see Hughes, 1982), the punitive parenting techniques employed by these mothers may have been linked to unhealthy parenting role models from their families of origin. Specifically, Rose and Stephanie had been exposed to physical and sexual abuse during their childhoods, Cathy's mother was an alcoholic and although it was unclear about Gina's childhood, it appeared that her parents were strict. Additionally, this parenting style may have also be linked with the stresses of single parenthood (see Jaffe et al., 1990), in that mothers perceived themselves as having little time for preventative feeling-based parenting techniques. Regardless of the reasons for the parenting style, at least three of the four children in the case studies were exposed to parenting techniques that focused upon discipline, punishment and the negative behaviours of the child. It thus offered little opportunity for mutual explaining or understanding, and had the potential to promote anger and frustration in the child.

In addition to aggression, issues pertaining to protection and safety were also significant among the case study clients. For instance, all four children had current or

recent issues pertaining to sleeping with their mothers. At the time of referral, Tracey, Joey and, occasionally, Sean would sleep with their mothers. Kirsten, on the other hand, used to do so until her mother set limits around it; she then recruited her sister for the task. While the issue of co-sleeping tends to be linked with the need for protection and security, it was unclear whose needs it was meeting. For instance, the children may have wanted to feel safe by being near their mothers during the potentially vulnerable hours of the night. This may have been reinforced by mothers who required the physical closeness to assure themselves of safety of their children. Additionally, co-sleeping may also be indicative of the role children play as protectors in a violent household (Jaffe et al., 1990). They may feel compelled to ensure their mother's safety, which may be a true need of their mothers. Thus, the pattern of co-sleeping may have served the mutual needs of parent and child for protection and safety. Consequently, the role of violence may have contributed to the issue by creating a family context that is vulnerable and unprotected. By sleeping together, the needs of both mother and child were addressed in that each provided a protective role for the other. The fact that co-sleeping was perceived as an issue for Tracey, Joey and to a lesser extent, Kirsten and Sean, may imply that these families were beginning to feel more secure in their current environments and thus were attempting to break their dependency. Yet, it may have also pointed to the fact that the mothers were starting to heal quicker than their children as they were the ones who identified the issue and wanted a change.

Finally, the experience of violence in the lives of mothers coupled with the cultural context of families also contributed to some of the presenting issues of the children. This

was evident with Tracey who was being challenged by developmental issues and the threat of gang involvement. Rose was familiar with these issues as a result of her own experience as a teenage girl and a mother of gang members. She was thus attempting to minimize her daughter's vulnerability to cultural and developmental issues. Consequently, Rose and Tracey struggled with one another as each had her own agenda; Rose wanted to protect her daughter, while Tracey wanted to experiment with her growing independence.

Sean's issues also reflected his mother's situation as a victimized woman living within a patriarchal religious and cultural context. For instance, Gina had received minimal counselling regarding the abuse and instead, preferred not to address the past. She coped with the guilt of divorce and the pain of the abuse by attempting to ignore it and focused instead upon her present tasks. As a single parent, Gina lacked a partner for co-parenting; thus, she needed her son to "behave" and "respect" her so that she could centre her energies upon her job and running a household. She thus required him to understand and attend to her needs, while she suppressed the past to deal with present concerns.

The influence of violence on children thus extends beyond the immediate reaction to exposure to violent incidents. As was noted by Jaffe et al. (1990) and Straus et al. (1980), the experience can teach children about interacting with others, so as to extend into relationship with peers, siblings, parents and their own future children. Not only does it appear to influence behaviour, but, as Jaffe, et al., (1990) noted, it also seems to teach children about gender expectations, whereby females are victims and males are batterers.

As indicated by Porter and O'Leary (1980), such may contribute to the intergenerational pattern of future involvement in abusive intimate relationships. Finally, even after the violence has stopped, partner abuse threatens the family's sense of safety which may lead to hypervigilant defenses and unhealthy coping mechanisms such as the battered woman's syndrome (Walker, 1984), that ultimately permeate the system as a whole and influence the children in particular.

Despite the fact that all children in this practicum had been exposed to partner abuse, for many, "violence" was not necessarily the issue that exerted its greatest impact. For Sean and Joey, for instance, the separation and subsequent divorce of their parents contributed to anxiety and confusion. However, each was at the opposite end of the spectrum regarding the issue. Specifically, there was a rigid boundary between Sean and his father in that he was closed off from the topic of divorce. On the other hand, the boundary between Joey and his father was too permeable; thus, he was faced with mixed messages about his father and his parents' relationship. Consequently, an additional issue which influenced Tracey, Kirsten and Joey was ongoing inconsistent contact with the perpetrator. Furthermore, the impact of abuse was not necessarily confined to that directed at their mother. Tracey and Joey, for example, had both been exposed to their mother's substance abuse. In addition, child abuse was an issue for Kirsten and in Tracey's family. Thus, each child had been exposed to a multitude of issues, some of which were more immediate and significant than others in the life of the child. It is difficult, therefore, to focus exclusively upon partner abuse as a sole causal factor of the salient issues

exhibited by these children. In many families, partner abuse can be only one of a number of significant variables that work together to affect the child.

CONCLUSIONS

Learning Objectives

The therapist embarked upon this practicum with a number of client-focused and personal objectives. Reflection of the practicum process thus entailed an evaluation of whether they had been achieved.

- Client-focused objectives

As evidenced by the qualitative and quantitative evaluation methods, a number of client-focused objectives had been accomplished. In particular, the therapist was able to create a therapeutic environment that was safe, fun and supportive, help children communicate their feelings and experiences related to family violence, and bolster self-esteem. The achievement of the remaining objectives varied among the clients, and was largely dependent upon consistency of attendance and familial support. With longer term work, the therapist would have had greater opportunities to help children to understand family violence so as to alleviate self-blame and attribute responsibility for the violence to its true source, develop non-violent conflict resolution skills and internalize a foundation of safety and coping skills to be used in relationships and in response to future stressors.

- Personal objectives

As my personal objectives were more controllable than those focused upon the clients, the majority were achieved during the course of the practicum. In particular, the therapist increased her knowledge about the impact of witnessing violence in the home for children. While she became familiar with the common symptoms, behaviours and

attitudes among children in this population, she also learned that the salient issues were not necessarily linked with the severity of violence; on the other hand, they were more likely influenced by other factors such as divorce, impaired attachment or unclear boundaries within the family. Secondly, through the practical application of each, the therapist learned the value of unstructured play and directive tasks in working with children in this population. Thirdly, the therapist used both qualitative and quantitative assessment and evaluation methods and learned to value their utility. Lastly, the therapist was able to provide a positive adult role model to children and their caregivers, which was supported by comments offered in the feedback forms completed by children and caregivers.

What the Therapist Learned

Working with children who had been exposed to partner abuse has been challenging, stimulating and rewarding. In doing so, the therapist learned that this population is not homogenous. Thus, careful consideration of children's past and current ecosystemic transactions provided insight into the factors which created and perpetuated their significant issues, expanded options for intervention and hopefully produced opportunities for healthy coping and resiliency. An ecosystemic framework minimized the role of therapist as "expert", as the person's environment was employed to bolster healing. This functioned to reinforce the therapeutic objectives beyond the playroom walls, while helping to empower caregivers, many of whom had been victimized by past abuse, as

competent people who are capable of helping their children to heal and develop in a healthy manner.

This practicum has also illustrated that the influence of partner abuse on children extends beyond the direct exposure to abusive incidents. In particular, children were impacted by what violence in the family conveyed regarding interpersonal relationships, gender roles, conflict resolution and coping skills. In addition to these attitudes and beliefs, children were also affected by the reactions of other family subsystems, such as their siblings and mothers, to violence in the family. For instance, a mother may be hypervigilant or unavailable to her children as a result of her experience as a victim of partner abuse. Overall, the effects of violence in the family extended beyond the perpetrator's act of abuse in both time and space. In the majority of families, the violence stopped a number of years of ago, yet, the effects of this past reality continued to influence family members. Children in this population were also affected by the learned behaviours and circularity of reactions exhibited by themselves and their family members.

