PARENTING THE PARENT IN A CHILD WELFARE SYSTEM: A Systemic Perspective with At Risk to Abuse Multi-Agency Families

by

Therese Costes

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July 12, 1989

Therese Costes

Winnipeg, Manitoba

Dear Miss Costes:

Thank you for your letter of May 27th requesting permission to use the Parenting Scale which we developed for the Special Families Care Project. We would be very pleased for you to use the measure in you practicum work. Obviously we would be interested in any feedback you might have. We are still in the process of refining the measure. Since it was first printed in the the Journal of Maternal/Child Nursing, there have been several changes.

Please let me know if you require any further assistance.

Sincerely,

(

Joan Velasquez, M.S.W., Ph.D.
Research Administrator

ARF

August 16, 1989.

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Therese Costes

Winnipeg, Manitoba
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Dear Ms. Costes,

I am responding to your recent letter regarding the Family Assessment Measure. You have my permission to use FAM-III in your practicum work with Multi-Agency Families.

Please respect our copyright and do not make copies of the instrument available to others without my permission.

Obviously, I would be quite interested in your findings. All the best with your research and please let me know if I can provide you with further information.

Sincerely,

Dr. Harvey A. Skinner
Professor and Chairman
Department of Behavioural Science
Faculty of Medicine
University of Toronto
and
Senior Scientist
AddictionResearchFoundation

PARENTING THE PARENT IN A CHILD WELFARE SYSTEM: A SYSTEMIC PERSPECTIVE WITH AT RISK TO ABUSE MULTI-AGENCY FAMILIES

BY

THERESE COSTES

A practicum submitted to the Faculty of Graduate Studies of the University of Manitoba in partial fulfillment of the requirements of the degree of

MASTER OF SOCIAL WORK

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Chapter One

Introduction

Over the years as our child welfare system has grown and gained in sophistication, the labels used to describe the family relationships, situations and problems that this system must daily confront have also become more sophisticated. This transformation is the result of attitudinal changes taking place in our culture at both the social and the helping systems level. This has been an ongoing process. To find evidence of it one need only look to the way in which the concept and definition of the term 'family' has changed over the last forty years. Out of demographic necessity this definition has come to include single parent, blended and divorced families. This new awareness and recognition of families has in turn greatly affected the services available to them.

Today the treatment goals and needs of families in trouble are being seriously questioned and re-evaluated by the social services. Techniques are changing. As one example of this change, we can observe the treatment of multi-agency families, or those families involved simultaneously with three or more helping systems. As helpers become more aware of the unique issues, challenges and systemic implications that working with multi-agency families has to offer, the attitudinal shifts which take place are reflected in the new nonjudgmental language used to describe these families. Families who were once labeled 'disorganized', 'underorganized' or 'multi-problem' are now referred to as 'multi-agency families'. Behavior which was once deemed

resistant or defiant, is now judged less harshly when put into a systemic framework.

Tracking multi-agency families, one observes that they share common characteristics. Such families often operate from crisis to crisis, and engage more and more helpers in an attempt to stabilize the system. We now view this pattern as a natural process for multi-agency families. This splitting and triangulation of agencies has in the past caused interventions to be poorly conceived, and resulted in conflictual and/or overlapping service provision. If the threat of intergenerational child abuse is added, the picture becomes even more disturbing. With the concern about abuse comes a new urgency for appropriate intervention and resources. Children abused or at risk for abuse must be protected and the family must be serviced. Addressing these treatment goals with multiple agency involvement can be a monumental task.

This practicum focuses on three aspects of that task: joining with multi-agency families, evolving an intervention which combines an intrapersonal and systemic perspective, and coordinating the helping network.

Generally, multi-agency abusing families have had many disappointing and unpleasant interactions with the child welfare system, leaving them mistrusting and suspicious of helpers in general. Families may have experienced coercion, and the forced removal of members by child welfare workers. Infrequent and fragmented contact may have resulted in poor quality service. This may have been further compounded by the family's inability to comprehend the necessity of intervention, and thus their natural inclination to resist such service.

One observes that the adults in such families are generally low in self-esteem, possess poor socialization and cognitive skills and often have many unresolved issues related to their own abuse. Adults and children are in competition for nurturance, validation and attention.

Ideally, because of mistrust, distorted perceptions, and a natural resistance to unwelcome change on the part of these families, common sense dictates that as a worker, one must join very carefully and slowly with these families. Ironically, however, the nature of the present child welfare system hinders this process.

Multi-agency families involved in intergenerational abuse typically enter the system at the child welfare level and have their most frequent contact with front line child welfare workers. In our social service hierarchy it is at this level that our most recent graduates and those workers with the least clinical experience and training are employed. Thus, the helpers who are least experienced, trained and supported must work with a very complex and challenging client population. And because it is not uncommon for such a worker to be expected to service a caseload of 50 to 65 families with resources that can service only half that number, the worker is further saddled with the very difficult job of deciding which families receive help and which families do not. As a consequence, intervention is typically from crisis to crisis. Workers have neither the time, the energy nor the experience to focus on a long term therapeutic plan. As contact is sporadic and inconsistent, the joining that does occur between family and worker is out of necessity brief and fragmented. As a further complication, despite inadequate joining, the worker is still called upon to play the role of the "heavy" when intervening in an

abusive situation, and when involved in discussing such issues as apprehension, court orders of supervision, and continued monitoring of the abuse.

While certainly not impossible, the expectation that one person play both the role of heavy and of therapist necessitates that such a person be highly skilled and experienced in using agency mandate as an entry into therapy. Practically speaking, one must also have the time to arrange regular contact with clients. Poor joining will most certainly render intervention ineffectual. And it seems obvious from the issues presented here that, in our present situation, front line child welfare workers are in no position, both because of skill and time, to undertake this necessary joining process with the family.

What is needed is a member of the team who <u>can</u> evolve a long term therapeutic relationship and use it as a basis for intervention, and who is also free of the front line child welfare stigma, and does not operate under a mandate to apprehend children. When these pressures are relieved, such a worker is then free to undertake the delicate task of joining with the family .

Research (Helfer and Kempe, 1976; Kaplan, 1986; Melnick and Hurley, 1969; and Steele and Pollack, 1968) indicates that intergenerational abusers are locked in a cycle of abuse. They abuse their own children and were themselves often abused as children. Abusing adults and adults who allow abuse to be perpetrated are often developmentally arrested at the age of their own abuse. Sometimes the cycle of abuse can be traced back for several generations. Many dysfunctional family interactions and patterns can be identified in intergenerational abusing families, such problems encompass the family's communication style, affective expression, and socialization. It has

been this writer's experience that in addition one can uncover in the adult(s) in the family, a wealth of unaddressed and unresolved individual material pertaining to the abuse they suffered a generation before. To address only the present dysfunctional family interactions, as some systems models do, is to ignore the developmental arrest and unresolved issues of the adults in the family. While some systems models do allow for more flexibility regarding the amount of attention paid to generational issues, if one uses a systemic model alone, one runs the risk of failing to successfully address unresolved individual issues and of providing family members with the degree of support, nurturance and focus on development of personal skills, coping strategies and competencies required to face the demands life places on such families. The adults in these families must develop skills to deal with chronically poor self-esteem and a lack of confidence. This requires a blend of individual and systems perspectives. In their emotionally deprived state, the children and adults in this family begin to compete jealously for the therapist's attention and nurturance, resisting the focus of the systemic model that fails to address each member's individual deprivation. In such a family, the degree of deprivation and stress expressed in family sessions may serve to compromise the therapist's "neutrality". Individual sessions may be concurrently required to meet individual needs for further attention. By combining an intrapersonal and systemic perspective, one has the opportunity to re-parent the parent while also addressing dysfunctional intergenerational patterns.

When working with multi-agency abusing families I have encountered families involved simultaneously with up to 15 agencies. These agencies typically include child welfare, judicial, economic assistance, daycare,

homemaking, and child protection. Sometimes these agencies have become involved on a piece-meal basis as the family has sought out services during a crisis. In other instances these services have been imposed on the family when it is judged to be at risk by outside systems such as child welfare or the court. When a service is imposed on a family, the family may disagree regarding the necessity or desirability of the service. Often the imposed service is introduced because of concern about the possibility of child neglect or abuse. When this concern originates from outside the family system, one can not assume that the family is also aware of the problem. If they are not, the task becomes making the family aware of how and why specific risks do exist. If the family remains unaware, intervention will have little meaning. This is an important phase of intervention that in our present system is sometimes ignored. Instead the confusion in such families over the need and purpose of intervention is labeled as resistance and the family is thought to be incorrigible.

As each agency goes about assessing and servicing the family, it does so from its own autonomous vantage point. Regularly the mandates and philosophical orientations of these agencies conflict, overlap and generally confuse one another. Agencies may disagree as to the degree of risk or the definition of prevention and/or treatment. The family is caught up in this cross fire, but is unable to empower itself to challenge the services being offered. Ironically, rather than breaking the pattern of intergenerational abuse, the system is helping the family to perpetuate its role as victim as it is 'done to', and buffeted around in a confusing and contradictory manner by the very agencies who offer help.

Viewing helpers systemically, it becomes clear that what is needed is a way of sorting out services to the family. Helpers need to come together as a team to decide whose continued involvement is necessary, whose is not, and how services in the future can be offered in a more unified noncontradictory manner.

The logical player to coordinate this process may be the member of the team who can evolve a long term therapeutic intervention, who also is free of the front line child welfare stigma, and who does not operate under a mandate to apprehend children. When these responsibilities are kept separate from the therapeutic tasks, the therapist is then able to act as an advocate for the family and to help empower them to take an active part in their own treatment plan.

During the past three years, I have become increasingly aware of the failure of the system to effectively service the population of at risk to abuse multi-agency families. At the same time I have begun to recognize that as an in-home treatment worker, attempting to establish intense, trusting relationships with the families I service, I am the team member best equipped to advocate for and empower the family while coordinating the helping system. To accomplish this it becomes necessary to look more carefully at the issues of the population and its helping system. It has been my experience that problems in treatment seem to commonly occur in one or more of three important areas: joining with the family, evolving an intervention and coordinating the roles of the helpers in the system. Already knowing the characteristics of these families, as well as the possible pitfalls of the system, I wondered if it would be possible to evolve a model of intervention which

would offer more appropriate and coordinated services to the population of at risk to abuse multi-agency families.

Personal Learning Goals

The purpose of this practicum was to develop a model of intervention to be used with at risk to abuse multi-agency families which took into consideration their unique characteristics and issues. Here multi-agency families were defined as single parent or two parent families who continued to have contact concurrently with three or more social service agencies, and who were at risk for the intergenerational emotional and/or physical abuse of children. Intergenerational child abuse was defined as abuse involving at least three generations, with the abused child in his/her family of origin becoming the abuser of his/her own children in the next generation. To help limit the scope of this practicum, sexual abuse was not addressed.

While the families targeted for this practicum were those who had not yet evolved a pattern of physically abusing their children, in some cases single incidences of harsh physical punishment had already occurred. The emotional abuse of children in the family may also have been ongoing for some time. Furthermore, while it was my intent to look at child abuse from an intergenerational perspective, practically speaking, this was accomplished by working with the second and third generations of a family (parents and children), and using their perceptions about the first generation (grandparents). The difficulty in relying on this method of information gathering was that in the initial stages of therapy, the second generation (parents who were abused as children and who are now at risk to abuse their

own children) had a tendency to minimize the severity of their own abuse (Buck, 1984). The intervention model focused on three important therapeutic tasks: joining successfully with multi-agency families, evolving an intervention that combines an intrapersonal focus with a systemic family therapy perspective, and coordinating the helping network from a network perspective.

1. JOINING WITH THE FAMILY--

As already alluded to, I suspected that the process of joining with multi-agency families would require long term, intense work on the part of the therapist. In order to address intrapersonal and systemic issues, I wondered to what degree it would be necessary for the therapist to develop a nurturing, trusting relationship with each family member. Families entered the therapeutic process at various levels of readiness and awareness. Some families were well aware of the issues to be addressed, others were not. When this was the case, the therapist's initial task was to bridge the gap between the family's perception of existing risk and the degree of risk for abuse perceived by other outside systems. I guessed that it would be important to know whether the label of 'at risk' was coming from inside or outside of the family, what being 'at risk' entailed, who else in the system was in agreement, and with whom this information had been shared. I suspected that my strategy for joining with the family would be influenced by all of the above information. In addition, I was interested in answering the following questions:

a. given that some families experienced inadequacies in cognition and socialization, and had unpleasant dealings in the

past with helpers, how could the therapist avoid being perceived as an extension of a child welfare agency, so that the necessary separation between treatment and monitoring was clear to the family?

b. while intervention was focused on the adults in the family, what additional resources and services would be necessary to protect and acknowledge the daily developmental needs of the abused child so that one could then be free to focus on joining with the adults in the family?

c. Was a more long term, gradual joining process required with this population? Because of the nature of parental deprivation and issues of trust, would it be an ongoing process throughout therapy?

d. How did the process of joining differ with families who openly acknowledged the risk of abuse versus families who did not?

2. INTERVENTION INTRAPERSONALLY AND SYSTEMICALLY --

It seemed that the complex issues involved in the treatment of multi-agency families would necessitate that treatment goals and a direction for therapy begin with good assessment. In this practicum assessment was to take place at the individual and the interpersonal level. The goals for therapy would be based on the outcome of the assessment. Assessment would then be directed to four areas: individual needs (basic trust, validation, autonomy, sense of mastery, differentiation, nurturance and love); family needs (flexibility,

adaptability, clear roles and expectations, good communication, congruent affective expression, and appropriate boundaries); parenting needs (healthy attachment, adequate physical care, protection, nurturance, and appropriate behavior management); and the joining process (client agrees to meet worker, worker gathers information in order to understand the client's perception about the world and self, relationship of basic trust is being established, client begins to use therapist as a model, client finally understands role of therapist and nature of relationship). At the conclusion of therapy follow-up assessment would be conducted. Questions to be asked were:

a. How did the intrapersonal needs of members interact with family dysfunction?

b. What intergenerational patterns became apparent?

c. How did the intrapersonal needs of the adults in the family affect their capacity to parent?

d. What were the markers that indicated the status of the joining process?

e. Was the family able to assess its own strengths and deficits, and perceived changes during the process of therapy?

3. COORDINATING THE HELPING NETWORK ---

At the same time that one was joining with the family, I suspected that one also needed to be joining with the team. I thought that an initial team meeting

would be important to negotiate roles: who stayed, who left, and who was responsible for what services. Questions to be asked were:

a. In meeting and mapping the care giving system and the family, who was presently involved, and how did they define the problem?

b. What interventions had already been tried with the family, what had worked and what had not? (joining and framing participants as collaborative)

c. With the introduction of a new player into the system, what were the expectations of my role by the referring agency?

d. How could I empower the family to participate as members of their own treatment team?

Having chosen three treatment tasks on which to focus: the nature of joining, integrating intrapersonal and family treatment, and coordinating the helping network, it next became necessary to review the literature for helpful information. My search of the literature is divided into two main sections: assessment and intervention. In the assessment section I identify the internal and external factors contributing to child abuse, the characteristics of at risk to abuse multi-agency families, and speak generically about some of the interactional and structural patterns that can be observed in this population. In the second section of the literature review, I discuss intervention and possible treatment models based on the needs and characteristics of the at risk to abuse multi-agency population.

Chapter Two

Review of the Literature

Assessment

The Emotional and Physical Abuse of Children

Helfer and Kempe (1976) state that cultural, social and psychological factors come together to create family violence. Valiant-Cook and Bowles (1980) write that in the real world social, cultural and psychological elements are inseparable. Child abuse is an action carried out by individuals, whose behaviors reflect the influences of social forces combined with the abuser's unique personality.

In defining the external contributing and causal elements in child abuse, one must study a variety of factors: society's basic philosophy, its dominant value premises, its concepts of humans, the nature of its socio-economic and political institutions, value premises and reinforcement of that philosophy and values, and the quality of its human relationships (Valiant-Cook and Bowles, 1980).

Society is not a monolithic whole. But it is based on certain puritan ethics and capitalistic premises that serve to justify and perpetuate child abuse at a philosophical level. Although many citizens in society no longer subscribe to these values, the values run very deep in our culture. Families who are trapped at the exploitative end of the capitalistic system, and those families who still strongly subscribe to traditional male/female roles in

society are more likely to incorporate these premises into daily life. Some of the most blatant premises, discussed by a variety of authors (Djao, 1983; Gil, 1975; Helfer and Kempe, 1976; Valiant-Cook and Bowles, 1980) are:

> 1. People in our society are not intrinsically equal, entitled to the same socio-economic and political rights. Capitalism encourages, at both the individual and social level, competition and exploitation in the struggle to get ahead and to enjoy special privileges and prosperity.
>
> 2. Traditionally our society has viewed children as the property of their parents. In our judicial system, they have been given few individual rights. We encourage children to be obedient and submissive. And finally, in our culture, a child's opportunity to realize his/her own potential is directly influenced by his/her sex, race and socio-economic position.
>
> 3. In our society the use of physical force for disciplinary objectives is encouraged at both the macro and microcosmic level. We believe that children are innately stubborn and willful, and that physical punishment can be an effective means of controlling these attributes. Our educational system has long been connected with the use of corporal punishment as an educational tool.
>
> If we take responsibility for supporting this value, then we must also expect that abuse of physical force will be a natural occurrence. This abuse of

power can occur as either a deliberate, premeditated action or as a spontaneous loss of self-control. In the case of child abuse, assaulting children temporarily accomplishes the release of frustration and tension and appears to at the moment, meet the emotional needs of the abuser.

4. Society creates a variety of triggering contexts in which child abuse is likely to occur. These triggering contexts are usually situations of high stress and/or frustration and include alienation and inequality in the workforce and in situations where economic and basic material needs remain unmet. Such situations are a product of basic societal forces and can trigger extreme frustration and stress which may then elicit a loss of self control which can result in child abuse.

Thus, we live in a society where inequality between individuals is still encouraged, where children are considered property, where the use of force is sanctioned and where a variety of situations can trigger extreme frustration and stress. Given these four factors, child abuse is actually a natural and predictable bi-product of a society such as ours. On an individual level, child abusers are simply re-constructing the distortion of power and force that is rooted in the social structure. Gil (1983) says:

'We know that psychological factors which shape individual behavior evolve out of the totality of life experiences in specific historical, cultural, social, economic and political contexts. Individual motivation and behavior are thus always tied to societal influence. Yet societal influence is always expressed, or mediated,

through the behavior of individuals, for societies cannot act except through their individual members' (Gil, l983, p.122).

Although an individual's behavior is certainly influenced by his/her external context, the final dimension which must be considered when tracking the causes of child abuse is interpersonal functioning.

Not all parents who experience poverty, social inequality and situations that are highly stressful become child abusers. Most do not. And although every abuser's situation is unique, for those parents who do become abusers, Helfer and Kempe (1976) cite certain predisposing interpersonal attributes which when combined with societal factors, appear to be predictors for the occurrence of child abuse. The most fundamental of these are: frustrated dependency needs, uncontrolled aggression, low self-esteem and a high need for nurturance. These basic interpersonal attributes set the stage for secondary attributes such as: fear of authority, low familial satisfaction, inability to empathize, violent reaction to stress, and avoidance of social interaction.

When the adults who possess these predisposing attributes become parents, one can predict the development of certain interactional factors which then contribute to the risk of child abuse. Such factors can include role reversal between parent and child as the parent in his/her quest for acceptance and love attempts to fill his/her own needs through the child; unrealistically high expectations of the child's capabilities and thus a misperception of the child's age-appropriate behavior as disobedience;

and/or a lack of understanding of what constitutes the normal emotional needs of children.

When these parenting factors exist in combination with the above interpersonal attributes, certain maladaptive patterns seem to develop in the family. Ebeling and Hill (1983) cite a number of these patterns which seem to contribute to the acting out of child abuse:

1. unpredictability characterizes the interpersonal contacts between members

2. executive functions are not clearly assigned

3. responsibility for child care shifts back and forth from parents to oldest child

4. attention to child fluctuates with parent's mood

5. limit setting is inconsistent

6. lack of internalized rules, family members reference their behavior to each other's shifting moods

7. violation of social rules outside the sphere of family interaction is not seen by parents as their responsibility because they were not there

8. noncompliance to a parent's mood is seen as an insult

9. boundaries between members are fluid

10. children are subjected to a lack of appropriate supervision, and harsh discipline

11. physical care vacillates between lavish and inadequate

Thus in families where the presence of certain predisposing interpersonal attributes exist in combination with the above patterns of interaction, the occurrence of child abuse becomes a risk.

The Nature of Multi-Agency Families: The Internal and External Struggle

In the last twenty years a variety of labels have been used to refer to those families who seem to be chronically involved with a number of helping systems, who seem to operate from crisis to crisis and are unable on their own to maintain a healthy system. Geismar and La Sorte (1964) describe these families as those that take up the bulk of services and account for a disproportionate share of deviant behavior. These are the families involved in the abuse and neglect of children, in juvenile delinquency, in adult crime and in substance abuse. Their labels include: problem poverty families, disorganized families, multi-problem families, hard to reach families, and more recently, multi-agency families.

Janzen and Harris (1980) emphasize that the labels used to describe the parents and children that make up these families are important in that they very clearly reflect how helpers think about and respond to these families. They state that in the past, helpers have failed these families because they have not possessed the appropriate skills and techniques with which to reach them. As a consequence, a sense of hopelessness has resided in the helper as well as in the family. They suggest that in order to work successfully with this population one must analyze the deprivation at work both inside and outside of the family. This includes looking at economic, social and political factors as well as the family's own interpersonal and intergenerational context.

Most authors who have studied and written about the multi-agency family agree that this population suffers from both internal and external dysfunction (Aponte,1976; Geismar and La Sorte,1964; Janzen and Harris,1980; Kaplan, 1986). Internally there are deficits in the degree of constancy, differentiation and flexibility in the structural organization of the family system (Aponte, 1976). The family is internally organized, but in a dysfunctional way. While in functional families, members play roles that are reciprocal and complementary to overall family goals, the multi-agency family is unable to achieve integration for the sake of common goals. This internal disorganization renders the family unable to interact in a functional way with its greater social context.

Gilbert, Christensen, and Margolin (1984) describe this population as both possessing low levels of mutual support which reduces the ability to change effectively in response to internal and external requirements; and as having especially weak marital and parental subsystems which renders the family leaderless.

Externally, problems can include the economic, social, educational, and/or vocational systems. The family is angered by past encounters with the system, is overwhelmed by its present contact with the system and is unable to get the services it requires (Kaplan 1986).

As an illustration of how internal and external problems combine to hinder the multi-agency family, Janzen and Harris (1980) give the example of our economic system which fails not only to provide opportunities for employment and income production for families, but also fails to provide adequate alternative means of support. These limited inputs from the external system

diminish a family's ability to maintain itself materially, and this in turn acts internally upon the status and role assignments within the family system. As the family becomes economically dependent, the negative attitudes and hostility toward the family generated by the public, by the social assistance agencies and by the workers in these agencies lowers the family's image of self and of individual members. In addition, the middle-class values held by most helpers lead to expectations of the family that are beyond its capacity to realize. The family gets no self enhancing gratification from the outside, and is unable to generate any for itself from its already depleted bank .

In our present system, when these internal and external problems feed upon one another, it is common for helpers to view the resulting chaos as part of the family's pathology rather than as a systemic problem. The family, on the other hand, learns that pleas for help go unanswered. So it becomes apathetic, demanding, and/or resistant (Kaplan, 1986).

Geismar and La Sorte (1964) describe the integration of internal and external factors that creates a multi-agency family. In addition to an external situation of poverty and lack of social support, internally the family must also possess an impoverished heritage with respect to problem solving, must have poor intrafamilial communication, a general lack of confidence and trust among members and have past relationships with helping agencies which ranged from indifferent to hostile. These internal factors act on the family's ability to secure needed economic and social resources, creating a vicious cycle.

Agencies perceive such families as making repeated application for services, but failing to follow through on recommended treatment. They

describe these families as suffering from recidivism, as deviant, as engaged in frequent crisis, as suffering from chronicity of need, as resistant to treatment and as possessing handicapping attitudes. Internally the family is unable to handle its own problems or to obtain services through the community due to its own self defeating problem solving skills.

Abuse and The Intergenerational Connection

While difficulties with communication, boundaries, role organization and interaction render the multi-agency family incapable of internally managing its own interpersonal tension and conflict, these same difficulties also sabotage the family's attempts to gain support from the external system. The family is left in a position where it is unable to obtain gratification either internally or externally. When such a pattern is perpetuated, it creates tremendous stress on the internal system (Janzen and Harris, 1980). One possible outcome of this volatile and maladaptive situation is family violence.

Whether or not the family's high level of interpersonal tension in combination with the low level of internal and external support will result in child abuse depends on additional factors. These additional factors include the information the parent gleaned from his/her own family of origin on such important topics as the role of the child in the family, the nature of the parent/child relationship and coping with stress.

If the parent has experienced an abusive model of parenting in his/her own family of origins, there is a risk that he/she will perpetuate this pattern with his/her own children (Buck, 1984). In such families the abuse of children is a

natural occurrence (Helfer and Kempe, 1976; Valiant-Cook and Bowles, 1980).

Research shows that as children most abusive parents were themselves exposed to emotional abuse and neglect with or without significant physical abuse (Buck, 1984; Ebeling and Hill, 1983; Polansky, 1981). Ebeling and Hill (1983) state that as young children, these parents were made to feel inadequate, guilty and innately bad. Their first intimate relationship taught them a sense of worthlessness. The unmet needs of childhood do not simply disappear, but instead set the stage for future attachments. Ackley (1977) paints a poignant description:

> "Potential abusers both seek and shun intimate relationships. On the one hand, they seek intimacy in order to obtain what was missing in the earlier parental relationship. These needs lead them to define a close relationship as one in which, like a child, they can: obtain emotional support and warmth without giving much in return, and depend on their partner to solve the problems of living that adults are called upon to solve. Alternatively, intimacy is shunned because the first childhood attempts were such failures. It is these failures that now lead them to believe that close relationships are dangerous and doomed to produce disappointment and threats to self-esteem because people cannot be trusted' (Ackley, l977, p.58).

Helfer and Kempe (1976) conclude that due to the deprivation and abuse early on in the parent's life, interaction is now oriented to satisfy one's own needs. This may show up in later life as excessive dependency, an insatiable need for love and acceptance or as extreme mistrust of people and relationships. The emotional relationships of abusive parents are often inadequate, fraught with conflict and minimally supportive. The parent is unable to receive gratification and support from adult relationships and so,

misunderstanding the nature of child-rearing, turns to his/her own children expecting them to meet the increased demand for nurturance (Valiant-Cook and Bowles, 1980). The parent, feeling unloved and unlovable, looks to the child as a source of reassurance and comfort almost as if the child were an adult (Steel and Pollack, 1968). Inevitability the child is unable to meet these needs, as they are in direct competition with the child's own demands for nurturance and acceptance. Once again the parent is severely frustrated. If the abusing parent's personality is such that it allows aggressive impulses to be expressed freely and without control, the result may be an assault on the child (Nomura, 1966; Steele and Pollack, 1968).

Family Functioning In At Risk To Abuse Multi-Agency Families

Family operations depend on the ability of the adults in a family to form a strong bond with one another, yet as already stated, these families are characterized as having especially weak marital and parental subsystems (Gilbert , Christensen and Margolin, 1984). While in the functional family, satisfaction in the marital relationship comes from the strength of the bond as well as in the ability of the couple to support each other's child rearing, multi-agency families are characterized by distance, conflict and transience (Janzen and Harris, 1980).

In these families, when problems in the marital subsystem develop, it is usual for one or both adults to withdraw either temporarily or permanently from the parenting system and/or from the spousal role. When this happens a child in the family may take on one or both roles; generational lines are crossed

and boundaries become blurred (Minuchin, Montalvo, Guerney, Rosman and Schumer, 1967; Janzen and Harris, 1980).

Another marital subsystem pattern that is quite common is the triangulation of a child for the purpose of alliance and support for one of the parents. This regularly happens when marital conflict spills across subsystem boundaries as one of the adults seeks support from a child in the family or seeks to use the child as a way of attacking his/her spouse. When this happens the child gets close to one parent and distances from the other. The child is suddenly stuck between the wishes and needs of both parents. She may even take on the distant parent's role, especially if the family is now functioning as a single parent family. The likelihood of this scenario being realized in an at risk to abuse multi-agency family is great because, as already stated, such a family lacks connection to outside systems as a source of need gratification. As a result they suffer from reduced need satisfaction, self-esteem and status and so may turn to members within the family in an attempt to attain gratification (Geismar and La Sorte, 1964; Kaplan, 1986; Minuchin et al, 1967). This becomes a problem if the members targeted are unable to meet these needs.

Aponte (1976) describes the alignments in the underorganized family. He portrays the functional family as one in which there is a dependable, differentiated and flexible internal system of structural alignments. Each family member knows who can be counted on to carry out family related operations. And in addition, the family is able to make structural shifts in family alignments over time due to its own resources and flexibility. In contrast, Aponte states that underorganized family alignments are not well elaborated or reliable. On

the one extreme, this may be due to the inflexibility and limited structure of the family which in turn overtaxes rigidly aligned relationships. On the other hand, lack of developed patterns or loose alignment causes problems in communication and expectations of specific sources of help in the family.

Another difficulty for at risk to abuse multi-agency families, is maintaining clear separation between the parent and child subsystems. Boundaries between these two subsystems are generally blurred. Parents are unable to set consistent limits for behavior. They tend to make injunctions without explanation about why a given behavior should stop, about the circumstances in which it is permitted, or what behavior should be substituted. Children in the family are then unable to internalize rules and become self-regulating when they are not with their parents. Children in the family are thus unable to carry out the task of individuation and self differentiation. As a consequence, parents in the family must remain enmeshed and totally absorbed in child care, as they inconsistently and arbitrarily regulate children's behavior (Minuchin et al, 1967).

Parents are not free to pursue their own needs and as a consequence feel overwhelmed and overburdened. If a parent leaves this already stressed system, the family experiences a further sense of inconsistency and instability. If a parent remains in this situation, abuse may become an issue. Either way, it is at this point that external systems may become involved with the family (Janzen and Harris, 1980).

Communication In At Risk to Abuse Multi-Agency Families

In these families communication between members is characterized by interruptions, simultaneous talking, topic changes and unclear meanings. Verbal messages are often lost in contradicting affective content. Members have very little sense of being listened to and of being heard (Minuchin et al, 1967). What is communicated, though perhaps not clearly, is each member's frustration and isolation. Interpersonal content dominates over verbal content. Members fail to receive validation or nurturance, thus communication in the family perpetuates unsatisfactory relationships between members (Janzen and Harris, 1980).

Minuchin et al (1967) write that:

> 'Psychologically these people are impoverished, rather than complex; their areas of experience are limited. Family themes are restricted, with an emphasis on aggression, helplessness, abandonment, and nurturance. Role organization around family themes is narrow and stereotyped. Communication involves an unusually large amount of disconnected monologue, meaning being most often expressed through para-verbal channels. Since family members find it difficult to carry subject matter through to some conclusion, exchange of information is faulty. Interaction centers on the here and now, and transactions among members can shift abruptly from a high pitched emotional charge to passive disengagement. Consequently these families are relatively helpless in the face of interpersonal tension, with very few tools for conflict resolution' (Minuchin et al, 1967, p.197).