Regardless of the apparent influence of violence, past abuse may not be the most pressing issue in the post-crisis and post-separation phase of the life-cycle of these families. As a result, it was important to look beyond the violence to consider other factors. For instance, some children were affected by substance or child abuse. Additionally, the issue of divorce emerged a number of times. Consistent with Carter and McGoldrick's (1988) stages of the family life cycle, many practicum clients were attempting to cope with mourning the loss of a father-figure and adjusting to family restructuring that is characteristic of families dealing with separation and divorce.

Therefore, it was sometimes difficult to address the issue of violence without focusing first upon the most urgent issues for the child. Consequently, therapeutic flexibility was an asset as the specific needs of the children and families commonly preceded practicum-dictated objectives.

In addition to further knowledge about this population, this practicum provided the opportunity for self-growth as a therapist. For example, the therapist developed stronger interviewing and assessment skills, recognized the value of unstructured play, expanded her repertoire of directive play therapy techniques and learned to integrate play into family therapy. Overall, she gained greater confidence in her capabilities as a therapist in working with children, adults and families. Furthermore, from the process of the practicum she learned to appreciate clinical measures to support subjective judgments, the value of videotaping for case notes, supervision and self-criticism, and the importance of attending to personal needs to subvert the risk of vicarious traumatization.

Recommendations for the Future

A number of recommendations for future work in this area emerged based upon this practicum experience. From a process perspective, the compilation of an in-depth literature review and the definition of clear objectives and methodology simplified the initial phases of the practical work. An understanding of contemporary research in the field helped to structure the process. This foundation of knowledge provided the opportunity to reflect upon the work during each stage of the practicum process and conceptualize the similarities and differences between practicum observations and reports

from other researchers. Additionally, an understanding of the common interventions for this population provided a repertoire of ideas and defined the need for more research focusing upon ecosystemic play therapy. Finally, this corpus of knowledge also simplified the task of formulating conclusions for evaluation, termination summaries and the practicum report. In particular, the therapist was able to use the themes highlighted in the literature to compare and contrast findings.

There was little difficulty receiving appropriate referrals for this practicum, thus, reflecting the community need for play therapy services, especially for children who had been exposed to partner abuse. Despite the need for services, it took a number of weeks for potential clients to hear about the call for referrals and for intake sessions to be arranged. As this initial process is extremely time-consuming and emotionally taxing, it is recommended that students incorporate sufficient time for this phase and embark on it as early as possible.

Additionally, in hindsight, too much time was spent gathering intake data from caregivers. Early on, the therapist met with some caregivers for three or four sessions, during which a lot of data was gathered. However, this information solely reflected the caregivers' perspectives and nearly a month lapsed while this was being done. For later referrals, the number of caregiver intake sessions decreased to one or two as the therapist's assessment skills improved. The latter approach appeared to be more beneficial, because it allowed for the important stage of relationship building with children to begin sooner. Additionally, with information gathered from the child, developing an assessment and goals for intervention was quicker and more efficient. If more information

was needed, the therapist would meet for further clarification with the caregivers in person or correspond by telephone. Minimizing the caregiver intake procedure to approximately two sessions provided the opportunity for the therapist to develop a working relationship with them, while sending a message that the therapy is child-centred.

From a methodological point of view, an approach to child-centred intervention with a consideration for the caregivers' needs is important. This practicum report has noted the high needs of caregivers in contributing to their children's issues and as a barrier to engaging with families. In a number of cases, the therapist attempted to address the personal needs of the caregivers, yet, often the task was too immense and referral to a separate therapist was necessary. Anticipating such a pattern, however, would simplify this logistical co-ordination. For instance, an idea for future work in this area would be to employ a team of two co-therapists, in which one would focus upon the children and the other would concentrate upon the caregivers. In particular, the therapists would field referrals for children exposed to partner abuse and based upon their assessments, the clients would be offered some of a number of interventions. This continuum of services would span from individual counselling for personal needs to family therapy focusing upon the past violence and current parent-child interactions. The level of caregiver and child needs at intake would determine the type of services initially received; however, assessment would be ongoing so that clients could easily move along the continuum of interventions when appropriate. Yet, there are a number of potential drawbacks to such a framework. Most notably, it would require a great deal of flexibility on the part of the therapists. Additionally, it is also contingent upon the caregivers' motivation. From my

practicum experience, however, the number of caregivers who wanted to be involved outweighed those who did not.

Conclusion

The need for more research regarding children who have been exposed to partner abuse is indisputable. Much of the current literature focuses upon shelter-based populations, yet statistics indicate that such a sample represents only a minority of women who leave abusive partners (Statistics Canada, 1994). Thus, the findings of research focusing exclusively upon a shelter-based population may be biased and may instead reflect the needs of this specific population. On the other hand, the lack of literature in this area and the reality of such a statistic may be indicative of a gap in available social services whereby the emotional needs of women and children who have successfully secured physical safety are not being adequately addressed. While the importance of women's shelters is undeniable, future social service planning should also consider the needs of a population that possesses the resources for shelter, but may not have access to emotional support to address the violence and associated issues.

Further analysis of the long term implications of partner abuse on the family for assessment and intervention would be useful for social work practice at the mezzo- and micro-levels. For the majority of the practicum sample, for instance, the violence ceased approximately five years prior to the referral. It could be hypothesized, therefore, that this common time frame was significant. For instance, it may have been indicative of a stage in which the family became ready for healing or perhaps the needs of certain family

members were heightened, which led the family to seek resources. It would be beneficial, therefore, for future research to address such questions.

The literature has only begun to explore different avenues for intervention. While a variety of modalities have been suggested, empirical studies focusing upon the efficacy of each are lacking. Even studies focusing upon children's groups, what appears to be the most commonly suggested and implemented modality, have been small and mainly inconclusive. Yet, such groups are generally psycho-educational in nature and therefore, some children in this population may require interventions which are more intensive. Models for practice with children and families who have experienced violence, however, are virtually non-existant.

Social work practice with children who have been exposed to partner abuse necessitates a consideration of children within the context of their environmental networks. Assessment of these transactions will serve to highlight significant issues which may have otherwise been overlooked when focusing upon acute violent incidents. This practicum has demonstrated that issues pertaining to partner abuse may persist in the absence of the violent stressors. Additionally, careful assessment is important to understand not only the externalizing behaviour, but to focus upon covert internalized attitudes, beliefs and coping skills. Furthermore, it has been shown that an ecosystemic perspective allows for an exploration of issues beyond individual variables, whereby the relationships between children and their environment, such as parents, siblings, extended family, peers and school, are focused upon to indicate areas of strength and stress. By doing so, assessment is broadened and a number of avenues for intervention can be

identified and targeted. Thus, intervention through the school, caregivers, peers and children are possible routes for producing change.

Overall, literature and practice focusing upon this population is still in its infancy. Current models for practice which stem from shelter-based children's groups, however, are not sufficient to address the multiple needs of this population. While the literature points to more intensive work with children exposed to partner abuse, it offers few guidelines to do so. This practicum has demonstrated the important role of non-offending caregivers for the development of skills for resiliency in general and for the success of the counselling process in particular. Thus, practice which focuses upon the primary relationships between the family and children can be empowering and efficacious. While children's groups and school interventions focus upon prevention, education and the development of social skills, play therapy from an ecosystemic perspective, on the other hand, is able to focus upon the unique issues of children, while encouraging their families to take a proactive role for healing in a post-violence context.

REFERENCES

Abidin, R.R. (1990a). Introduction to the special issue: The stresses of parenting. Journal of Child Psychology, 19, 298-301.