Cade (1975) states that these families need to learn to talk together with purpose, to talk straight, and to express their needs of each other. Problem solving requires such skills as: dissecting issues, priorizing problems,

assessing options and making choices. He says that the therapist's role is to maximize the family's internal resources.

Janzen and Harris (1980) describe two types of dysfunctional communication commonly found in these families: never resolving issues, and overtly disagreing without attempting resolution. They observe that if these types of communication patterns persist in a family, positive feelings among members dissipate. They advise that in the initial stages of therapy, the worker must take an active role in regulating family communication. Members must be encouraged to stop interrupting one another, they must be specific about the person to whom a message is addressed and about what specifically is being said. The worker can help family members who are in the habit of communicating blame, anger or hostility by relabeling or rephrasing negative communication to draw attention to the real need hidden beneath.

When a worker regulates the communications of a multi-agency family, the family has the opportunity to experience a new way of communicating. This can offer new information and new understanding to family members who have been stuck in their perceptions of one another.

Minuchin et al (1967) speak at length about the communication patterns that are in existence in 'disorganized' families.

> 'The low socio-economic disorganized family shows deficits in the knowledge of the implicit rules that regulate the communicational flow.....in these families parents pay little attention to the requests of the individual children, and the children in turn accept the fact that they will not be heard. In the development of necessary techniques for attracting attention to themselves, the children find that intensity of sound is more effective than the power of the themes; assertion by power is more important than knowledge.

> The result is a style of communication wherein people do not expect to be heard and in which they assert themselves by yelling. Conflicts do not have closure; there is faulty development of themes, a restricted affective range, and lack of training in the elaboration of questions to gather information. This style is perhaps adequate for the transaction of gross nurturing and power relationships, but it is insufficient for dealing with chronic and more subtle conflicts, for this requires the search for, ordering of, and sharing of different or new information' (Minuchin et al, 1967, p.200).

Minuchin et al (l967) predict the expected characteristics which can be observed in families poor communication skills, paraphrased they are:

1. family members do not expect to be heard

2. if someone does respond, it is not necessarily along the lines of the preceding communication

3. a subject will rarely be carried to any conclusion

4. members can endure a dislocated shift in content by using a variety of coping mechanisms

5. intensity of sound frequently displaces the theme content

6. mother's role is that of regulator

7. the mother is a central pathway for most transactions among family member when they are together

8. spouses very rarely talk to each other, they are in parallel, not reciprocal contact

9. aggressive antisocial themes can be the expression of inner pressures, but also the description and handling of outer realities

10. ways of transacting power operations occupy a large part of the siblings' interactions

11. the mother's messages to the children are mostly framed in "don'ts", without the accompanying "because" that would imply a system of ordering outside of herself

12. the mother's responses to one child's disruptive behavior are often generalized to the whole group

13. rarely do the mothers' messages to the children emphasize positives

Minuchin et al (1967) conclude that children in these families learn that the person to whom they are communicating warrants more attention than the content of the message. The underlying lesson here is that the purpose of communication is to define relationships between family members, rather than to focus on the content or meaning of the message. Minuchin identifies this type of communication as a natural process for very young children, but inappropriate for a family. He says that it is a style of communication that is indicative of people who, because they are unclear about their own power and sense of self, need to use other people for definition of themselves and of their social situation.

Conclusion

In summary, one can identify the macro-causal factors of child abuse as societal premises which serve to perpetuate the maltreatment of children. These include: (1) the unequal distribution of socio-economic and political rights in society, (2) society's view of children as property, and (3) society's sanction of the use of force for disciplinary objectives. The consideration of social factors alone, however, cannot account for the phenomenon of child

abuse. Certain predisposing interpersonal attributes are needed as well. The most fundamental of these micro-causal factors are frustrated dependency needs, uncontrolled aggression, low self esteem, and a high need for nurturance.

When macro and micro-causal factors are united, with certain parenting factors, such as role reversal between parent and child, unrealistically high expectations of the child's capabilities, and a lack of understanding of what constitutes the normal emotional needs of children, an atmosphere is created in which child abuse is a predictable outcome.

The families most commonly involved with child abuse are often the families who seem to be chronically engaged with a number of helping systems. Their labels include problem poverty families, disorganized families, multi-problem families and more recently multi-agency families.

Most authors who have studied and written about the multi-agency family agree that this population suffers from both internal and external dysfunction. Internally the family is deficient in a number of skills which cause difficulties in differentiation and flexibility, thus creating weak subsystems and low levels of mutual support; all of which render the family unable to change effectively in response to internal and external requirements. Because of the family's internal dysfunctions, it is unable to manage its own interpersonal tension and conflict. These same difficulties also sabotage its ability to elicit support from external sources. The family is thus unable to obtain gratification either internally or externally. At this point, given the right combination of interpersonal attributes and deficits in parenting skills, the stress placed on the internal system can trigger child abuse.

Understanding how the micro and macro-causal factors of child abuse, and the characteristics of the multi-agency family combine to create the at risk to abuse multi-agency family, is an important first step in the process of designing useful intervention. With this information, one can begin to target possible treatment issues and goals, and finally to tackle the question of what effective intervention might include for this population. The next section of this literature review will cover the area of intervention: possible issues, goals for the population and potential treatment models.

Chapter Three

Review of the Literature

Intervention

Janzen and Harris (1980) conclude that traditional approaches have not been successful in meeting the needs of or in gaining cooperation with treatment efforts from multi-agency families. Workers have tended to view these families as unmotivated and resistant. Janzen and Harris state that describing multi-agency families as unmotivated or hard to reach is simply another way of admitting that the external helping system has failed to engage the family.

Aponte (1976) echoes this sentiment when he discusses the difficulties that middle-class therapists have in understanding this population, due to the socio-economic differences between client and worker. He states that this gap can be further widened if cultural and racial differences are also introduced.

The reason for this failure is usually due to the conceptual and/or attitudinal orientation of the helping system. These differences need not necessarily exist or be insurmountable. They exist for a number of reasons: (1) helpers lack special knowledge and understanding of the characteristics of the population, (2) there is a failure to recognize gaps in learning, values and norms between worker and client, and (3) because of their high level of deprivation and victimization, such families may need service that exceeds the helper's traditional concept of treatment. Gelinas (1986) suggests that the patterns of resistance encountered in these families which have been

perceived by helpers to be a major obstacle to treatment, can actually be reframed to be the family's most powerful resource for change. If the therapist is careful to support loyalties in the family, to avoid scapegoating the perpetrator, and to employ multi-laterality (taking a look at everyone's side), resistance will usually be alleviated.

Treatment must address the family's interpersonal and intergenerational context, and maximize the family's internal resources. In general the family must be helped to improve communication, strengthen boundaries between the various subsystems, meet the needs of its members, improve role organization, gain more adaptive problem solving skills, improve member's self-esteem and differentiation, gain more adaptive parenting skills and expand its social support network.

Janzen and Harris (1980) encourage workers to explore new ways of working with these families. They suggest that workers make an effort to relate to each family's unique special needs and concerns, and that focusing simultaneously on the internal and external systems enables the workers to meet the material and psychosocial needs of the family. Necessary modifications in approach may include meeting the family at their home rather than in the office, being available to the family outside regularly scheduled appointment times, and engaging in activities with the family in addition to regular talking sessions. They state that in this way the worker is meeting the real material and psychosocial needs of the family, trust is developing, and the family is being taught through instruction and demonstration how to alter dysfunctional interaction between members.

Umbarger (1972) describes one possible approach which utilizes an ecological perspective:

> 'A family therapy approach oriented toward the ecological system can attend simultaneously to the realities of poverty and to intrafamilial issues. It can employ tactics necessary for assistance with poverty problems, such as home visits, school visits, agency visits, and work with the extended family, and these become the occasion for restructuring relations within the family unit. The management of poverty is part of the treatment procedure context, and not simply an effort to remove obstacles so the the "real treatment" might then begin. The therapist works at the interface between the family and non-familial systems, using typical poverty events--such as unemployment, legal troubles, unpaid rent, or housing difficulties-- as the occasion for interventions into the affective, communicational, and structural aspects of family organization. Every new external emergency is an opportunity for restructuring the psychosocial interior of the family' (Umbarger, l972, p.156).

Kaplan (1986) explains that another problem that leads to failure when working with multi-agency families is when agencies and families become caught in a cycle of mutual withdrawal. As traditional services fail to respond to the multi-agency family's complex needs, the family is perceived as disinterested in helping itself. The agency then slowly withdraws services from the family because it has failed to meet the social and behavioral expectations of the agency. The family is left without service, feeling taken advantage of and misunderstood. Their perception is that the worker's involvement has made things worse. The family's natural instinct is to protect itself from future involvement with external helping systems. This is perceived by the helping system as resistance to treatment. The relationship between

the helping system and the multi-agency family becomes one of mutual disappointment and hostility.

In the external system the family develops the stigma of being known and disliked by many agencies. Based on these many encounters, the family now perceives the external system as unhelpful and hostile. A circular pattern has evolved: when the family fails to utilize services offered, it is rejected by the helping system and so it withdraws, setting up a pattern of failure and withdrawal in both family and helping systems. When this cycle is allowed to perpetuate itself, chronicity is the result. This cycle will be perpetuated in each succeeding generation of the multi-agency family.

Kaplan (l986) stresses that helping systems often work in isolation of one another and provide fragmented services that are duplicated, unplanned and crisis-oriented. It is therefore a natural response on the part of the family to be skeptical of such services. Kaplan advises that an important step when working with multi-agency families is to interrupt this cycle of mutual withdrawal, thereby breaking the generational progression.

Therapists who are working with multi-agency families can operate from a systemic perspective, viewing the family as a system in interaction with other external systems. From this perspective a therapeutic goal becomes solving problems, while helping the family to improve its own problem solving process (Janzen and Harris, 1980). The therapist works to improve the family's problem solving skills, using his/her own attempts at problems solving in the larger system as a model for the family. Janzen and Harris argue that educating and helping the family to try on new and different behaviors is more important than gaining insight into past actions. Here the focus is on what is to

be done, rather than on understanding why the family is in its particular situation. They claim that this will help the family to view itself as a unit, perfect its problem solving skills, and as these skills improve, will further demonstrate that something is to be gained from common effort and work. This model emphasizes the interrelatedness of family problems and of family problem solving mechanisms.

Parts of this model such as viewing the family as a system in interaction with other systems, helping the family to improve its own problem solving process by modeling this process for the family in the larger helping system, and educating and helping the family to try new adaptive behaviors are very useful. Emphasizing these will help the family learn to view itself as an interrelated unit, demonstrating the connection between family problems and family problem solving mechanisms. This can be a very important goal for the family who has never before experienced itself as a unified whole.

Not to be forgotten, however, is the equally important task of helping the at risk to abuse multi-agency family to understand the intergenerational connection, and its part in perpetuating the cycle of abuse. Abusing adults are typically abused themselves as children, and in turn tend to practice the same style of parenting that they experienced (Buck, 1984). It has been my experience that in working with deprived, abused adults, one must address maladaptive patterns in the present family while concurrently addressing the abuse issues of a generation before. The degree of deprivation in these adults is such that they are able to modify present dysfunctional patterns, only when they as individuals feel nurtured and cared for. It is through the tracking of the intergenerational connection, that the at risk to abuse adult is able to

acknowledge, often for the first time, his/her own suffering and deprivation as an abused child. With this realization, the parent can be taught to develop empathy for his/her own child's maltreatment. With the development of empathy, the parent is able to challenge and modify learned maladaptive parent-child interactions and finally absolve him/herself of the notion that as a child he/she somehow deserved the abuse. If the therapist fails to address this intergenerational connection, the abused adult looses the opportunity to view his/her present maltreatment of children in this important intergenerational context.

The Helping Network

Erickson, Rachlis and Tobin (1973) state that it is common for multi-agency families to be involved with a number of helpers. Often these helpers don't know of each other's existence, and so may be undermining, overlapping and contradicting each other's efforts. In times of stress, family systems will triangulate with more and more outsiders in an attempt to diffuse inner family tension. As helping systems become triangulated, it is possible for family stresses to be acted-out by these outside systems (Carl and Jurkovic, 1983). They state that even the relationship between the family and one outside agency is unstable under stress, so there will be a tendency to form a three party system to diffuse the stress.

This was illustrated in one family who because of difficulties with an adolescent member, simultaneously sought service from two different helpers (Child and Family Services, and Child Guidance). Neither service was initially told about the involvement of any other service with the family. After several

months each helper became aware of the other helper only because the family was taking the opportunity to complain of one helper while in the company of another helper. Each helper believing that he/she was the only truly appreciated helper worked harder to support the family with seemingly little result. Gradually conflict between helpers escalated until they began to unwittingly act out the family's struggle. Each helper perceiving him/herself in the role of parent was attempting to control the other helper who was being perceived as the rebelling adolescent. Ironically, while this battle was being played out, the family described itself as doing much better.

Reder (1986) has found that when a family is in crisis they tend to present simultaneously rather than consecutively to a variety of helping agencies. Each agency, not realizing the other's existence, works harder and harder to help the family with seemingly little result. As agencies learn about each other in time, dissonance between helpers escalates until it may result in a bigger problem than the original presenting complaint. Reder says that by the time the dissonance reaches this proportion, helpers have unwittingly joined the very system they are trying to change.

Imber-Black (1986) feels that our culture supports multiple helpers by promotion of specialization. Each helper deals with a different aspect of the same problem, and helpers are rewarded by the number of problems they uncover. In addition, Imber-Black says that although the professional has good intentions, due to his/her own confusion or lack of expertise, he/she may enlist yet another helper and rather than terminating with the family at the point when the new worker becomes engaged, may also stay on, contributing to the ever growing number of helpers working with the family.

Reder states that such multi-agency networks seem to develop around families who show unpredictability and instability in their relationships, and who get minimal support from their families of origin. Sometimes helpers are drafted to fill family member's roles. Some families may draft helpers to fill the role of absent extended family members such as authoritarian parent or nurturing caring parent. Imber-Black (1986) adds that families may engage multi-helpers because it is a pattern of involvement over several generations, and is a familiar and comfortable way to conduct family life. Single parent families may engage helpers to fill the role of the missing parent.

Imber-Black (1986) says that when family therapists are asked to describe their most difficult cases, they frequently identify those involving multi-agency families. She advises that before the therapist becomes involved with a family that he/she needs to identify and assess the helping system, in order to understand the relationships between the family and the various outside systems involved. She suggests that one look at alliance patterns, multi-generational involvement, which interventions have been helpful in the past, and which have not. Unless this process is carried out, the therapist will discover that he/she is just another helper in the long list of outsiders who have failed with the family.

Erickson et al (1973) advises that one needs to view the family and its helpers as one system. Next one must look at the conditions under which the family can solve problems, and the conditions under which old problems are perpetuated. Reder (1986) suggests mapping the system to identify significant members and relationships. And that as a new helper, it is best to remain neutral until the necessary information is gathered, and the type of

help required is identified. Mapping the system includes identifying current members in the family, getting a sense of relationships, gathering a family history, having network meetings, defining the problem, finding out what has been done in the past, what has been effective, what has not, what the system is expecting from the new worker, and roles of the other helpers.

Imber-Black (1986) states that armed with this information, the therapist can then initiate a new relationship with the family, one that avoids old patterns and mistakes, and instead facilitates effective intervention.

Erickson et al (1973) stress the important socializing effect that team meetings have. They suggest that the focus for such a meeting be on problem solving in the present context, and on whatever strengths seem to exist in the family and in the larger system. This is an important deviation from traditional team meetings, which tend to focus on family pathology.

Imber-Black (1986) says that the purpose of including the helping network in the family system is to widen the conceptual base for understanding family problems. When one attempts to understand the complex interpersonal dynamics that evolve between family and multiple helpers, one moves away from blaming families and their helpers for existing dysfunction.

Taking Imber-Black's idea one step further, Levin , Raser, Niles and Reese (1986) present the problem system model. The belief behind this approach is simply that systems develop around problems as attempts are made to solve them. They view the problem determined system as both nonpathological and nonhierarchical.

In this model Levin et al (1986) state that the therapist must consider: his/her influence on the system, the context of the problem, and who is

affected by the problem. This model acknowledges that all helpers ultimately want the best solution to the family's problem, but everyone has their own opinion as to what this might be. Each helper operates from his/her own perception, orientation and vantage point. The result is a lack of coordination between helpers which competes for the client's loyalty. If contradicting interventions develop, these contribute to the already existing structural deficits in the family.

Anderson and Stewart (1984) utilize a nonpathological model with clients which includes other helpers in the process of treatment, in an attempt to identify how these helpers may be maintaining the problem. She introduces the idea that everyone is involved with trying to solve the problem, but is trying simultaneously to solve it with techniques generated by their different orientations and belief systems. She concludes that all helpers bring useful information and skills that help resolve the problem. The therapist must make use of these people and their strengths in the process of treatment.

Levin et al (1986) conclude that this way of reframing the helping system's existence negates the model of hierarchy, since all helpers have the ability to help. If everyone is helpful on some level, then pathology is not included in this model. They state that this way of thinking takes the therapist out of the role of expert.

Having looked at some of the issues of intervention, we must now explore possible treatment models.

Intervention Models

The literature identifies three possible interventions with abusing multi-agency families: working with the adults, where the therapist is attempting to help the parent re-experience the nurturing and good parenting they missed as a child (Helfer and Kempe, 1976; Melnick and Hurley, 1969; Merrill, 1962); the family-oriented therapy approach (Bandler, 1967; Helfer and Kempe, 1976); and the family therapy approach (Helfer and Kempe, 1976). Although emphasizing different issues and tasks, these three models share many common perceptions and methods. These will be discussed in a separate section after each model has been introduced.

Re-parenting Model:

In the first model a therapist actively uses his/her self as a therapeutic tool, believing that the relationship between self and client is a very important and symbolic one. The therapist seeks out opportunities to reach out and give to the client, rather than expecting the client to meet the therapist half way (Ebeling and Hill, 1983). This model has its roots in psychoanalytic theory. The therapist must gear treatment to the developmental level of the client. As the multi-agency population tends to be action oriented rather than verbally oriented, they do not easily see cause and effect connections. As a consequence, behavior is often impulsive and the adults continue to enact the same situations and episodes, not realizing their own responsibility in perpetuating and repeating old patterns. As well, these parents view excessive sympathy and concern shown for the children by the therapist as not caring about them. They are in competition with the children for the

therapist's (parent's) affection and may be jealous if their child receives more. A therapist utilizing this model must therefore decide early on in the treatment process how much danger is involved in leaving the child in the home, and what additional services for the child are appropriate.

The therapist should expect the client to be infantile, overwhelmed by the task of parenting and desperately requiring parenting themselves. This model operates on the assumption that as the client begins to build a trusting relationship with the therapist, he/she will also want to emulate the actions, attitudes and behaviors of this important person, much like a child does with his/her own parent (Buck, 1984; Ebeling and Hill, 1983). When this restitutional process is successful, the parent is able to replace dysfunctional parenting skills with functional ones and regression back to the original pathological pattern does not occur (Ebeling and Hill, 1983).

Such a treatment approach seeks out client strengths. The therapist must know about past and present meaningful relationships in the client's life, and about what the client found helpful and nurturing in these relationships. Ebeling and Hill state that client strengths will show up in the form of:

1. wanting to please the therapist, which assures continued access and commitment

2. existence of maternal caring, despite abusive behavior, this can be strengthened and developed in the course of therapy

3. client experiences self as a separate individual

4. having the ability to get comfort from his/her children, because although this pattern can be an indication of role reversal, it can also demonstrate that the parent feels deserving of someone's attention

5. ability to exhibit a small sense of objectivity around own behavior

6. sense of appropriate basic needs of children: attention, limits, food, clothing, supervision, opportunity to learn

7. expectations of children conveys hope for future

8. ability to manipulate the environment, to get what is needed to survive

This model of intervention with abusing parents goes beyond crisis intervention or symptom elimination, its goal is to help parents understand and cope with the causal factors of their dysfunction (Ebeling and Hill, 1983). They go on to say that this type of client requires a period of intensive involvement before she can benefit from such modalities as family therapy. With this approach therapeutic goals are:

1. To improve client's skills for coping with daily stresses

2. To increase positive self-image

3. To improve client's attitude towards others

4. To improve parent's capacity to develop his/her own potential

Bandler (1967) talks about the importance of working with parents first and children later. This will convey a sense of being valued and cared about to the parents. Even though the worker becomes known to the family through concerns about the safety of the child, the meeting of the parent's needs addresses the parent's rivalry with their children for attention and affection. Once a relationship based on trust has evolved between therapist and client,

the therapist can then expand treatment to include addressing parenting and interactional concerns.

Family Oriented Therapy Model:

Therapists utilizing this model believe that in situations of child abuse, it is the entire family who requires and deserves help. Helfer and Kempe (1976) describes therapeutic goals as: parents relinquish abusive and/or neglectful patterns of child rearing, and replace them with parenting that is more rewarding for both parent and child. This model acknowledges that treatment focus must rest initially on the adults in order to: enhance self-esteem, develop better basic trust and confidence, and develop the ability to enjoy life and have rewarding, pleasurable experiences with other adults and with one's own children.

Therapists operating within this model see therapy as a two part process (Helfer and Kempe, 1976):

1. Restitution of parenting process: during this phase the therapist is interested in supplying support and nurturing to the adults, regardless of the child's situation (it must be arranged that services to support the child will be in place simultaneously). In this way the parent is able to stop using the child to meet his/her own needs and the abuse is momentarily blocked. It is understood that parents must have some of their own emotional needs met before they have the energy and interest to learn about their child.

2. Providing abusive families with more outreach and available services than provided in traditional therapy: this includes home

visits during times of crisis so that the therapist can actually educate the family in new methods of coping and problem solving. This is a valuable model for looking directly at family relationships. The therapist models appropriate child care methods, letting the parents have the opportunity to observe another person dealing with children.

In this model the therapist must not expect that parents be able to identify what their deficits are. In fact, initially the parent may be confused as to why the worker is there and what the relationship may entail.

The basic goals attached to this model are:

1. to help parents re-experience in phase one the nurturing and good parenting that they missed as children

2. to help parents become adequate parents, able to view the child as an individual with his/her own thoughts and needs

3. parent becomes able to tolerate child's negative behaviors, allowing child to express anger

4. parents can allow child to receive emotional rewards from outside the family, as it is no longer necessary to maintain enmeshed isolative patterns designed to meet parent's emotional needs

Family Therapy Model

In this model child abuse is seen as a family problem. Helfer and Kempe (1976) describe child abuse as an indication of a dysfunctional family, that brings the abused child along with his or her entire family to the attention of the helping network. As yet, family therapy has not been widely used with the multi-agency abusing family. But it seems to be the most direct method for dealing with dysfunctional family interactions. Helfer and Kempe (1976)

caution however, that when using this model, the therapist must be careful to measure the parent's need to vent their frustration and anger with the child. If this need is extreme, they suggest that the parents have an opportunity to meet with the therapist without the child present. The child may also have a similar need to vent his/her own feelings of frustration and anger towards his/her parents. The therapist must also weigh the degree of emotional deprivation and neediness in both parents and children. One would have to assess whether the parents have the capacity for nurturance and caring, and explore the degree of their guilt, if any, regarding causing harm to the child. In cases of extreme deprivation, individual as well as conjoint sessions may be required in order for the family to tolerate sharing the therapist's attention and interest.

Helfer and Kempe (1976) state that the advantage of family therapy as a treatment method with multi-agency families is that it provides the opportunity to emphasize the interrelatedness of individual family members. With all family members present, there is less opportunity for family members to distort reality or for individuals to influence the therapist's opinion of other members.

Utilizing this model, the overriding goal is to empower the family to become differentiated and able to meet its own internal needs (Kaplan, 1986). This goal can be realized by helping the family to participate as equal members of the treatment team. This can include such nontraditional actions as inviting the family to team meetings, and expecting them to take part in the planning and decision making throughout the treatment.

Throughout this process, the family therapy model emphasizes that the family is a unit and needs to work together to resolve conflict. While the family

may enter therapy with the perception of the child as the identified client, it is the task of the family therapist to reframe this perception so that family members become aware of the interactional patterns that contribute to their dilemma. For some multi-agency families, this may be the first time they have viewed their difficulties in this light.

Complementarity Between Models

While these three models, appear to differ, in reality all three share a variety of common goals, and methods. Using either the Re-parenting Model or the Family Oriented Therapy Model, therapy is conceptualized as a two step process. The first phase of treatment is geared toward re-parenting the parent in an attempt to meet his/her frustrated dependency needs. Both models focus attention on the adults in the family while other services are simultaneously coordinated to meet the needs of the children. Goals in this stage are to enhance self-esteem, develop basic trust, and offer the opportunity for the parent to experience a rewarding, pleasurable relationship with another adult. Both models describe this first stage of treatment as crucial to enabling the parent to later relinquish abusive patterns of parenting. This stage has been successful when the parent is able to establish basic trust and the therapist has successfully joined with the client. While unlike the Re-parenting and Family Oriented Therapy models, the Family Therapy model does not indicate that a separate period of individual work with the adults in the family should proceed family work, it does acknowledge that in the case of extremely deprived adults, conjoint individual and family sessions may be required.

All three approaches identify a stage of treatment which involves educating the family in new methods of coping, problem solving and parenting. Both the Re-parenting and Family Oriented Therapy models achieve this by placing the therapist in the family's home. There the therapist is on hand to observe dysfunctional interactions and actively intervene when necessary. In this way the family is offered hands-on learning in the form of modeling and coaching by the therapist. This is the stage at which parenting skills are taught and refined. The Family Therapy model relies on enactment and discussion to achieve this same result. In all models, this stage has been successful when the family is able to replace abusive and/or neglectful patterns of child rearing with parenting which is more rewarding for both the parent and the child.

While both the Re-parenting and Family Oriented Therapy models adequately address the difficulties of individual family members as well as the family as a whole, they do not attempt to connect the family to a social context. Neither model seems inclined to discuss the family as a system involved with other systems. This is unfortunate because for at risk to abuse multi-agency families, who suffer from social isolation and an inability to successfully engage with external systems, this is an important treatment issue which needs to be addressed.

Depending on the specific model employed, a family therapy approach does conceptualize the family as a system involved with other systems. In this way it becomes possible in treatment to help the family develop more adaptive interaction with such important external systems as the helping and social networks. In addition, family therapy models are flexible enough to allow the

therapist to decide, based on the needs of the family, how much emphasis to place on this task during treatment.

For the purpose of this practicum, I chose parts from all three models which I then integrated into my own intervention model. In this way I was able to acknowledge individual, family and systems issues in the course of treatment. Because of the unique characteristics of the at risk to abuse multi-agency family, I found that I needed a model which would allow me (1) to conceptualize the family as a system interacting with other systems, and (2) to provide individual attention for the adults while also allowing me to actively engage in hands-on teaching session with the family as a whole. I also required a model that was flexible enough to allow for different levels of awareness and 'readiness' between families. The adults in some families required initial individual sessions before they could participate in family sessions, while the adults in other families where able to participate concurrently in both individual and family sessions.

The re-parenting component allowed me to address the deprivation and need of the abused adults through individual sessions either before family sessions or concurrently with family sessions. The family sessions were a time for educating the family in new methods of coping and problem solving and for teaching and refining parenting skills. Sometimes the family sessions were carried out informally as I intervened directly in dysfunctional parent-child interactions. At other times the family sessions were conducted as formal family therapy meetings.

Integrating the Family Therapy component enabled me to conceptualize the family as a system interacting with other systems and to maximize the

family's ability to engage with the external helping system. It also enabled me to reinforce the interrelatedness of individual family members and to emphasize the necessity of working together to learn new skills. Like the Re-parenting and Family Oriented Therapy models, I conducted the family sessions in the family's home.

Conclusion

In this section I have provided a look at the issues of intervention with the at risk to abuse multi-agency family. I have discussed that in general, the helping system has not been successful in providing services to this population. Helpers have often misunderstood the characteristics and unique qualities of at risk to abuse multi-agency families. They have failed to recognize the gaps in learning and values between themselves and the client(s). They have also underestimated the family's need for service when this need has exceeded the helper's concept of traditional treatment.

Because I was interested in devising a method of intervention that avoided repeating many of these problems, I have used this section to become more acquainted with the lack of "fit" between the helping system and the population of at risk to abuse multi-agency families, and to explore important treatment goals and potential models of intervention.

I conclude that the therapist working with this population from a systemic perspective must be very careful to track and address individual, family and helping systems issues simultaneously throughout the course of treatment. While attempting to maximize the family's internal resources, the therapist must be aware of the helping system's role in relation to the family. He/she

must map the system, and continually monitor whether or not helpers have assumed maladaptive family roles.

In the next section I will present the clinical component of this practicum, including the setting, the families, assessment information, procedure and outcome.

Chapter Four

THE PRACTICUM

Setting

As already stated, this practicum was conducted through the Parent Support Program, a long-term, in-home counselling program specializing in the treatment of multi-agency families where there is a concern for child abuse (physical, emotional and sexual). This is a voluntary program. Clients are referred by a variety of agencies who regularly work with families and/or abuse, including Child and Family Services and the Child Protection Centre, Health Sciences. The goals of the program are to counsel, educate and provide support for families under stress. Five counsellors work out of the program, each carrying a maximum caseload of five families.

Clientele

For the purpose of this practicum, the writer worked with five families, from approximately June, 1988 through January, 1989. The caseload consisted of three two-parent families and two single parent families. Three of the families were referred to our program by child welfare workers, one by a social worker at the Child Protection Centre, Health Sciences, and one by a therapist at St. Boniface Hospital. Four of the families had previous interventions, one had not. All of the families had multiple helpers currently involved.

Of the five families seen in practice, one case will be presented at length, and four cases presented in shorter format. Weekly clinical supervision was provided by professors Ruth Rachlis, and George Buranyi. Less frequent supervision was provided by Chris Cassels, Assistant Clinical Director, Children's Home of Winnipeg, and Margot Buck, Co-Director, Child Protection Centre, Health Sciences.

As already acknowledged, families entered the therapeutic process at various levels of readiness and awareness. Some families, aware of the issues to be addressed, and were in agreement with service. In other cases, referrals were made to our program by workers who felt his/her clients were in need of the services, but the family was not necessarily in agreement with the worker's assessment of their need. In such cases, the therapist's initial task was to bridge the gap between the family's perception of existing risk of abuse and the degree of risk perceived by other outside systems. My strategy for working with the family was influenced by whether the label of 'at risk' was coming from inside or outside of the family, by the definition of 'at risk', and by who else in the system was in agreement with the label. This will be discussed further in each individual case presentation as well as in the evaluation section of this paper.

Process

All of the families participated in an in-take meeting which included family members, the referring worker, and the Parent Support Program Manager. Sometimes the Parent Support counsellor to be assigned to the family also attended this meeting. The meeting took place in the family's home. The

purpose was to meet the perspective client, assess the relationship between the referring worker and the family, hear both party's definition of the problem, involve the family in the treatment process, and describe clearly to both referring worker and family the specific services that the Parent Support counsellor could offer.

I met on the average of once or twice weekly with each family, for approximately 1 1/2 to 2 1/2 hours each visit. The frequency and duration of visits fluctuated with the degree of need and/or risk observed with each family. All visits took place in the client's home.