Abidin, R.R. (1990b). Parenting Stress Index: Short Form - Test manual. Charlottesville, Virginia: Pediatric Psychology Press.

Abidin, R.R. (1995). Parenting Stress Index (3rd ed.). Odessa, Florida: Psychological Assessment Resources, Inc.

Achenbach, T.M. (1991). Manual for the Child Behaviour Checklist / 4-18 and 1991 Profile. Burlington, VT: University of Vermont.

Ainsworth, M.D.S. (1973). The development of infant-mother attachment. In Caldwell, B.M & Riccuiti (Eds.). Review of child development research, Vol. 3, (pp. 1-94). Chicago: The University of Chicago Press.

Alessi, J. J., & Hearn, K. (1984). Group treatment of children in shelters for battered women. In A.R. Roberts (Ed.), Battered women and their families: Intervention strategies and treatment programs (pp. 49-62). New York: Springer Publishing Company.

Allen-Meares, P. & Lane, B.A. (1987). Grounding social work practice in theory: Ecosystems. The Journal of Contemporary Social Work, 515-521.

American Psychiatric Association. (1987). Diagnostic and statistical manual of mental disorders, (3rd ed.). Washington, DC: Author.

Anthony, E. J. & Cohler, B.J. (Eds.). (1987). The invulnerable child. New York: The Guilford Press.

Archie, C.L. (1992). Licit and illicit drug use in pregnancy. In N.F. Hacker & J.G. Moore (Eds.). Essentials of obstetrics and gynecology (pp. 189-196). Philadelphia: W.B. Saunders Company.

Arroyo, W. & Eth, S. (1995). Assessment following violence-witnessing trauma. In E. Peled, P. G. Jaffe & J.L. Edleson (Eds.), Ending the cycle of violence: Community responses to children of battered women (pp. 27-42). London: Sage Publications.

Belsky, J. (1984). The determinants of parenting: A process model. Child Development, 55,83-96.

Belsky, J., Lerner, R.M. & Spanier, G.B. (1984). The child in the family. New York: Random House.

Bendell, R.D., Stone, W., Field, T & Goldstein, S. (1989). Children's effects on parenting stress in a low income, minority population. Topics in Early Childhood Special Education, 8, 58-71.

Berry, J.O. & Jones, W.H. (1995). The Parental Stress Scale: Initial psychometric evidence. Journal of Social and Personal Relationships, 12, 463-472.

Bigras, M., LaFreniere, P.J & Dumas, J.E. (1996). Discriminant validity of the parent and child scales of the Parenting Stress Index. Early Education and Development, 7, 167-178.

Bilinkoff, J. (1995). Empowering battered women as mothers. In E. Peled, P. G. Jaffe & J. L. Edleson (Eds). Ending the cycle of violence: Community responses to children of battered women (pp. 97-105). London: Sage Publications.

Birns, B. (1988). The mother-infant tie: Of bonding and abuse. In M.B. Straus (Ed). Abuse and victimization across the life span (pp.9-31). Baltimore: Johns Hopkins University Press.

Bigner, J.J. (1989). Parent-Child relations: An introduction to parenting. New York: Macmillan Publishing Company.

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

Bowlby, J. (1982). Attachment and loss: Vol. 1. Attachment. London: The Hogarth Press.

Bowlby, J. (1988). A secure base: Parent-Child attachment and healthy human development. New York: Basic Books, Inc., Publishers.

Brooks, J.B. (1994). Parenting in the 90s. Toronto: Mayfield Publishing Company.

Bronfenbrenner, U., Moen, P. & Garbarino, J. (1984). Child, family, and community. In R.D. Parke (Ed.), Review of child development research (Vol. 7, pp. 283-328). Chicago: The University of Chicago Press.

Browne, A. (1987). When battered women kill. New York: The Free Press.

Busby, D. M. & Inman, J. R. (1996). Physical abuse of women in marriage. In D. M.Busby (Ed). The impact of violence on the family: Treatment approaches for

therapists and other professionals (pp.10-22). Needham Heights, Massachusetts: Allyn and Bacon.

Carter, B. & McGoldrick, M. (1988). Overview: The changing family life cycle - A framework for family therapy. In B. Carter & M. McGoldrick (Eds.). The changing family life cycle: A framework for family therapy. (pp. 1-28). Boston: Allyn and Bacon.

Cosden, M. (1984). Piers-Harris Children's Self-Concept Scale. In D.J. Keyser & R.C. Sweetland (Eds.). Test critiques: Vol. 1 (pp. 511- 521). New York: Test Corporation of America.

Davidson, T. (1978). Conjugal crime: Understanding and changing the wifebeating pattern. New York: Hawthorn Books, Inc.

Davidson, J.& Smith, R. (1990). Traumatic experiences in psychiatric outpatients. Journal of Traumatic Stress, 3, 459-475.

Dubowitz, H. & Egan, H. (1990). The maltreatment of infants. In M.B. Straus (Ed). Abuse and victimization across the life span (pp. 32-53). Baltimore: Johns Hopkins University Press.

Drell, M. J., Siegel, C. H. & Gaensbauer, T. J. (1993). Post-traumatic stress disorder. In C. H. Zaenah, (Ed). Handbook of infant mental health (pp. 291-304). New York: The Guilford Press.

Echlin, C. & Marshall, L. (1995). Child protection services for children of battered women: Practice and controversy. In E. Peled, P. G. Jaffe & J. L. Edleson (Eds.). Ending the cycle of violence: Community responses to children of battered women (pp. 170-185). London: Sage Publications.

Eth, S. and Pynoos, R. S. (Eds.). (1985). Post-Traumatic stress disorder in children. Washington, DC: American Psychiatric Press, Inc..

Epstein, J.H. (1994). Review of the Piers-Harris Children's Self-Concept Scale (The Way I Feel About Myself). In J.C. Impara & L.L. Murphy (Eds.). Psychological assessment in the schools (pp. 342-344). Lincoln, Nebraska: University of Nebraska-Lincoln.

Fantuzzo, J. W. & Ummel Lindquist, C. (1989). The effects of observing conjugal violence on children: A review and analysis of research methodology. Journal of Family Violence, 4 (1), 77-94.

Fahlberg, V.I. (1991). A child's journey through placement. Indianapolis, IN: Perspectives Press.

Gamache, D. & Snapp, S. (1995). Teach your children well: Elementary schools and violence prevention. In E. Peled, P. G. Jaffe & J. L. Edleson (Eds.). Ending the cycle of violence: Community responses to children of battered women (pp. 209-231). London: Sage Publications.

Garbarino, J., Dubrow, N., Kostelny, K., & Pardo, C. (1992). Children in danger: Coping with the consequences of community violence. San Francisco: Jossey-Bass Publishers.

Garbarino, J. & Gilliam, G. (1980). Understanding abusive families. Lexington, Massachusetts: Lexington Books.

Germain, C.B. (1991) Human behaviour in the social environment: An ecological view. New York: Columbia University Press.

Gil, E. (1991). The healing power of play: Working with abused children. New York: Guilford Press.

Goldman, J., L'Engle-Stein, C. & Guerry, S. (1983). Psychological methods of child assessment. New York: Brunner/Mazel Publishers.

Guerney, L. F. (1983). Client-centred (nondirective) play therapy. In C. E. Schaefer & K. J. O'Conner (Eds.). Handbook of play therapy (pp.21-64). New York: John Wiley and Sons.

Hawley, D.R. & DeHaan, L. (1996). Toward a definition of family resilience: Integrating life-span and family perspectives. Family Process, 35 (3), 283-298.

Holden, G.W. & Ritchie, K.L. (1991). Linking extreme marital discord, child rearing, and child behaviour problems: Evidence from battered women. Child Development, 62, 311-327.

Hughes, H. M. (1982, October). Brief interventions with children in a battered women's shelter: A model preventive program. Family Relations, 31, 495-502.

Hughes, J. N. & Baker, D. B. (1990). The clinical child interview. New York: The Guilford Press.

Jaffe, P., Wilson, S., & Wolfe, D. (1986, October). Promoting changes in attitudes and understanding of conflict resolution among child witnesses of family violence. Ottawa, ON: Family Violence Prevention Division, National Clearinghouse of Family Violence, Health and Welfare Canada.

Jaffe, P. G., Wolfe, D., & Wilson, S. K. (1990). Children of battered women. London: Sage Publications.

Jaffe, P., Wolfe, D., Wilson, S. & Zak, L. (1986). Similarities in behavioural and social maladjustment among child victims and witnesses to family violence. American Journal of Orthopsychiatry, 56, 142-146.

James, B. (1989). Treating traumatized children: New Insights and creative interventions. Lexington, Massachusetts: Lexington Books.

James, B. (1994). Handbook for treatment of attachment trauma problems in children. New York: Lexington Books.

Jeske, P.J. (1994). Review of the Piers-Harris Children's Self-Concept Scale (The Way I Feel About Myself). In J.C. Impara & L.L.Murphy (Eds.). Psychological assessment in the schools. (pp. 344-345). Lincoln, Nebraska: University of Nebraska-Lincoln.

Karen, R. (1990, February). Becoming attached. The Atlantic Monthly, 35-70.

Loosley, S. (1997). Group treatment program. In Loosley, S., Bentley, L., Rabenstein & Sudermann, M. (Eds.). Group treatment for children who witness woman abuse: A manual for practitioners (pp. 27-126). London: Children's Aid Society of London and Middlesex.

Loyd, B.H. & Abidin, R.R. (1985). Revision of the Parenting Stress Index. Journal of Pediatric Psychology, 10, 169-177.

MacLeod, L. (1987). Battered but not beaten ... Preventing wife battering in Canada. Ottawa, ON: Canadian Advisory Council on the Status of Women.

Mathews, D. J. (1995). Parenting groups for men who batter. In E. Peled, P. G. Jaffe & J. L. Edleson (Eds). Ending the cycle of violence: Community responses to children of battered women (pp. 106-120). London: Sage Publications.

McAlister Groves, B. (1991). (unnamed chapter). In Zero to Three/ National Centre for Clinical Infant Programs. Can they hope to feel again? The impact of community violence on infants, toddlers, their parents and practitioners: A report from the final plenary session seventh biennial national training institute (pp. 20-27). Washington, DC: Author.

McMahon, L. (1992). The handbook of play therapy. London: Tavistock/Routledge.

Miedzian, M. (1995). Learning to be violent. In E. Peled, P. G. Jaffe & J. L. Edleson (Eds). Ending the cycle of violence: Community responses to children of battered women (pp. 10-26). London: Sage Publications.

Miller, K. (1985). Ages and stages: developmental descriptions and activities: birth through eight years. Chelsea, Massachusetts: Telshare Publishing Co, Inc..

Miller, S. B.(1995). When parents have problems: A book for teens and older children with an abusive, alcoholic, or mentally ill parent. Springfield, Illinois: Charles C. Thomas Publisher.

Mullender, A. & Morley, R. (Eds.). (1994). Children living with domestic violence: Putting men's abuse of women on the child care agenda. London: Whiting and Birch Ltd.

Murphy, L. B. & A. E. Moriarty (1976). Vulnerability, coping, and growth: From infancy to adolescence. New Haven, CT: Yale University Press.

National Clearinghouse on Family Violence. (1993, February). Parent-child relationships. Ottawa: Health and Welfare Canada.

Nichols, M.P. & Schwartz, R.C. (1995). Family therapy: Concepts and methods. Boston: Allyn and Bacon.

Pagelow, M.D. (1984). Family violence.New York: Praeger Special Studies.

Peled, E. & Davis, D. (1995). Groupwork with children of battered women: A practitioner's guide. London: Sage Publications.

Peled, E. & Edleson, J. L. (1995). Process and outcome in small groups for children of battered women. In E. Peled, P. G. Jaffe & J. L. Edleson (Eds). Ending the cycle of violence: Community responses to children of battered women (pp. 77-96). London: Sage Publications.

Piers, E. V. (1984). Piers-Harris Children's Self-Concept Scale (Revised Manual). Los Angeles: Western Psychological Services.

Porter, B. & O'Leary, K. D. (1980). Marital discord and childhood behaviour problems. Journal of Abnormal Child Psychology, 8, 287-295.

Pressman, B. M. (1984). Family violence: Origins and treatment. Guelph, ON: Children's Aid Society of the City of Guelph/University of Guelph.

Pressman, B.M. (1987). Family violence: Origins and treatment. Guelph, ON: Raithby House, University of Guelph.

Rabenstein, S. (1997). Parent child group program. In S. Loosley, L. Bentley, Rabenstein & M. Sudermann (Eds.). Group treatment for children who witness woman

abuse: A manual for practitioners (pp. 127-136). London: Children's Aid Society of London and Middlesex.

Rosenbaum, A. & O'Leary, K. D. (1981). Children: The unintended victims of marital violence. American Journal Orthopsychiatry, 51 692-699.

Roy, M. (1988). Children in the crossfire: Violence in the home-How does it affect our children?. Deerfield Beach, FL: Health Communications, Inc.

Rutter, M. (1983). Stress, coping and development: Some issues and some questions. In N. Garmezy & M. Rutter (Eds.) Stress, coping and development in children (pp. 1-42). New York: McGraw-Hill Book Company.

Shirk, S. R. (1988). The interpersonal legacy of physical abuse of children. In M. B. Straus (Ed.). Abuse and victimization across the life span (pp. 57-81). Baltimore : Johns Hopkins University Press.

Silber, S. (1989, Winter). Family influences on early development. Topics in Early Childhood Special Education, 8 (4), 1-23.

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

Silvern, L., Karyl, J., & Landis, T.Y. (1995). Individual psychotherapy for the traumatized children of abused women. In E. Peled, P. G. Jaffe & J. L. Edleson (Eds). Ending the cycle of violence: Community responses to children of battered women (pp. 43-76). London: Sage Publications.

Sopp-Gilson, S. (1980). Children from violent homes. Ontario Association of Children's Aid Societies, 23(10), 1-5 &10.

Statistics Canada. (1994). Family violence in Canada. Ottawa: Minister of Industry, Science and Technology.

Steinhauer, P.D. (1991). The least detrimental alternative: A systematic guide to case planning and decision making for children in care. Toronto, ON: University of Toronto Press.

Straus, M. B. (Ed.) (1990). Abuse and victimization across the life span. Baltimore: The Johns Hopkins University Press.

Straus, M. A., Gelles, R. J. & Steinmetz, S. K. (1980). Behind closed doors: Violence in the american family. New York: Anchor Press/Doubleday.

Sudermann, M. (1997). Evaluation of groups for children who have witnessed violence. In Loosley, S., Bentley, L., Rabenstein & Sudermann, M. (Eds.). Group treatment for children who witness woman abuse: A manual for practitioners (pp. 141-150). London: Children's Aid Society of London and Middlesex.

Sudermann, M., Jaffe, P. G.& Hastings, E. (1995). Violence prevention programs in secondary (high) schools. In E. Peled, P. G. Jaffe & J. L. Edleson (Eds). Ending the cycle of violence: Community responses to children of battered women (pp. 232-254). London: Sage Publications.

Terr, L. (1990). Too scared to cry: Psychic trauma in childhood. New York: Harper and Row Publishers.

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

Walker, L.E.A. (1986). Psychological causes of family violence. In M. Lystad (Ed.). Violence in the home: Interdisciplinary perspectives (pp. 71-97). New York: Brunner/Mazel Publishers.