When I began working with these families, I suspected that joining could be a continuing process, to be re-negotiated at key therapeutic markers and ongoing throughout the intervention process. I also thought that the task of coordinating helpers would occur at different times depending on such factors as the size of the team, their level of involvement, and their definition of the problem. As it turned out, with some families, the team meeting to coordinate helpers took place before meeting the family. In other situations it was necessary to spend time delicately joining with the family before such a meeting could be arranged. The initial meeting with the family was a time to explain my role and to begin to define the client's perception of the problem.

Assessment

Assessment was individual-family focused and, with the exception of the Family Assessment Measure 3 (FAM 3), qualitative in nature. The purpose of testing was to aid in developing appropriate therapy goals for each family. An informal pretest and follow-up assessment format was initiated within the first

one to four meetings. The following instruments were used: the FAM 3, and a parenting scale from "The Maternal Child Nursing Journal"(MCN), l984 (Appendices 2 and 3).

The FAM 3 was developed out of the Process Model of Family Functioning (Skinner, Steinhauer and Santa-Barbara, 1983). It has reliability coefficients ranging from .86 to .95. The General Scale has internal consistency reliability estimates ranging from .62 to .93 for adults and .60 to .94 for children. The FAM 3 assessed intrapersonal and family function on seven planes: task accomplishment, role performance, communication, affective expression, involvement, control and values and norms. It assessed the family as a system, examined dyadic relationships within the family, and measured the individual's perception of his/her functioning within the family. FAM 3 may be used as an assessment tool for clinical intervention or as an outcome measure. In this practicum it was used as a pretest to help target therapeutic intervention.

The MCN Parenting Scale is an informal scale used by the therapist to assess the capacity to parent, breaking this task into the following categories: attachment and interaction between parent(s) and child, physical care and hygiene, parent(s) attitude toward the child, ability to provide survival needs, parent's ability to meet own needs, coping behavior, level or responsibility, ability to supervise child, ability to identify environmental hazards, supervision, health practices, methods of discipline, and relationship patterns with peers, family and professionals (Velasquez, Christensen and Schommer, 1984). The MCN Parenting Scale was used as an informal measure to give me a structure for assessing parenting skills.

In addition to the FAM 3 and the MCN Parenting Scale, genograms were used to track intergenerational patterns at work in the family. Eco-maps were used to assess the family's involvement with outside agencies and systems and the quality of this involvement. In addition, each adult was asked to discuss, (1) his/her own perceptions of him/herself as a potential abuser, and (2) what parenting skills, if any did they perceive that they lack?

Finally, this writer tracked the joining process with each family, observing important markers along the way. Such markers included: the client consenting to see worker, the client being willingly to share his/her own perceptions about the world and about self, his/her ability to form a trusting relationship, his/her desire to use therapist as a model, and his/her understanding of the function and role of therapist and of the work to be accomplished.

As suspected, each family entered the therapeutic process at a different level of readiness and awareness. Because of this, the process of obtaining the pretest information also varied. Families A, C and D, believing the therapist's explanation of the importance of such measures in gathering useful information about the family as a precursor to knowing how best to help, were able to participate in the pretest assessment within the first two meetings. Family B was initially very reluctant to disclose any information, even compiling a genogram was suspect until the fourth meeting. Joining with this family was in general a difficult and delicate task. Family E took the pretest assessment in the third meeting, in the first three meetings the level of chaos, disorganization and noise were such that the writer was unable to administer the pretest.

Follow-up Assessment

At the termination of therapy, families underwent the following informal assessments to determine the outcome of therapy:

1. families were questioned informally to determine their own experience of the joining process: when they felt comfortable, when they did not, what they liked about the sessions, and their critiques of the therapeutic process.

2. a new eco-map were drawn to track any systems changes that had taken place in the course of therapy.

3. each family was separately assessed as to whether treatment goals were successfully accomplished.

4. family members had the opportunity to discuss their own experience of the therapy process. What gains they had made, what perceptions had been altered.

5. adults were once again asked to rate themselves as potential abusers. How had this perception changed through therapy?

Case Presentation

In each of the following chapters (five through nine), one of the five practicum families will be presented. Case #1, the A Family will be presented at length, the remaining four cases will be presented in shorter format. All five case presentations will include general information about the family, presenting problem, pertinent previous intervention and abuse history, assessment information, goals for therapy, therapy format and outcome.

Chapter Five

Family #1: The A Family

Sue 33 yrs old (mother)
Peter 54 yrs old (boyfriend)
John 13 yrs old (son)
Jason 6 yrs old (son)

Helping Network:

Child and Family Services Worker
CFS Childcare Worker
Parent Support Counsellor
Psychological Services Therapist
Economic Security Worker

Introduction

This family was referred to the Parent Support Program by a social worker at one of the regional Child and Family Services (CFS) Agencies. Sue, the mother, who has had repeated involvement with CFS since 1984, contacted CFS by phone to seek help with the management of her then 12 year old son, John. She described John as being physically and verbally abusive towards her, and as having tantrums and rages. She stated that he frightened her and unless someone could change his behavior quickly, she wanted him placed outside of the home.

At the time of this call, Sue was living alone with her two sons, John, 12, and Jason, 5. She was currently involved with Peter, 53, and they had been seeing each other for one year. Peter was an alcoholic, chronically unemployed man who had recently lost his wife to cancer. Peter and John

were fighting regularly and Sue was alarmed that Peter would leave the relationship if this level of tension continued.

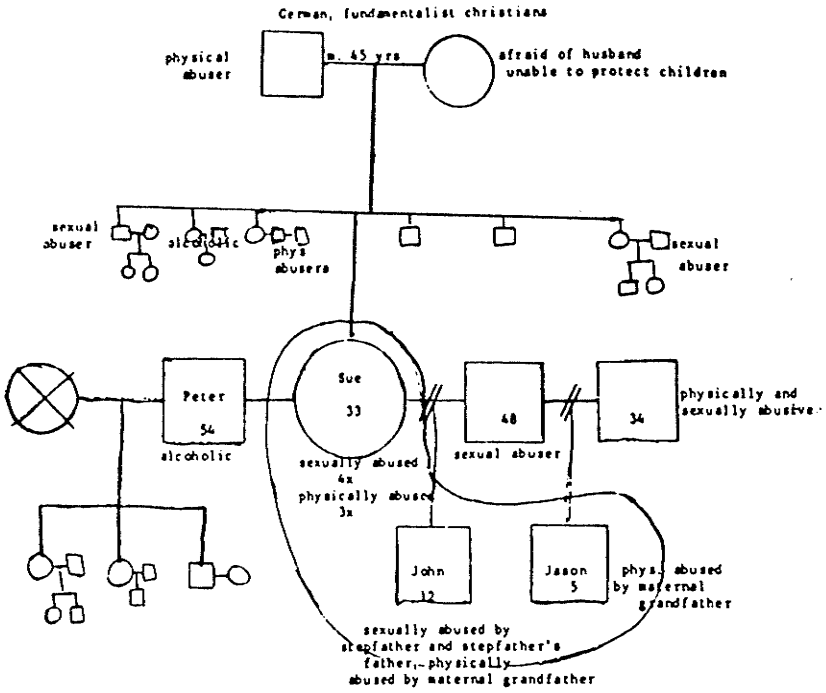
Both Sue and John had been physically and sexually abused on numerous occasions by several different perpetrators. This information is elaborated in the section titled 'Previous Abuse History'. Neither had had an opportunity to address their resulting abuse issues. John was currently experiencing night terrors and daytime crying episodes. Often these activities set off arguments in the family, as Sue became very upset when John attempted to talk about his abuse.

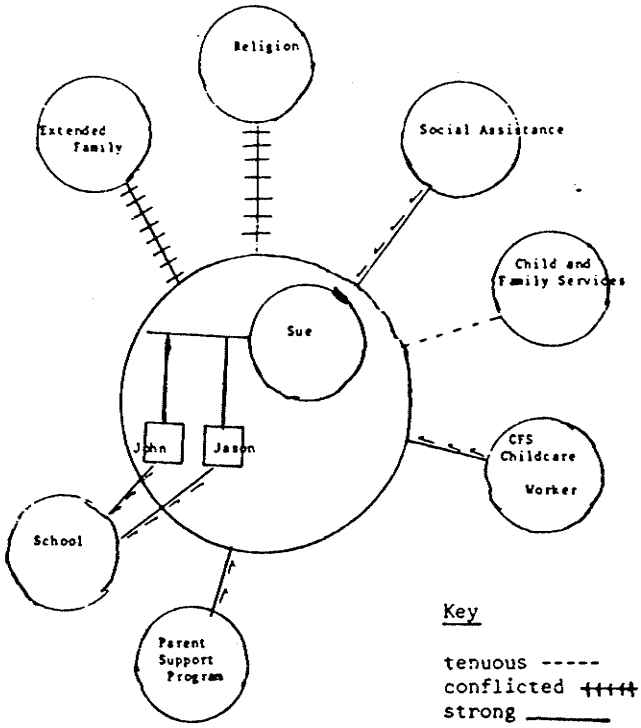
When Sue was assigned a CFS social worker a voluntary placement agreement was drawn up to place John in a foster home. At the same time a referral was made by phone to our program requesting that someone work with this family on behavior management issues. Because our program had no available workers, the family was placed on our waiting list as a priority referral.

The genogram on the following page tracks the family for three generations. One can begin to see some of the intergenerational abuse connections, and their influence on present problems in the family. The Eco-Map on the following page was drawn at the beginning of treatment. It identifies systems involved with the family at that time.

In early June l988 an opening became available, the A family was tentatively accepted into our program. As is our procedure, the director of our program arranged a meeting with the family in their home with the CFS worker present to meet the family members. Ideally the purpose of this first meeting is: (1) to explain our program in more detail, (2) to find out if the family wants

A Family Genogram and Eco-Map





to work with us, and (3) to get a more in-depth description from the family of what concerns and issues they might want to address. At the time of this intake meeting the CFS social worker informed us that she was leaving the agency and that a new worker would be taking over the case. Both workers were present at the meeting. The outcome of this meeting was a voluntary commitment from the family to work with a counsellor from our program, and a list of three concerns the family wanted to address: (1) improve Sue and John's relationship, (2) help John deal with his abuse, (3) help Sue feel less overwhelmed and overburdened. The family was told that a counsellor would be contacting them in several days to set up a meeting. I met them the following week on June 15th in their home.

In my first meeting with the family Sue quite spontaneously detailed previous interventions. I have included them here because they have had a definite impact on my intervention. They offer important historical and process information about the family.

Previous Intervention

January 1985---Sue's second husband sexually abused John on numerous occasions and was charged, John began seeing a psychiatrist.

April 1985--------John terminated with the psychiatrist, the reason for termination is unclear, Sue said that she initiated termination because she felt that information was being kept from her and that the psychiatrist was very rude to her, John said termination occurred because he complained to his mom that the psychiatrist only wanted to play.

July 1985---------Sue called CFS to complain that John was unmanageable and that she needed help. A teaching

homemaker was placed in the home 5 days a week, 4 hours a day. A quasi-behavior modification program was implemented. The homemaker remained in the home for six months and was terminated only when Sue felt she was able to handle John.

March l986-------Sue began attending a group for women who have a child who has been sexually abused. Sue was referred to this group by her CFS worker. She dropped out of the group half way through the sessions because she found the group did not address her issues.

October 1986---Sue again contacted CFS to complain that John was unmanageable. He was now verbally and physically abusive to her and she feared that he would become violent. A CFS Child Care Worker was placed in the home 5 days a week for 3 or 4 hours daily. Sue reported feeling much less stress because the worker was able to redirect John and keep him occupied. The worker terminated after 5 months reporting that she was unable to work with Sue. Sue was confused as to why this happened, but she said the worker was very disappointed with her because she was unable to follow through on limit setting with John.

November l987-Sue called CFS again to request that John be removed from the home. He was placed in foster care for 3 weeks after which time Sue demanded that he be sent home as he was not receiving proper care. While waiting for a counsellor from our program, a CFS Child Care Worker was assigned for 8 hours a week to counsel John, take him on outings and talk to Sue about her concerns.

Presenting Problem

Sue in our first meeting, spoke quickly in a tense, high, pressured voice. She stated that what needed to be changed was John. She described him as full of anger and hate and said that she was not deserving of his rage or of his blame. She said that she was afraid of him because he had attacked her four

times. When she was asked to detail these attacks, she described behavior which sounded relatively normal for an emerging adolescent: yelling, stomping up stairs, banging doors, occasionally throwing toys and swearing. The threat for Sue seemed to be in how she interpreted this behavior and felt frightened by it. She said that since she had met Peter a year and a half ago, John had gotten worse and worse. She wondered if John purposely wanted to drive Peter away. Lately Peter stormed out of the house whenever Sue and John argued. Sue blamed Peter's leaving on John's behavior and said that she didn't know how many more times Peter would be willing to put up with such behavior. She was afraid that she would loose her boyfriend if John didn't change. She said that Peter had begun saying that unless John's behavior became more manageable, he would like to postpone their marriage. Sue stated many times that John seemed to purposely try to make her upset or angry. She wondered if he acted this way intentionally to give her a head ache or bring on a seizure. She spoke as if she expected John to be able to anticipate her needs, almost as if she were the child and John were the adult. Sue said that she got so angry at John that it scared her. She was afraid that if she ever gave into her anger that she might really injure John. She said that she was unable to feel affectionate or supportive toward him even when he requested it. It was much easier for her to give to Jason. Sue felt she was unable to manage John and she wondered if the best thing might be to have him placed in foster care to show him that other people would not treat him as well as she did.

While discussing the situation, it was very difficult for Sue to stay on topic. She jumped from subject to subject and continually directed the discussion to

her own experiences with abuse. She constantly interrupted her sons to answer questions for them. She chastised them inappropriately, one minute threatening harsh, unrealistic punishments, and in the next moment giving in to them if they persisted with the behavior. She discussed being strangled and raped in the same breath that she talked about normal daily living experiences. She continued to speak in a nervous, tense voice. Her moods shifted rapidly. One moment she would blurt out insightful comments, the next moment she would go off on an unrelated tangent, forgetting what she was originally talking about and bursting into tears as she described an event in her past. In listening to this woman it was easy to imagine her life as a series of threats, frightening experiences and situations over which she had had no control.

Peter said that he saw two basic problems. First he thought that Sue was too involved with her family and kids. He said that Sue did too much for her kids. He gave examples of Sue running John's bath water, of pouring his milk for him at dinner, of running up and down the stairs whenever the kids needed her help to find a misplaced toy, and of feeding Jason if he was eating slowly. He thought that the boys were both spoiled. He said that John and Sue both flew off the handle too easily and that Sue was too quick to react to John's taunts. When they argued both Sue and John typically introduced new unrelated complaints and topics until neither knew what the original argument was about. He thought that Sue needed to learn to calm down because when she got upset it affected her health (Sue was epileptic, she had 7 seizures last year, she has an ulcer and she got frequent headaches which left her

incapacitated). Peter said that Sue kept information from her family of origin because she feared being judged and criticized. At home Peter said that Sue complained about how much she hated her father, yet whenever he asked her to do anything she complied.

Secondly Peter thought that Sue put too much pressure on him about their relationship. She wanted him to move in, be a father to the boys and a husband to her. He was not sure that he was ready to do that. He had lost his wife of many years in l987. He said that he cared a lot for Sue but that he felt overwhelmed by all of her problems. He wanted to postpone their marriage until things were running smoother.

Peter was an alcoholic, although he was very reluctant to admit this, and has had three serious drinking binges during his involvement with Sue. All three binges were preceded by fights, with the shared theme of Peter perceiving that Sue was pushing him to get more involved with the kids, to marry her and to move in. Peter reacted to Sue's demands by backing off and finally leaving the house and going off on a drunk. The first time this happened coincides with the beginning of Sue and John's most recent difficulties.