Walker, L.E.A. (1993). The battered woman syndrome is a psychological consequence of abuse. In R.J. Gelles & D.R. Loseke (Eds.). Current controversies on family violence (pp. 133-153). London: Sage Publications.

Walsh, F. (1996). The concept of family resilience: Crisis and challenge. Family Process, 35 , 261-281.

Werner, E. E. (1990). Protective factors and individual resilience. In S. J. Meisels & J. P. Shonkoff (Eds). Handbook of early childhood intervention. Cambridge, England: Cambridge University Press.

Westra, B. & Martin, H. P. (1981). Children of battered women. Maternal-Child Nursing Journal, 10, 41-54.

Wodrich, D. L., & Kush, S. A. (1990). Children's psychological testing: A guide for nonpsychologists. Baltimore: Paul H. Brookes Publishing Company.

Wohl, A.& Kaufman, B. (1985). Silent screams and hidden cries: An Interpretation of artwork by children from violent homes. New York: Brunner/Mazel Publishers.

Wolfe, D. A., Zak, L., Wilson, S. & Jaffe, P. (1986). Child witnesses to violence between parents: Critical issues in behavioural and social adjustment. Journal of Abnormal Child Psychology, 14 , 95-104.

Appendix A
Announcement for Referrals

The Elizabeth Hill Counseling Centre is now accepting referrals for play therapy with:

Children Who Have Witnessed Violence

who is eligible?
- boys & girls
- ages 4-12

where?
- Elizabeth Hill Counseling Centre
  301-321 McDermot Ave

cost?
- free of charge

If interested or for more information, please call:

Joanna 956-6560

Appendix B

Letter to Agencies

Joanna Salit
c/o Elizabeth Counseling Centre
301-321 McDermot Ave
Winnipeg, MB
R3A 0A3
(204) 956-6560

(address of agency)

October 4, 1996

Dear --- ,

As we had discussed over the phone, I am a Masters of Social Work student at the University of Manitoba and am currently accepting referrals for my practicum. In particular, I will be engaging in individual play therapy at the Elizabeth Hill Counseling Centre with children between the ages of four and twelve who have witnessed violence in their homes. Enclosed are flyers which may be posted at your office and/or distributed among your staff. Interested clients or workers can contact me at 956-6560 for referring purposes or for more information. Additionally, I am available to meet with your staff so as to discuss the practicum in greater detail. I hope that I will speak with you again in the near future.

Thank you,

Joanna Salit

Appendix C
Consent Forms

THE UNIVERSITY OF MANITOBA ELIZABETH HILL COUNSELLING CENTRE

301-321 McDermot Avenue
Winnipeg, Manitoba
Canada R3A 0A3

Tel: (204) 956-6560
Fax: (204) 943-4073

I hereby consent to allow the Elizabeth Hill Counselling Centre of the University of Manitoba to assess and/or treat the following minor child:

_____

Signature: _____
(Parent or Guardian)

Witness: _____

Date: _____

THE UNIVERSITY OF MANITOBA ELIZABETH HILL COUNSELLING CENTRE

301-321 McDermot Avenue
Winnipeg, Manitoba
Canada R3A 0A3

Tel: (204) 956-6560
Fax: (204) 943-4073

PERMISSION FOR OBSERVATION

In utilizing the services of the Elizabeth Hill Counselling Centre of the University of Manitoba, clients are participating in the activities of a teaching centre. As a client, I understand:

1) That information obtained from psychological tests, interviews, psychotherapy sessions, or follow-up questionnaires may be shared with clinical supervisors and with other clinicians-in-training during case conferences;
2) That information, whether on paper or computer record, is shared solely for the purposes of aiding treatment, contributing to student training, and Centre administration and research;
3) That all information is kept under strict conditions of professional confidentiality;
4) That observation and/or audiotaping or videotaping of a therapy session may be required.

Read and agreed to:
Name of Client(s):

_____

Signature of Client(s)
of Parent/Guardian(s):

_____ _____
Date

_____

Signature of Clinician
or Other Witness:

_____ _____
Date

ELIZABETH HILL COUNSELLING CENTRE

301-321 McDERMOT AVENUE
WINNIPEG, MANITOBA R3A 0A3

It has been explained to me that the Elizabeth Hill Counselling Centre is also a training and research facility. As a recipient of service at the Centre I understand:

- That the service I, and those who are in my care, will receive is part of a practicum for the Masters of Social Work program at the University of Manitoba.
- That any information obtained from psychological tests, interviews, counselling sessions and questionnaires may be used as a part of a published evaluation of this practicum.
- That the information gathered as part of this practicum can only be reported in a manner which does not reveal my identity or that of anyone in my care.

My signature below indicates I have read and understood this document and agree to being involved, or having those in my care involved, in this practicum.

Signature of client(s) or parent/guardian:

_____

_____ Date _____

Signature of clinician or other witness:

_____ Date _____

Appendix D
Consumer Feedback: Caregiver

FEEDBACK FORM

The purpose of this form is to provide you with the opportunity to give me feedback about the counselling you and your child(ren) received at the Elizabeth Hill Counselling Centre.

1. What was most helpful about coming for counselling?

2. What was least helpful about coming for counselling?

3. What did you like about coming for counselling?

4. What didn't you like about coming for counselling?

5. Do you have any other comments or suggestions?

Appendix E
Consumer Feedback: Child

FEEDBACK FORM

I would like to know your thoughts and feelings about coming to the Elizabeth Hill Counselling Centre.

1. What was good about coming to the Elizabeth Hill Counselling Centre?

2. What was not so good about coming to the Elizabeth Hill Counselling Centre?

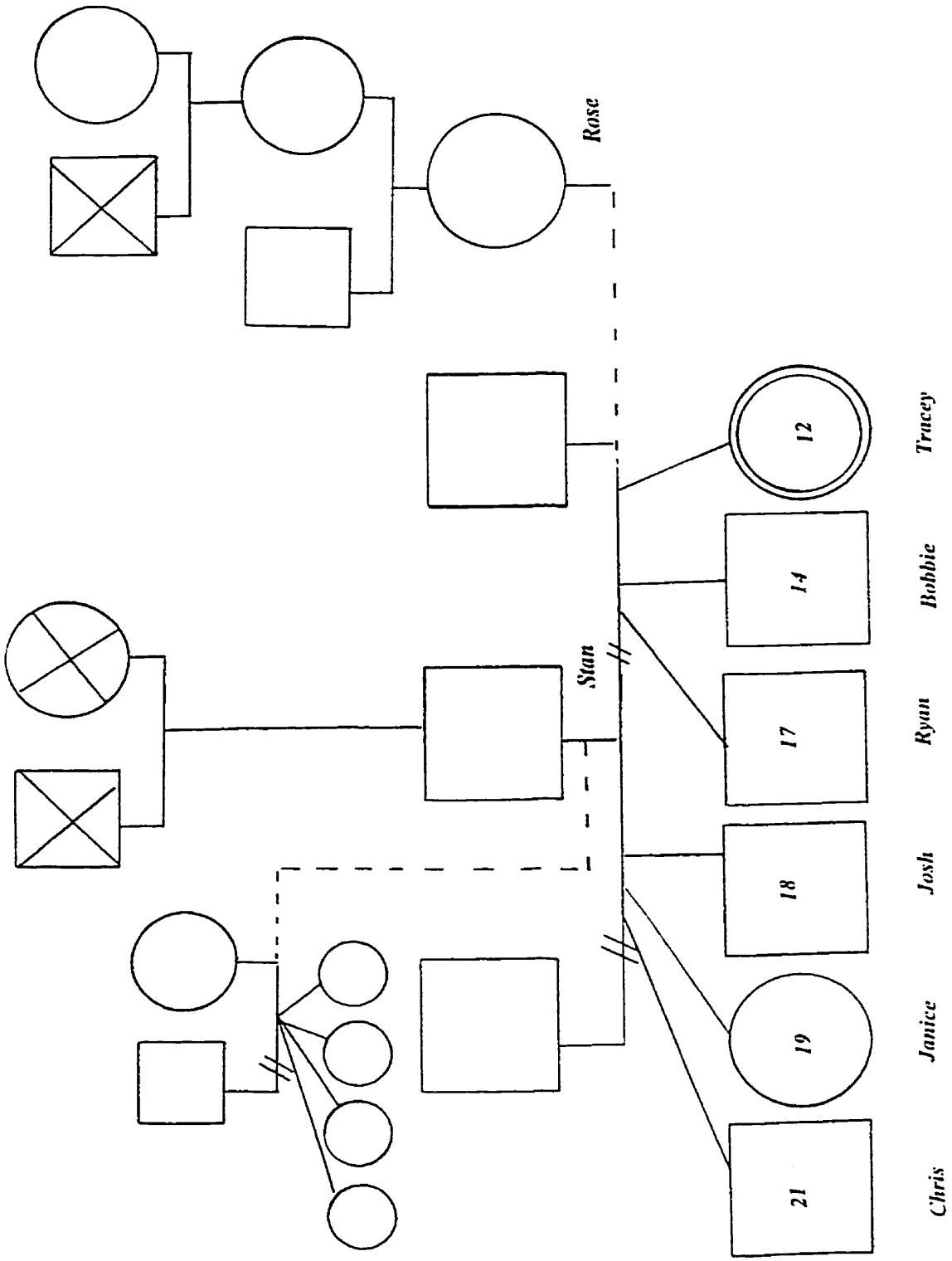
3. What did you learn from coming to the Elizabeth Hill Counselling Centre?

4. If things could have been different about coming to the Elizabeth Hill Counselling Centre, how would you have changed them?

5. Is there anything else you would like to say about coming the Elizabeth Hill Counselling Centre?

Appendix F

Tracey's Genogram



Appendix G

Summary of quantitative scores

	Tracey		Kirsten		Sean		Joey	
	Pre	Post	Pre	Post	Pre	Post	Pre	Post[1]
Parenting Stress Index/Short Form (PSI/SF)[2]								
Total Stress Score	99+ (144)	85 (84)	95 (99)	81 (83)	90 (90)	97 (107)	96 (102)	--
Parental Distress	99+ (49)	55 (26)	86 (34)	65 (28)	75 (30)	83 (32)	80 (31)	--
Parent-Child Dysfunctional Interaction	99+ (41)	80 (25)	91 (28)	70 (23)	91 (28)	96 (31)	92 (29)	--
Difficult Child	99+ (54)	85 (33)	91 (37)	81 (32)	83 (32)	97 (44)	96 (42)	--
Defensive Responding[3]	99+ (31)	80 (16)	96 (20)	95 (19)	95 (19)	97 (21)	99+ (31)	--
Child Behaviour Checklist (CBCL)[4]								
Total Score	75 (88)	61 (39)	66 (52)	55 (29)	49 (20)	--[5]	71 (66)	--
Internalizing	76 (31)	60 (14)	71 (23)	59 (11)	43 (2)	--	71 (19)	--
Externalizing	75 (33)	64 (16)	58 (13)	52 (8)	56 (14)	--	65 (21)	--
I. Withdrawn	67 (8)	54 (3)	73 (9)	62 (4)	50 (0)	--	54 (2)	--
II.Somatic Complaints	63 (4)	66 (5)	62 (3)	62 (3)	50 (0)	--	67 (4)	--

	Tracey		Kirsten		Sean		Joey	
	Pre	Post	Pre	Post	Pre	Post	Pre	Post
III. Anxious / Depressed	83 (20)	61 (7)	69 (12)	57 (5)	50 (2)	--	75 (14)	--
IV. Social Problems	69 (7)	55 (2)	63 (4)	52 (2)	55 (3)	--	73 (8)	--
V. Thought Problems	67 (3)	63 (2)	67 (3)	65 (2)	50 (0)	--	70 (4)	--
VI. Attention Problems	76 (13)	57 (4)	67 (8)	61 (5)	50 (1)	--	75 (13)	--
VII. Delinquent Behaviour	73 (8)	61 (3)	57 (2)	52 (1)	55 (2)	--	59 (3)	--
VII. Aggressive Behaviour	78 (25)	64 (13)	57 (11)	52 (7)	57 (12)	--	65 (18)	--
Youth Self Report (YSR)								
Total Score	64 (71)	69 (85)						
Internalizing	64 (26)	75 (38)						
Externalizing	67 (23)	70 (26)						
I. Withdrawn	63 (7)	69 (9)						
II. Somatic Complaints	69 (10)	74 (12)						
III. Anxious / Depressed	55 (9)	68 (17)						
IV. Social Problems	62 (5)	65 (6)						
V. Thought Problems	65 (6)	65 (6)						
VI. Attention Problems	67 (10)	65 (9)						
VII. Delinquent Behaviour	70 (9)	67 (7)						

	Tracey		Kirsten		Sean		Joey	
	Pre	Post	Pre	Post	Pre	Post	Pre	Post
VIII. Aggressive Behaviour	63 (14)	69 (19)						
Piers-Harris[6]								
Total Score	56 (61)	62 (68)	56 (61)	56 (62)	62 (68)	63 (69)	38 (34)	--
I. Behaviour	71 (16)	46 (11)	54 (14)	59 (15)	48 (12)	55 (14)	39 (8)	--
II. Intellectual and School Status	50 (12)	52 (13)	42 (9)	48 (11)	63 (16)	60 (15)	39 (7)	--
III. Physical Appearance and Attributes	69 (12)	60 (11)	53 (9)	64 (12)	53 (9)	64 (12)	24 (3)	--
IV. Anxiety	47 (8)	47 (8)	69 (14)	59 (12)	59 (12)	69 (14)	34 (1)	--
V. Popularity	55 (10)	47 (8)	61 (11)	51 (9)	51 (9)	69 (12)	39 (5)	--
VI. Happiness and Satisfaction	63 (10)	63 (10)	56 (9)	63 (10)	63 (10)	63 (10)	36 (5)	--

[1] Note: Only pre-test data was gathered for Joey due to early termination.

[2] Note: For the PSI/SF, percentile ranks are reported and raw scores indicated in brackets. Higher scores indicate significant issues.

[3] Note:"The DEFENSIVE RESPONDING scale asseses the extent to which the respondent approaches the questionnaire with a strong bias to present the most favourable picture of herself to minimize indications of problems or stress in the parent-child relationship."(Abidin, 1990, P.18). The critical score is less than 11.