John was a very awkward and gangly 12 year old. His hair was sticking out in every direction and he looked like a frightened waif. He seemed much younger than 12. He spoke slowly and deliberately, he looked off into the distance or at his mother constantly. He seemed very hesitant to speak in front of his mother. Initially he said that he didn't know what he would like to change in his family. He said that he thought that everything was okay. When

I questioned further he said that he would like his mom to let him go to bed later than 8:00 pm, and he wanted his mom to stop yelling at him all the time. He seemed to be talking about very concrete requests, but one had the sense that there was much more going on beneath the surface. He spoke haltingly and quietly. He wore a worried expression on his face and he looked at his mother often. Several times when he seemed unable to answer a question, he fell over on the couch, burying his face in the cushions. He was worried that he would be abused again but was unable to elaborate. He was afraid that when Peter got drunk that he might physically hurt his mom. Looking very sad he said that he had lots of worries.

Jason, 5, wanted all the yelling to stop. He said that John scared him when he got really mad and he was afraid that John might hurt him. He also wanted Peter to be his daddy.

Summary of Presenting Family Issues

The problems presented by the family have existed off and on for two and a half years. Sue has had various helpers coming in to the family, and this has temporarily made a difference, but the helpers have generally terminated prematurely and once gone, the family has resumed its old way of functioning. The latest deterioration between Sue and John began almost immediately after Sue and Peter began to see each other seriously. Arguments between Sue and John seemed to escalate when Sue was feeling the pressure of keeping the peace, meaning when Peter was present and was threatening to leave or pull away from the relationship because John was too much to

handle. In such a situation Sue described herself as being pulled in two opposite directions. She was afraid that she would loose Peter if John's behavior did not improve, but she also felt strong loyalties to John and resented Peter when she felt that he was asking her to choose his side over John's side.

At other times, arguments between Sue and John seemed to develop when he either covertly or overtly asked for nurturance and support from his mom and she felt too drained and/or resentful to give him what she knew that he wanted. The behavior that Sue targeted as violent or out of control, when described seemed like relatively normal behavior for an emerging adolescent. The problem for Sue seemed to be how she interpreted this behavior and felt threatened by it. For Peter the problem seemed to be watching Sue become so upset during John's outbursts and jumping in to help Sue maintain control.

Sue was the person in the family who sought out counselling. She was motivated by two forces: fear of loosing Peter and a fear that she would get so angry at John that she would loose control and physically injure him. She generally resorted to corporal punishment when she felt John was out of control. In fact, her need to place this child might have been her way of protecting him. Twice in the past when problems had become overwhelming Sue had called CFS and asked for help. Thus, Sue has had intense involvement with both a teaching homemaker and a childcare worker. Sue's perception of both of these workers was that they interacted with John and kept him occupied, but that she did not learn new skills for coping with the problem. It seems that the pattern has been for someone to intervene for Sue, taking away the stress but not addressing the dysfunctional underpinnings

that perpetuate the problem. Sue was again looking for someone who would relieve the stress by focusing on John and his behavior.

Abuse History

There is a long history of physical, emotional and sexual abuse in this family which continues to have an impact on their present situation. Because of this, I would like to present a brief chronicle of the abuse beginning with Sue's childhood:

-physically and verbally abused by her father as a child, severely punished for minor infractions, mother unable to offer protection

-sexually assaulted as a teenager by a relative, although she disclosed to her parents, the next day she was forced to attend a party in her honor at the abuser's home with the abuser present

-gang raped at age 18 while walking home at night

-married first husband at age 19, he physically abused her on multiple occasions, married one year, left when husband tried to suffocate John who was an infant at the time

-married second husband when John was 3 1/2 years old, married 6 1/2 years, second husband verbally and emotionally abusive to her after first few weeks of marriage

-left marriage when John disclosed that his stepfather had been sexually assaulting him for the past 3 years

John also has a history of physical and sexual abuse:

-physically abused on many occasions by maternal grandfather

-sexually abused by stepfather's father from the ages of 4 to 6, eventually John disclosed to Sue and Sue stopped contact

-sexually abused by stepfather from age of 7 to 10, when John finally disclosed to Sue, stepfather was charged and sentenced to 18 months in jail, the family has not seen him since, during time of sexual abuse, John was labeled as developmentally delayed, and was sent to a special school and failed several grades

Assessment

(1) Clinical Assessment

This is a family who possesses many traits commonly possessed by at risk to abuse multi-agency families (Aponte, 1976; Gilbert, Christensen and Margolin, 1984). This is a family who:

-operates from crisis to crisis
-possesses weak boundaries (marital, parental, inside and outside the family)
-has an unclear hierarchy
-has poor differentiation between members (Sue has not individuated from her family of origin)
-has poor problem solving skills
-has an inability to plan, as focus is on the present
-has family themes of aggression, helplessness, abandonment
-has poor self-esteem, both individually and as a family
-has poor communication
-has an adult who functions as a regulator of the children's behavior
-has interactions which shift abruptly in mood and theme
-is unable to set limits
-is enmeshed
-has adults who are overwhelmed and overburdened
-has power struggles between adult and children
-has a poor idea of normal child development
-has role reversal between Sue and John
-has an adult who attempts to fill her needs through her children

-has an adult in competition with her children for love and need fulfillment
- perceives children's behavior as willful and disobedient

(2) **FAM 3**

The FAM 3 was taken by Sue and John. Jason was too young to participate in the assessment and Peter was unwilling to participate. FAM 3, while not a replacement for clinical assessment of the family, does elaborate and validate the impressions of the writer in the first interview with the family. FAM 3 profiles can be found in Appendix One.

One major problem targeted by FAM 3 was the family's very poor problem solving abilities. This corresponded with my assessment that the family was unable to either identify family difficulties or to generate or implement appropriate solutions. As a consequence, minor stresses tended to precipitate crisis. Thus, this family had a pattern of operating from crisis to crisis.

The family had also not managed to develop an acceptable level of role integration, and lacked agreement between members regarding role definition. This supported my clinical assessment of Sue as the regulator of everyone's behavior. As a consequence neither child had an opportunity to internalize rules or to evolve an independent role in the family. The family's poor problem solving skills left them unable to work together on a common task. Without a unified purpose or an agreement of role definition, the family was unable to adapt to new roles as required in the evolution of the family life cycle.

My assessment of poor communication skills was also supported by the FAM 3's identification of insufficient , displaced and masked communication in the family. The FAM 3 targeted a lack of mutual understanding between family members, and an inability to seek clarification in the case of confusion. The family's high level of anxiety resulted in continuous overly intense inappropriate affective expression.

The family's very dysfunctional score in the area of affective involvement supported my clinical assessment of poor differentiation between members, and blurred boundaries between subsystems. This was an enmeshed family whose members were in competition for nurturance and need fulfillment.

As was evident during my clinical assessment this was a family whose interactions did not allow family members to master the daily routines of family life. Sue's attempts at setting limits with the boys ranged from ineffectual to rigidly destructive and shaming. There were almost constant battles for control between parent and children. These struggles did not allow family members to be able to perceive and adjust to changing life demands.

Although one would expect John and Sue to have different perceptions of the family, it was surprising that their perceptions differed so extremely (Appendix One). This might have been due to their different interpretations of the questions. Sue's rating of the family as very dysfunctional along with her very low social desirability score indicated that she might be distorting the measurement through projection. John, on the other extreme, assessed his family as functioning within the normal range, but rated himself as a dysfunctional member in all areas. This was an extremely dysfunctional family who showed deficits in all seven areas of assessment.

(3) Maternal Child Nursing Scale

Sue showed ambivalence about her relationship with John but she was willing to discuss her feelings. With Jason she showed significant attachment and demonstrated sensitivity and responsiveness. This was consistent with my clinical observations of the family. Sue was inconsistent in her expectations of both children and sought to have her own emotional needs met by her children. Her ambivalence towards John and her expectation of nurturance from Jason was observable in our initial session. Sue was inconsistent in her ability to recognize her own limitations and resisted help when offered. Sue was inconsistent in developing and maintaining supportive relationships for extended periods of time. She described many losses in her life.

Sue was aware of the importance of adequate hygiene and nutritional standards for her children and was generally able to maintain these standards. Sue was consistently able to provide adequate housekeeping standards and stability for the children in the home environment. Sue seemed aware of most significant hazards, but would sometimes neglect safety if her stress level was high. Sue was aware of the negative effects of the excessive use of babysitters but would sometimes make inappropriate choices depending on her stress level. In general, Sue was able to meet the minimal basic living needs of her children, but the quality of her skills fluctuated with the degree of perceived stress.

Sue identified when her children needed medial care and had an ongoing satisfactory relationship with one doctor. She also anticipated the

need for maintaining an adequate standard of health care. In the area of discipline Sue, when angry would strike her children, she had unrealistic expectations of the children's capabilities and rationalized the use of physical discipline . Sue's relationship with John was adequate at times, but she often gave mixed messages and was unpredictable because she responded from her own emotional needs. Sue had the ability to accept support but was often dependent on friends. With her family of origin Sue had a hostile dependent relationship. Sue perceived a negative attitude in her parents about her capacity to function.

(4) Perception of Self as Abuser/Parenting Skills

Sue was frightened that if she got angry enough with John she could loose control and injure him very badly. She felt that every day she was getting closer and closer to loosing control. She described several incidences where she found herself beating John with a stick or a belt and had to force herself to stop. In those moments she described hating John and wanting to kill him. She was also very surprised at the depth of her feelings. She felt guilty and worried, but she also blamed John for forcing her to feel that way. She said that if he would only behave, she would not have to struggle with herself because she would not be pushed into these feelings.

Family Themes

(1) It seemed clear that all members of this family had unfinished business from the past that continued to have a big impact on their present. Sue was still very enmeshed with her own family of origin. She had been

unable to develop a clear, separate sense of self. She was used to leaning on dominating, abusive men. She was very angry at both of her parents for the physical and emotional abuse that she consistently endured as a child. There were also the three incidents of sexual abuse with which she had never dealt. As she herself was quick to admit, her own sexuality had been deeply affected by the abuse. Because of her early deprivation and abuse, she also lacked a certain amount of empathy and understanding for her own children's circumstances, and this affects her ability to parent. When she was agitated or upset by either John or Peter, many of these unresolved issues rushed into the present conflict. She described that when she was in the middle of arguing with John or Peter, she sometimes forgot where she was. At those times she had the sensation of being a child again and of being abused by her father. Sometimes she saw her father's face instead of John or Peter's. At this point in time her memories of the assaults washed over her and she lost track of the present.

Peter had not acknowledged his drinking problem or dealt with the death of his wife. He was overly concerned with Sue's health. He was unable to commit himself fully to his relationship with Sue.

John had not adequately dealt with either the physical or emotional abuse that he had suffered. The males in his life had all been abusive. His fear, pain and anger were very poorly contained and surged out during any and all conflicts. Many of these feelings were probably directed at his mother, who he perceived as unable to protect him.

Jason was very invested in having Peter become his dad. This added to the tension that was already present in the family.

All of the members in this family had loss issues which had not been addressed and which were now manifested in a variety of ways. John had lost both a father and a step-father. Although both of these men were abusive, his rejection of Peter was probably connected to unresolved issues around the loss of these two paternal figures. I suspect that Peter's hesitation to commit fully to his relationship with Sue had to do with unresolved issues around the loss of his wife. Sue had lost two husbands and never really felt connected to her parents. The fear of loosing either Peter or John probably re-activated issue around these past losses. Jason had never had a father. Peter was the first man in his life who could fulfill this role.

(2) This was an enmeshed family that had poor boundaries between subsystems and whose hierarchal structure was unclear. Because of the nature of her own enmeshed family of origin, Sue had been in the habit for many years of sharing any and all information with her children, with neighbors, with professional helpers, and with new acquaintances . She indiscriminately offered information about sexual matters between herself and Peter, about their conflicts, about her money concerns, about her own abuse history, about conflicts between herself and her parents, her worries, etc. Because he was the oldest, John was often singled out as her confidant. She had even told him that he was the man of the household. She had remarked that when she and John fought, he reminded her of her father. At those moments she forgot that it was John that she was arguing with and began to feel that she was a child again struggling with her father.

In her family of origin Sue often observed her father inappropriately release anger caused by external sources on his family, and especially on his

children in the form of severe corporal punishment and verbal abuse for small or nonexistent infractions. At those times Sue's mother allowed the children to be physically abused without protest because it meant escaping his wrath herself. Communication in this family was very masked and indirect. Members in conflict were unable to speak directly to one another. Often Sue's mother became the go-between, with each party privately complaining bitterly to her about the other person's actions. Although Sue's mother would promise not to share the conversation with the other person, she often breached confidentiality. Many times the information that she communicated to this family member was inaccurate and distorted. This often increased hard feelings between the two conflicting parties.

Many of these learned patterns were perpetuated in Sue's current family. Both Sue and the two boys released their anger impulsively and indirectly and usually at the wrong target. Sue and John had also taken on the role of victim. They were generally anxious, and easily frightened,

Sue looked to Jason for her own support. If Peter was not staying over, she would let Jason sleep with her. She solicited his hugs and kisses when she was feeling needy. The boundary between the parent and child subsystems was very blurred. When Sue and her two children were in conflict, one got the sense that they were three children all equal in power. The content of their conflict was generally unfocused, they jumped quickly from topic to topic in a confused and random manner.

When Peter was drawn into a fight between Sue and John, Sue seemed to step down in the hierarchy while John stepped up to take his mother's place

and fought Peter as an equal. At this point, the child subsystem shifted to allow Sue's entry.

(3) Sue and John were stuck at an important family life cycle stage. They had not dealt with issues relevant to separation. Ideally the family with an adolescent should be flexible enough to permit the adolescent to move in and out of the system, as he gains in independence. Instead, Sue was rigidly inflexible in reaction to John's demands for more independence. The enmeshed quality of this family as well as the lack of boundaries greatly hampered John's ability to self differentiate.

Another life cycle conflict was concurrently being played out between Sue and Peter. Peter's own children were grown and several of them were parents. For Peter to become committed to Sue and her young family was to step backwards in the family life cycle. He was obviously ambivalent about assuming this responsibility.

(4) Some of the issues in this family were the result of the coming together of a blended family. Issues around who disciplines the children, and how this was carried out, developing new boundaries, new loyalties, etc. This was further complicated by the fact that this particular family hadn't quite decided if it would come together or not. This was due to unfinished business remaining for each partner in terms of how well they had dealt with previous separations. The family was in limbo, some members were working hard to connect while other members were working hard to stay separate.

Hypotheses

In the present situation John was being asked to assume major responsibility for the family's dysfunction. If the focus and blame could rest on him, then all family members stood to gain and a certain fragile homeostasis could be maintained. If John continued to fight with Peter and his mom, conflict between Sue and Peter over Peter's drinking and Peter's reluctance to commit to the relationship could be put on hold as Peter and Sue tried to cope with John's behavior. Unresolved issues around past abuse were ignored, but both Sue and John attained some small degree of emotional release through their constant bickering and fighting. Jason could be the good, sweet kid who met Sue's needs for nurturance. In that role he also perpetuated the family myth that younger kids were easier to manage. John, in his role as out of control adolescent connected with Sue in several different ways. First, his behavior helped create a reason for another person in her life who could 'handle' John. It also met the family's learned need for enmeshment and intense interaction as a measure of connectedness.

Goals

Family:

Remove John as the cause of the family's problems, reframe as an interactional problem between all members

Improve skills for coping with daily stresses
Improve communication
Maximize internal resources
Strengthen boundaries between subsystems
Make hierarchy more clear

Sue:

Develop a relationship with basic trust
Address unresolved abuse issues
Increase self-esteem
Increase individuation
Develop interests outside the children

John: Develop a relationship with basic trust
Address unresolved abuse issues
Increase self-esteem
Increase individuation

Parenting:

Replace abusive patterns of child rearing with more rewarding patterns
Adults will view the children as separate individuals with their own thoughts and needs

Adults will tolerate the children's negative behaviors
Develop an appropriate behavior management strategy

Intervention

Structure of Therapy

Because of the degree of emotional deprivation and neediness exhibited by Sue and John, which put them in competition for attention, and because of Sue's need to vent her frustration and anger at John, a treatment plan was devised to support both individuals and the family as a whole. Arrangements were made for John to begin play therapy with a doctoral level psychology student at the Psychological Services Centre, University of Manitoba. At the same time I began weekly individual counselling sessions with Sue as well as weekly family sessions.