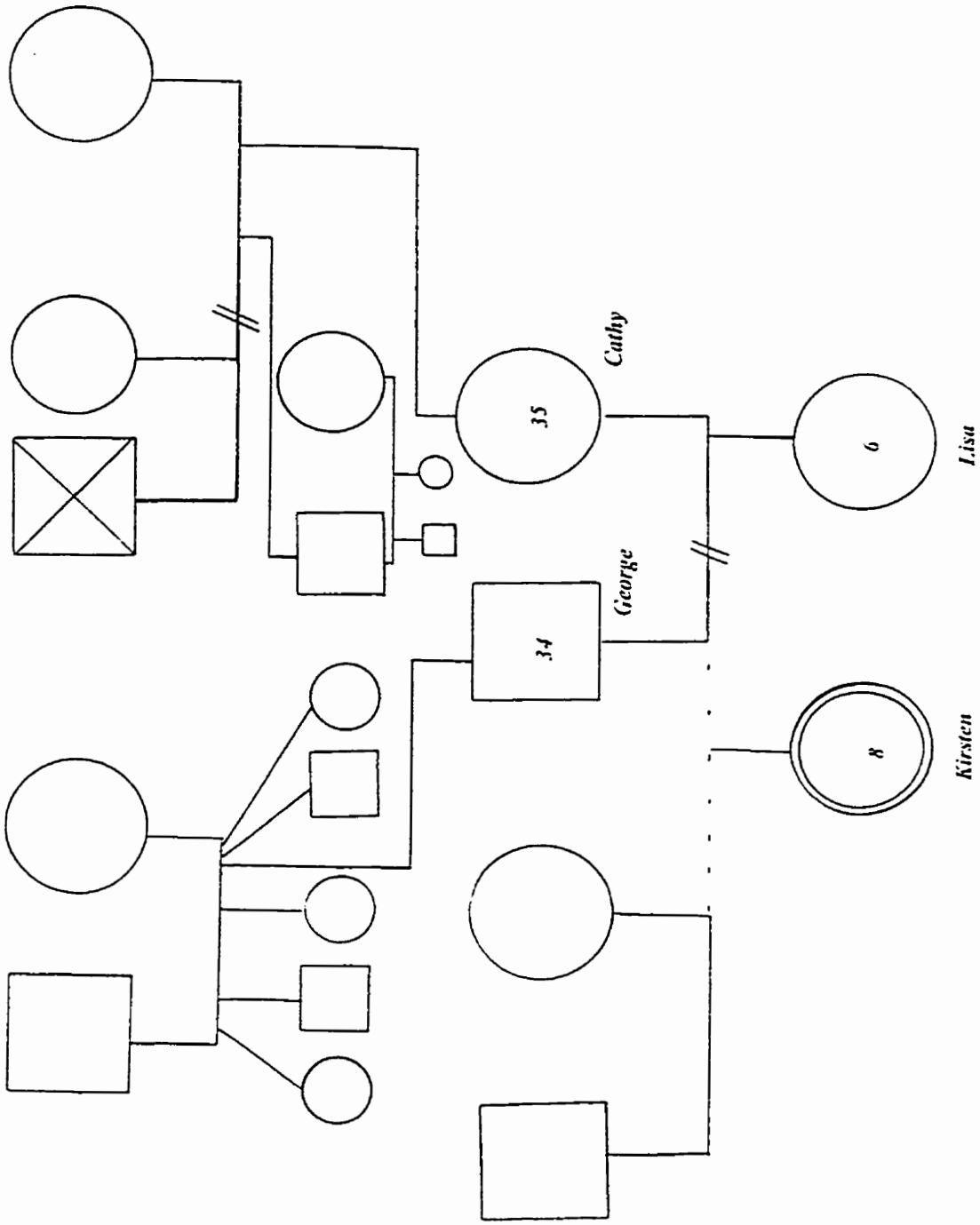
[4] Note: T-scores are reported for the CBCL and YSR. The raw scores are noted in brackets. Low scores indicate lack of behavioural problems. T-scores below 67 are in the normal range. T-scores of 67 to 70 are in the borderline range. T-scores above 70 are in the clinical range.

[5] Note: There were eleven invalid reponses on the post-test CBCL for Sean. The manual indicates that problem scale scores or total scores should not be completed when there are more than eight items missing (Achenbach, 1991).

[6] Note: For the Piers-Harris Children's Self-Concept Scale, T-scores are reported and raw scores are noted in brackets.High scores indicate positive self-concept.