This format was devised to allow Sue to begin to use me for support and nurturance and to allow John to step out of this role. The in-home therapy

approach allowed me many opportunities to observe the family functioning and to intervene and educate the family in new methods of coping and problem solving. Family sessions were used as opportunities to help the family practice new skills and to educate and model for the family.

Joining

Family A, while highly anxious and requiring a helper to play the role of co-parent, did not consider itself 'at risk'. In this situation, the same characteristics that were being labeled as 'at risk' by outside professionals were being supported and validated as appropriate by family and friends. The outside system based its assessment of 'at risk' on the parent's abusive history, on observed inappropriate parenting behavior, on the children's behavior and on the parent's own verbalization about the stress she was under and her fear of failing to cope.

While superficially, I was able to use the family's request for services due to the stress created by the identified patient as entry into the system, I was at once faced with the family's very rigid agenda and with Sue's obvious deprivation. Her own abuse history was manifested in her extreme need to compete with the rest of the family for my attention, in her inability to empathize with her children and thus understand how her inappropriate parenting was having an impact on their development, and in her extremely low self-esteem which left her hearing even neutral comments about her parenting as attacks, or blaming criticisms.

At the time of my entry into the system, the family was not yet ready to accept me as a vehicle for change, as "who's change" and "what change"

were not topics that the family had yet explored. It was my hypothesis that until Sue had some of her own emotional needs met, she did not have the energy or interest to learn about her children.

Joining with this family was a slow process that actually took several months. I began by meeting twice weekly with Sue alone to learn more from her about her situation. During these first initial visits much time was spent listening to her history, listening to what had been tried by other helpers and what she thought had been effective, tuning into her feelings of being overwhelmed and overburdened, and helping her to sort out what about the family she wanted to change. Sue had never thought in these terms before and it was as if she first had to develop a repertoire of skills before she could tackle the role of parent and leader of the family. Initially, because of her sensitivity to challenge and confrontation, I deliberately accepted the problems as she defined them and gave her some small but immediate behavior management skills which eased her feelings of being overwhelmed and overburdened.

Because I met Sue in her home, it was easy to have informal time with the whole family, to get to know members and to observe dysfunctional interactions. My time with the family began to include direct intervention, and hands-on teaching opportunities. There were many times when I became a coach during family arguments or when Sue tried to set limits with the boys and needed help following through. Slowly as Sue and I continued to talk, and the small changes that the family tried worked, something changed. Sue and her children began to look forward to my visits, they asked more

questions, and for the first time Sue seemed receptive to a gentle reframe of the problem as one affecting the entire family.

With this family I attempted to make the separation between myself as a treatment person and CFS as a monitoring agency both verbally and through my actions. The family had had several CFS workers so they were familiar with CFS process. From the beginning, I made a conscious attempt to define our two different roles, and what the family could expect from me in terms of service, confidentiality, and process. I also discussed what my involvement would be with CFS. I arrived at the house separately, before or after the CFS worker. I discussed with the family all contacts I had with their CFS worker. These attempts on my part to separate myself from child welfare were less meaningful for Sue than when she began on her own to recognize the different style of my agency from that of CFS. This is what actually helped her to separate my service from that of child welfare.

In this family John's need for service was as immediate as his mother's. While I was working with Sue, it was obvious that John too would require individual work to help him with his own abuse. He also needed validation, support and a channel for releasing the frustration and anger that he was beginning to direct to his family. I found a counsellor who was able to work with him. In this situation individual counselling for both Sue and John seemed to balance the neediness in the family to the extent that after several weeks of this regime, members were better able to come together as a family and begin to work on issues.

The joining process with this family was ongoing in the first three months. It was very easy for any comment I made to be interpreted by the family as

criticism and blame and once this happened for members to begin to operate in the myth they had always operated in: 'they were powerless to change, I was labeling them as bad and they had to pretend to agree with me and to comply while secretly being angry and hurt with me.' I spent a lot of my time trying to make this covert process overt.

Intrapersonal/Systemic Intervention

During our individual sessions Sue talked a lot about her past and about the abuse that she had experienced. Each meeting she detailed more specifically the treatment she has received at the hands of her parents. She described episodes of beatings, being locked in rooms, being locked out of the house and being tied up and of being verbally demeaned and humiliated. It is interesting that in the beginning, she did not label this treatment as abuse. She felt that as a child she had somehow deserved this treatment. She felt rejected and unloved by her parents, and she wanted desperately to change this. Initially she was very enmeshed with her family of origin. She repeated the pattern over and over again of sharing information with her parents during her stressful times and expecting support, only to receive criticism and blame. After such an episode, Sue would perceive John as being especially difficult and trying. This would be the time that she would threaten him with placement.

After several months, Sue was able to begin to recognize this pattern. She also began to realistically assess the level of support or nonsupport that she could consistently count on from her parents. She began to contact them less during her stressful times. She came to rely on her own developing skills

to handle stress. She also began to label the treatment she had received as a child as abuse. She became quite angry at her parents. She labeled her father as abusive and her mother as having been unable to protect her. She began to draw many connections between her mother's inability to protect and her own inability to protect John from the abuse. As these connections became more clear to her, she began to look at some of the family myths that were being perpetuated, myths about the roles of men and women in her family.

While working on this process, Sue began to actively reject some of the myths that she had been perpetuating in her own family. She no longer believed that women had to unconditionally accept abusive behavior from their husbands, that women were weak and men strong, or that older children were rebellious and bad.

Once Sue and John were supported by individual sessions, family sessions became possible. Initially I met with the family once weekly, and later bi-monthly in their home. Unfortunately, Peter refused from the beginning to be a part of these sessions. This was perhaps symbolic of his not wanting to be part of the family.

I used our time to address targeted family and parenting goals. Together we worked on strengthening boundaries and hierarchy, improving problem solving and communication skills. Sue learned new behavior management skills, was better able to tolerate her children's negative behavior, to see her sons as separate, autonomous beings, and as a consequence was able to accept a reframe of the original problem as one that affected all family

members. Her children came to accept and respect her new authority, and to enjoy the new freedom provided by more opportunity for individuation.

Family sessions were a combination of informal hands-on intervention as difficulties arose, and more formal 'talking' times. Informal sessions often evolved when I was in the home and witnessed dysfunctional interactions between family members. Often I would intervene during these times and together we would find alternative methods of dealing with the problem. As an example, one evening Sue and John got into a disagreement over how much to pet the cat. As their tempers escalated John childishly called Sue 'stupid'. In anger Sue impulsively grounded him for 2 weeks. John in his disappointment gave the coffee table a push with his foot and it moved 3 or 4 inches. Sue leapt up from her chair and grabbed John's hands to restrain him. Her perception was that he was out of control and was going to harm her. Sue moved so suddenly that John became frightened and began to struggle to get away from her. She perceived this as aggressive behavior directed towards her. At this point I intervened. After some calming down time, the three of us discussed what had taken place. We discussed alternatives ways that both Sue and John could have handled their disappointment and anger. We role played these different alternatives.

Over the course of our time together, many such opportunities were presented. Sometimes I modeled alternative behavior, sometimes I directed verbally, and sometimes we role played alternative scenarios after the fact. The family seemed relatively comfortable with all of these approaches.

The Helping System

From the beginning there was reluctance on the part of CFS to work from a team perspective. They are a large, bureaucratic, autonomous agency, used to making unilateral decisions. This particular regional office appeared to groom its workers as case managers, but they seemed to lack any clinical awareness of treatment issues or characteristics of the population. Attempting to create a team atmosphere was a constant struggle. Having two different workers in the space of 6 months added to the difficulty. Each worker had a very different style and assessment of the family.

I organized regular team meetings every 6 to 8 weeks to review progress and adjust treatment goals. I chaired these meetings. Several times, when the CFS worker was especially resistant, I met individually with her (twice with her supervisor in attendance) to elicit special services. In these meetings the CFS worker seemed overworked, and overburdened. I was given the impression that, because my program was involved, she expected me to service this family without involving CFS.

As an example of the difficulties, I will relate one incident. Four months into treatment with the family, the team had met 3 times. At each one of these meetings treatment members had clearly outlined goals and characteristics of the family. Important goals included building trusting relationships, empowering family members, and replacing the behavior of operating from crisis to crisis with the ability to problem solve and plan for the future. Even after all of this, the CFS worker, without consulting any member of the team or explaining her actions to the family before hand, fired the childcare worker who had worked with John for 4 months. This childcare worker was well

bonded with John and enjoyed a friendly and productive relationship with him. This unilateral decision had major repercussions on treatment goals. Both John and his mother had difficulty understanding what had happened. They immediately reverted to old dysfunctional behavior. The CFS worker was unreceptive to the team's disappointment at not being consulted, and not being able to help the family plan for the termination. She dogmatically defended her right to fire the worker, and seemed oblivious to the damage to the treatment goals created by this action.

Dealing with these kinds of occurrences was an ongoing challenge. It was difficult to attempt to empower the family and to encourage them to participate as members of their own treatment plan with this kind of unilateral thinking in place. In meeting and mapping the system, it was obvious that such helpers as CFS had a very different view of the family and of the process of helping.

Outcome

Posttest

(1) At the termination of therapy, the A Family was asked questions to determine their own experience of the joining process: when they felt comfortable, when they did not, what they liked about the sessions, and their critiques of the therapeutic process.

Sue talked about being surprised at how much she had shared with me about her abuse. She said that what she had liked best about the sessions was feeling that she could talk without worrying that I would judge or criticize her. She said that she had always gotten the sense from me that I was

interested in listening to her story. She felt that other workers had not allowed her to talk, and had been too quick to offer solutions. Often times she had not agreed with the solutions but had pretended to because she had felt intimidated.

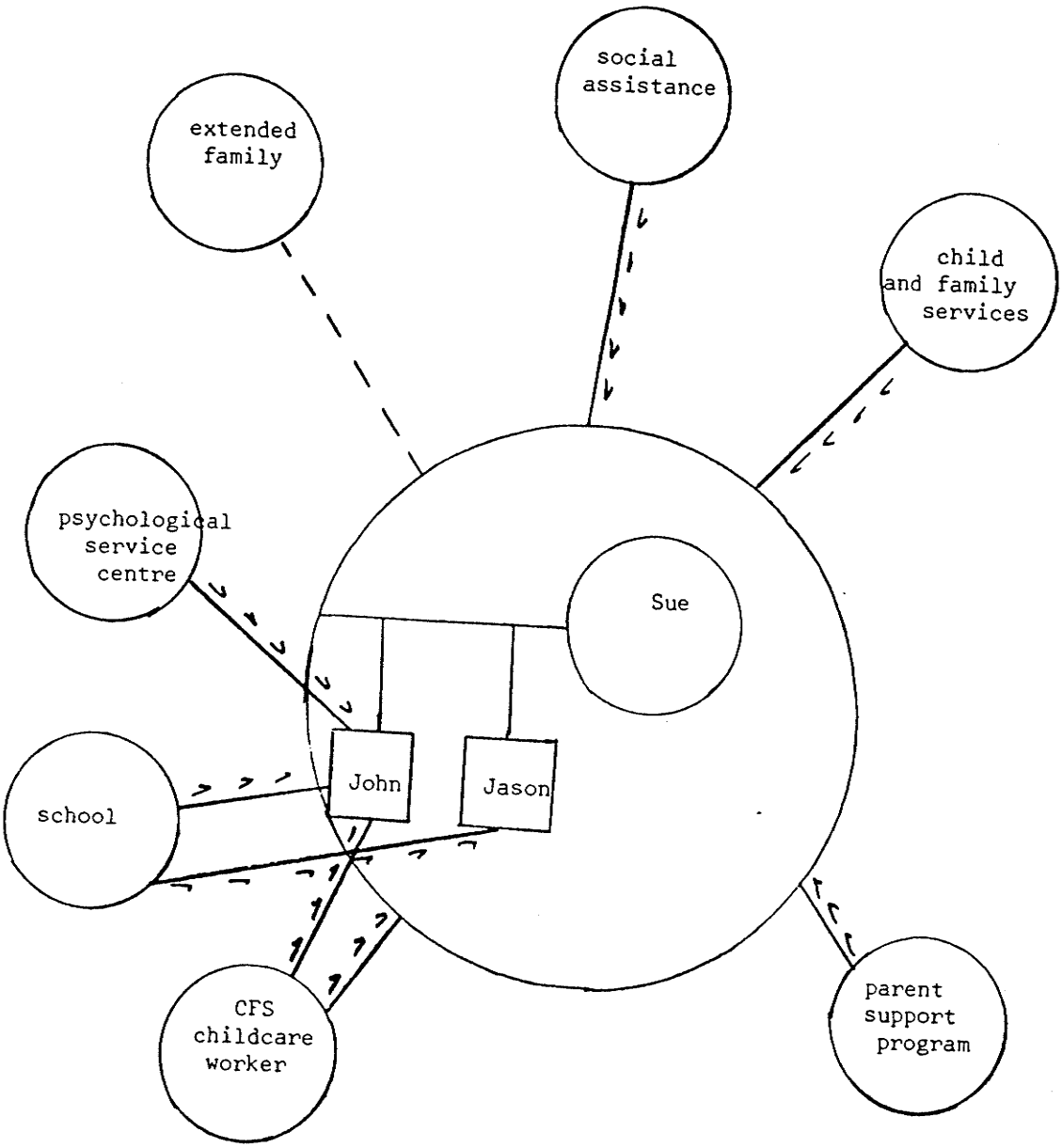
She said that I had a special way of making her feel good and competent. That I had a way of reframing what she told me that allowed her to see things in a different way. She said that she had felt comfortable with me after about 4 or 5 sessions. She had initially been hesitant to tell me about her abuse experience or to share John's abuse. But after the first few sessions, because she felt that I listened without judging, and seemed to really be interested in her point of view, she had felt safe in sharing with me.

Sue's only criticism of the treatment was that it was terminating. She was worried that she would still need me. Although she felt good about her new skills, she was a little nervous to be on her own. She thought that there should be more programs like mine because many people needed someone to come into their home and counsel them.

John had a difficult time talking about the joining process. He had a hard time deciding when he had felt comfortable and he was unable to offer any times that he had felt uncomfortable. He offered no criticism of the therapy process. I suspect that 6 months of family sessions with John was not sufficient to completely gain his trust. I also suspect that his reluctance to speak with me was connected to his overly developed sense of loyalty to his mother.

The Eco-Map on the following page tracks the system changes that took place in the course of therapy.

(2) Eco-Map


social assistance
extended family
child and family services
psychological service centre
Sue
John
Jason
school
CFS childcare worker
parent support program

(3) Goals

In reviewing the family goals that were accomplished during the course of treatment, the three most successful areas of gain for this family were improving communication, strengthening boundaries between subsystems and clarifying hierarchy. By the end of treatment these three areas were noticeably improved. In general Sue was able to set realistic limits with the boys and implement appropriate behavior management. The boys in return were more trusting that her choices of consequence for misdeeds would be just and fair. They respected her leadership and complied with her demands most of the time. She incorporated into her parenting repertoire the techniques of time-out, denying privileges, ignoring, and making clear, simple requests with the appropriate follow-up. She practices these techniques consistently. She no longer needed Peter's intervention in times of stress with the boys. And together Peter and Sue were able to negotiate the degree to which Peter would participate in the parenting tasks. Sue was no longer indiscriminately sharing inappropriate adult information with John, and John was no longer worrying about adult matters.

The entire family was less crisis oriented. During my involvement with the family I observed Sue and the boys cope very successfully with one of Peter's binge drinking episodes. Sue was able to set limits around Peter's contact with the family while drinking which helped John to feel protected, communicated clearly to Peter the rules, and put Sue firmly in charge as parent.