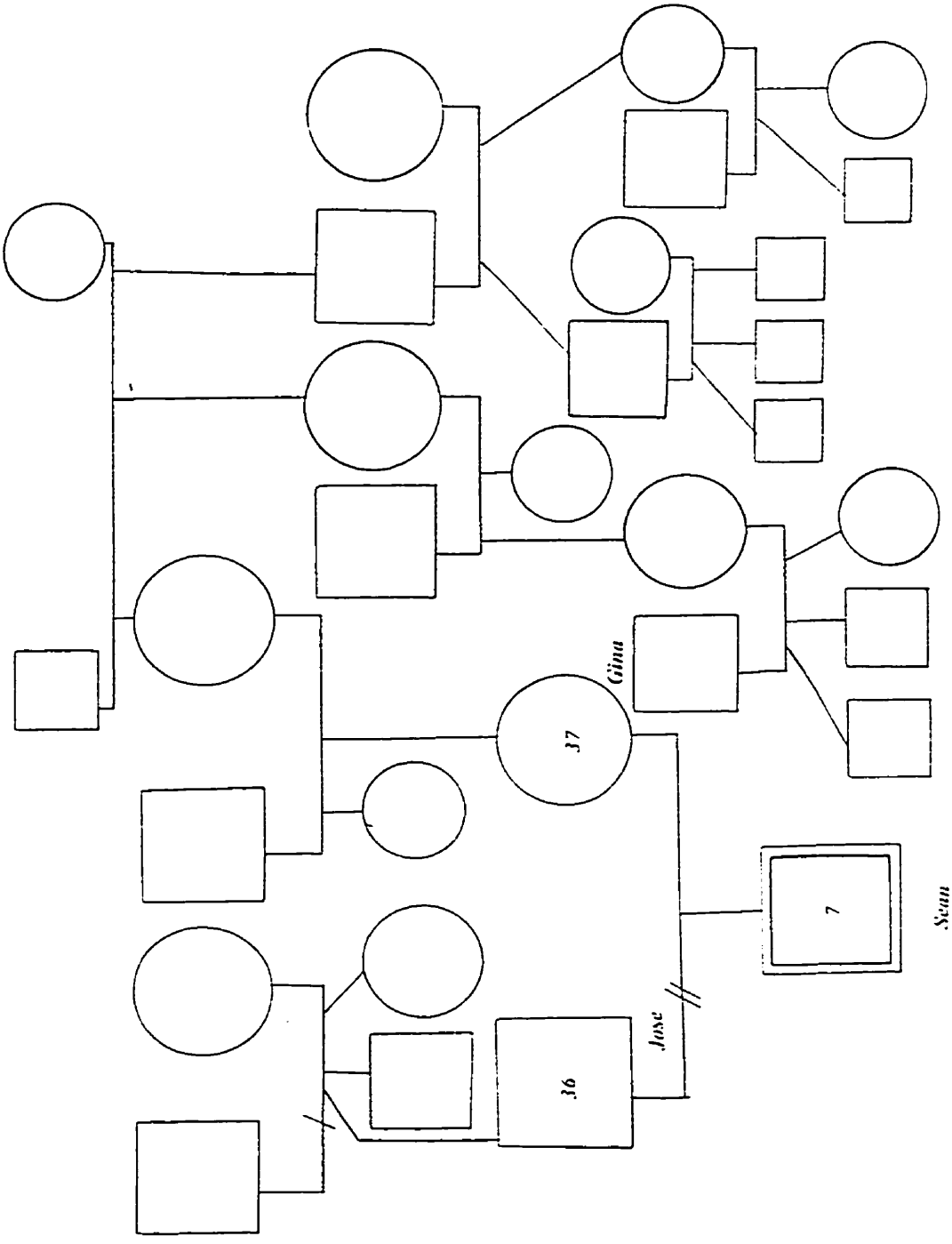
Appendix H

Kirsten's Genogram



Appendix I

Sean's Genogram



Appendix J

Joey's Genogram

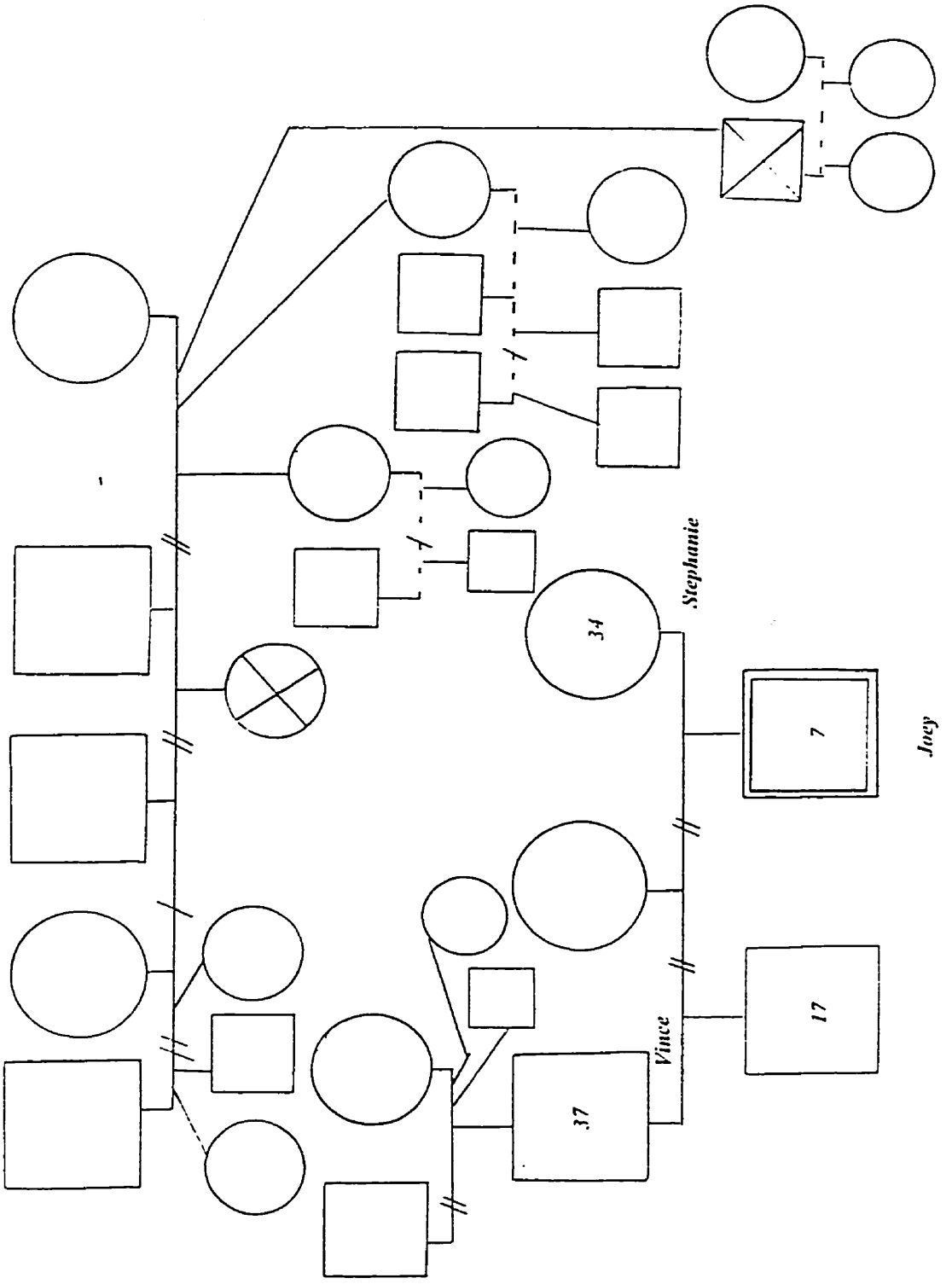
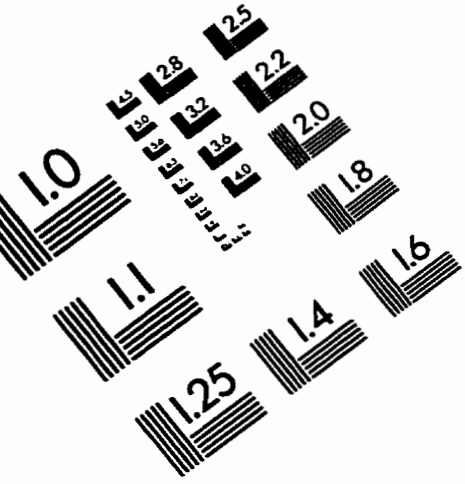
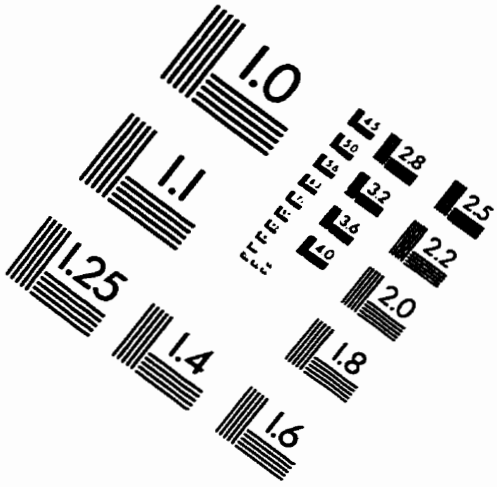
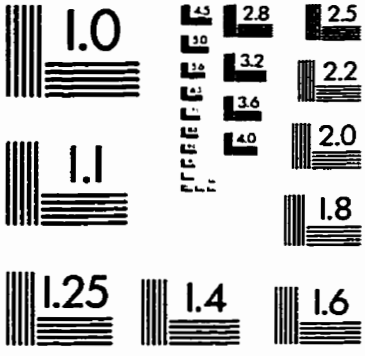
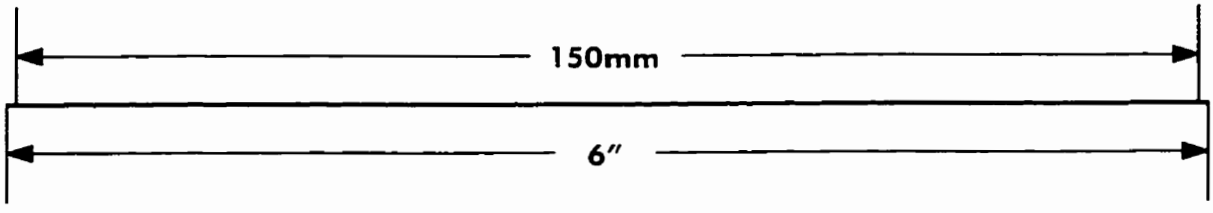


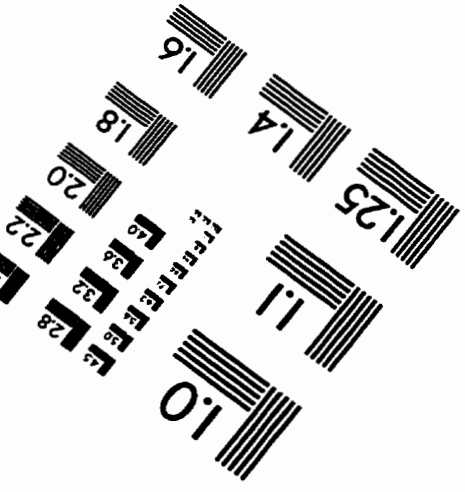
IMAGE EVALUATION
TEST TARGET (QA-3)

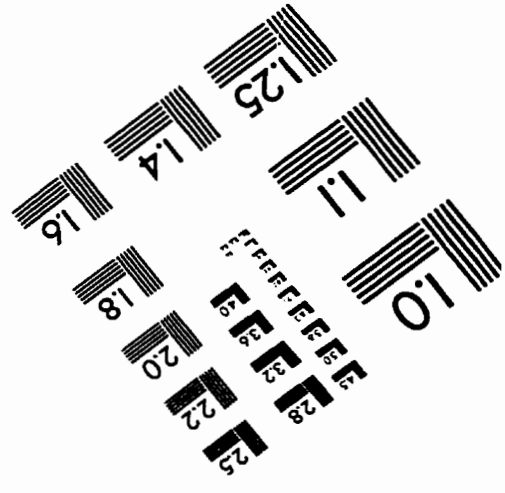












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