The family replaced their previously very dysfunctional communication patterns with more effective patterns. Sue stepped out of her role of regulator

of the boy's behavior. Sue learned to accompany her 'don'ts' with 'because'. She increased the number of positive messages to her children. John responded by speaking more to both Peter and his mother. He communicated less aggression and began to speak more honestly about his fears and worries. Both Sue and John remarked that they were enjoying each other's company more and that finally after many months they were expressing genuine affection to one another.

John had bonded successfully with his play therapist at PSC and continued to see her weekly. It was decided by the team that John would require long-term therapy. Both John's level of self esteem and individuation had been increased. He was now able to take the bus, and walk by himself to the store and to the park. He was no longer afraid of running into his abuser. And he was clear about what he would do if this did happen. He was no longer playing with very young children, and had made several friends at his new junior high.

Sue also had made many individual gains. She had successfully established a trusting relationship with me and was now generalizing many of the skills she had gained. She was able to communicate her disappointments and frustrations with her family of origin in a more direct manner. She was setting limits with her father around the amount of control she would allow him to have over her decisions and actions. She was no longer pressuring Peter to marry her, and in fact was expressing her own reluctance to marry before a number of important issues were resolved.

In our final two meetings, Sue and I discussed her desire to develop interests outside of the home. On her own she contacted Jason's school and

arranged to volunteer there twice weekly. At the time of my termination with the family she had visited the school and set up a schedule.

(4) Perception of Self As A Potential Abuser

At the termination of treatment Sue was asked to again rate herself as a potential abuser. Sue said that she no longer feared that she would injure her children. She had stopped hitting either child out of anger. She now spanked as a last resort and did so only when she was calm enough to use minimal force. She allowed herself to use only her hand, and only spanked on the bum. She stated that in most instances, she successfully employed other means of behavior management, such as time-out, denying privileges, etc. She found that these techniques worked better than spanking. She said that in general she was able to ignore many behaviors that in the past would have elicited an angry response. She was able to do this because she no longer thought that when her boys disagreed with her or expressed anger that this was an act of disrespect.

Conclusion

I decided to give Sue and John the FAM 3 again as an additional posttest (Appendix One). Again it adds support to my findings at termination. Although Sue rated the family as continuing to be generally dysfunctional, improvement could be noted in all areas. The family's main areas of improvement were communication, role performance and task accomplishment.

It was interesting to note that John rated the family as generally more dysfunctional in the posttest than he did in the pretest. I interpreted this as a

positive sign that he was now more able to express his opinions about his family without fear of retaliation. Also through the family sessions and individual therapy, he had developed a more realistic appraisal of some of the areas that needed work in the family.

Generally, it seems that intervention was successful with this family. I suspect that due to the level of dysfunction, however, that this family will continue to need support for many months to come.

The family was now able to acknowledge its difficulties and members were better equipped to accept responsibility for change. With a new worker, the family will continue its relationship with the Parent Support Program, and John will continue individual counselling.

Chapter Six

Family # 2: the B Family

Robin 28 yrs old (mother)
Matthew 31 yrs old (father)
Robert 13 months (son)

Helping Network

Child Protection Centre Worker
Parent Support Counsellor
Family Doctor

later:

Psychological Service Centre

This family was referred to the Parent Support Program by a social worker at the Child Protection Centre, Health Sciences. She had been seeing Robin in individual weekly sessions for approximately 6 months. Robin had called the centre because she was experiencing violent visual imagery of hurting her baby and she was afraid she would act on these images and injure her baby. Of late the family was occupying more and more of the social worker's time and she wanted an in-home worker from our program for added support. Another counsellor from the Parent Support Program was assigned to the family and was involved for three months before Robin asked that she be removed from the case. The worker had been unable to join satisfactorily with Robin. Robin had been severely sexually and physically abused by her mother and thus had difficulty establishing relationships with women. At the

time of my involvement with the family Robin was concerned on a daily basis that she might abuse her son, she was also pregnant with her second child.

Presenting Problem

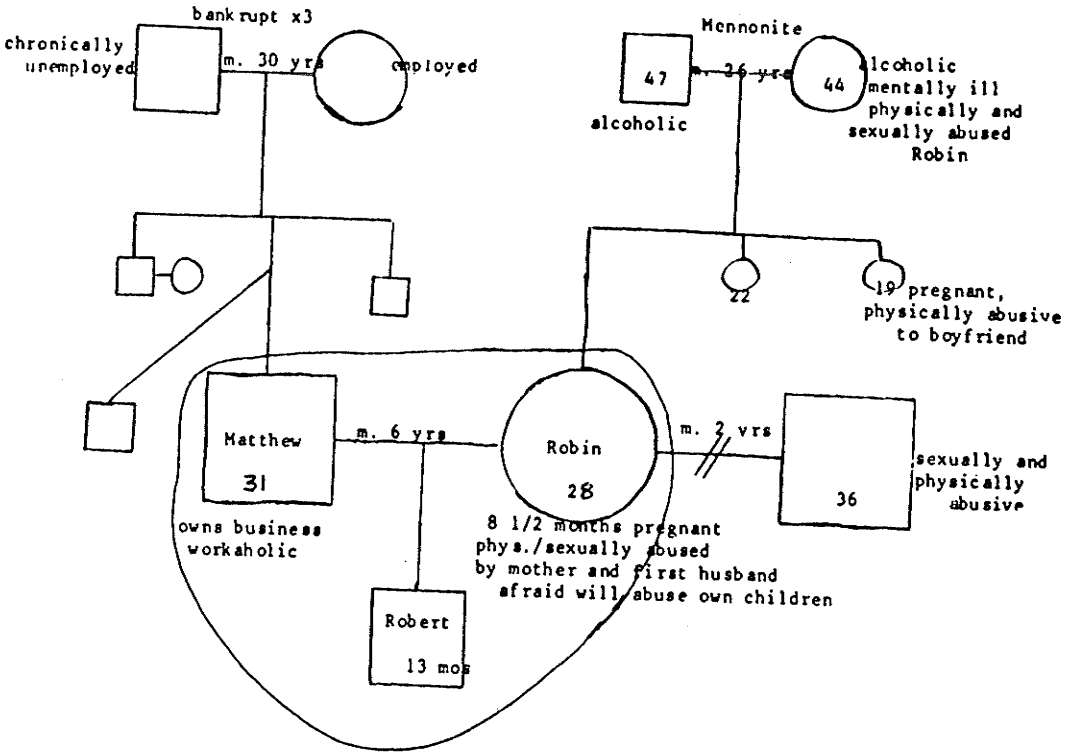
In the initial sessions it was not possible to meet with the couple because Robin was unwilling to discuss her problems with Matthew present. She was convinced that not only would he not understand, but that he would think she was crazy. Therefore, presenting problems were collected separately from both Robin and Matthew.

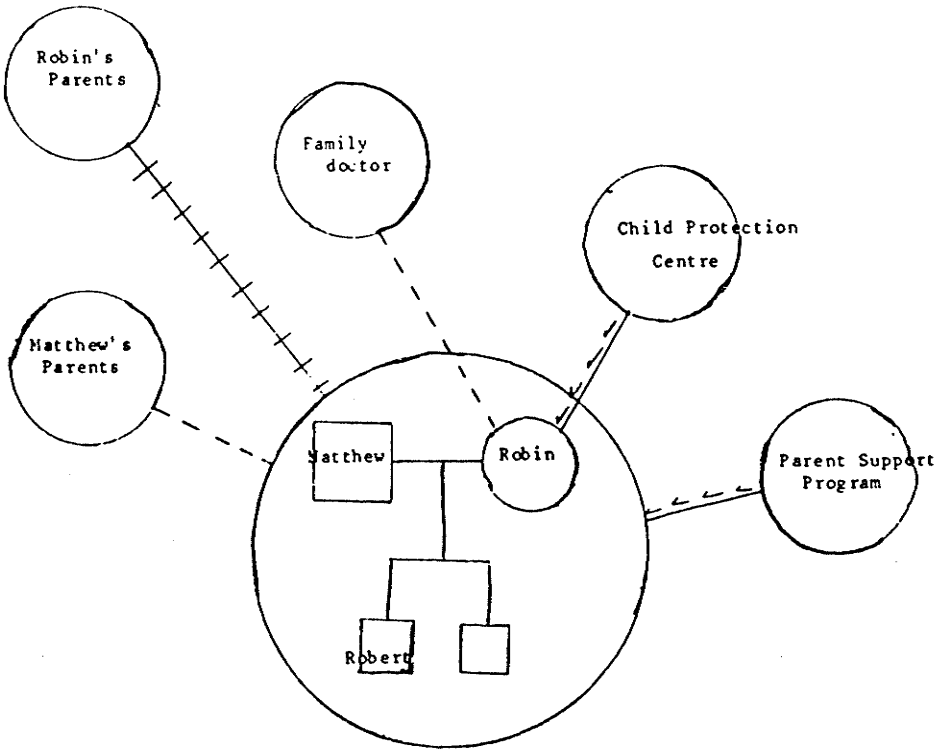
Robin explained that she was unable to bath, diaper or dress her son when alone because during these times she had fantasies about harming her son. She was afraid that she would act on these fantasies. In addition, Robin was afraid that with the birth of the new baby, the situation would worsen.

Robin had contacted the Child Protection Centre because she was unable to share her fears with anyone in her family. She had dropped some very general hints to a friend, and to her husband, but her perception was that they had not been receptive to the possibility of a mother having difficulty managing her child so she had not pursued the topic. At the time of my involvement Robin was very reluctant to share her true situation with her husband.

Matthew explained that his new advertising business was one year old and continued to demand most of his time and energy. As a consequence he was unable to spend much time at home or with his son. The problem was

B Family Genogram and Eco-Map





that Robin, angered by the situation,continued to pressure him to give the family more time. He felt pulled in two opposite directions. If he gave his family time, he might lose his business. If he put his energy into the business, Robin made his life very unpleasant. As a temporary solution he spent as little time as possible at home.

Abuse History

Robin grew up in a small town, the oldest of three daughters, raised in a conservative religious family. From the time she was a small baby until the age of 15 when she left home, Robin was severely abused sexually, emotionally and physically by her alcoholic and possibly mentally ill mother. The abuse was carried out in secret when other family members were away. While Robin's extended family knew she was being mistreated and regularly arranged for her to spend summers and holidays away from her mother, Robin was sure that they did not realize the extent to which she was abused. At the age of 15 after a suicide attempt, she ran away from home and was caught and put in residential treatment. She lived there for 2 and 1/2 years, leaving at the age of 17 1/2 to marry her first husband.

She remained with her first husband for 2 1/2 years. During that time he physically and sexually assaulted her. At the age of 20 she left him and met Matthew shortly after. Other than knowing that her first husband beat her and that she didn't get on with her mother, Matthew was unaware of Robin's abusive history.

Assessment

(1) Clinical Assessment

Couple:

poor communication
both adults overwhelmed and overburdened
feelings of guilt

Robin:

family themes of aggression, helplessness, abandonment
poor self-esteem
self as regulator
interactions shift abruptly in mood and theme
uncontrolled aggression
avoidance of social interaction
frustrated dependency needs
power struggles between self and child
violent response to stress
inability to empathize with others
poor idea of normal child development
child's behavior perceived as willful and disobedient

(2) FAM 3

The FAM 3 was taken by Robin and Matthew. FAM 3 profiles for the B family are located in Appendix One. On the general family scale Robin rated high for defensiveness which indicates a possible distortion of the FAM profile. This may mean either artificially depressed scores or a distortion in the shape of the profile. This was not surprising given Robin's tendency to employ distortion, and projection. Generally the results of the FAM 3 supported my clinical observations. Robin and Matthew had difficulty communicating in a clear, direct manner. They both often misunderstood the other's communication, yet lacked the ability to seek clarification. Communication was further hampered by the absence of appropriate affective involvement. In

addition, both Robin and Matthew camouflaged their true affective expression which inhibited accurate communication on an emotional level.

The FAM 3 identified their difficulty with insufficient role integration. This was further clarified in our session as a lack of agreement regarding male/female role definition. Each person's rigid adherence to their own definition of role left them unable to make the necessary adaptations required as the family continued to evolve.

Finally, the FAM 3 supported my observation of the family's poor problem solving abilities. Matthew and Robin were unable to accurately identify problems, and thus generate or implement solutions. As a consequence, minor stress in the couple precipitated crisis. (Scales can be found in Appendix One)

(3) MCN

Both Robin and Matthew showed significant attachment to their child, and demonstrated responsiveness and sensitivity. Robin actively pursued a positive interpersonal relationship with Robert, playing with him frequently, cuddling and praising. She also rated high in the area of physical care. She practiced good hygiene and nutritional standards, and she provided adequate housekeeping standards. Matthew spent very little time with Robert. He had not been involved with physical care.

Robin and Matthew were inconsistent in their ability to recognize their own limitations and resisted help when offered. Both were also inconsistent in developing and maintaining supportive relationships for extended periods of time.

In environmental supervision, Robin rated high. She could identify hazards and protected her child well. She provided age-appropriate supervision of her child. She also identified when her child needed medical care and had an ongoing relationship with one provider. She anticipated the need for maintaining an adequate standard of health care. Matthew was not involved in these areas. In disciplining, Robin showed realistic expectations and was generally consistent in responding to behavior and rarely used physical discipline. She was aware of the emotional needs of her child and made attempts to promote emotional development.

Robin lacked the capacity to develop a social relationship and did not reach out to others to build relationships. She had no contact with her family. She could accept help from professionals, but was very rigid about what this help would entail. Matthew could develop social relationships but showed discomfort when attempting this. He had regular contact with his family. However, there were mixed messages from his parents regarding expectations.

With this family the MCN was unable to discern the potential for abuse. Robin's parenting skills rate as adequate for most categories of the scale.

(4) <u>Perception of Self as Abuser/Parenting Skills</u>

Robin was the first to admit that she had learned most of what she knew about raising children from books and magazines. She had a small library. As a consequence, intellectually she knew a lot about child development, but emotionally had never had the opportunity to see or experience appropriate parenting.

Although Robin was determined not to abuse her child, she struggled daily with feelings of wanting to hurt Robert. She thought she had the potential to abuse and that without intervention she would eventually do something terrible. Many times daily she exerted all her energy to control her anger and not allow it to show externally. Robin equated this battle with holding on to her sanity.

Family Themes

(1) Robin had not yet finished looking at her own abuse as a child. The treatment she suffered in her family of origin had left her emotionally and cognitively unable to cope with the demands of her own children. Her first hand learning about attachment, love, basic trust, protection and nurturance between parent and child was so poor that Robin was unable to rely on her experiences as a model for how to parent. Many of the lessons she learned in her family about affective expression, control and role performance hindered the development of healthy relationships.

(2) Both adults in the couple had developed a style of communication which was masked and often indirect. Robin would complain bitterly to me about Matthew but in his presence she was unable to communicate these difficulties. Although quite articulate, Matthew became almost mute in Robin's presence. They both denied and minimized their problems instead of attempting to discuss and resolve their differences. When they did fight, Robin took a blaming and accusatory stance while Matthew silently simmered.

(3) Robin and Matthew differed in their definition of male and female roles and in how these roles express caring for the family. This caused problems as

what each anticipates would gain praise from the other actually met with disapproval and anger. This pattern had been repeated again and again over the years until the distress level had become so high as to leave both Robin and Matthew seriously considering separation.

Goals

Robin:

To improve self-esteem
To increase self differentiation
To explore the abuse
To explore family of origin issues
To meet dependency needs
To challenge distorted thinking

To decrease role as the regulator of all member's behavior
To decrease power struggles between adult and child
To integrate cognitive and emotional learning about children
To change perception of child's behavior as willful and disobedient

Matthew:

To improve communication
To explore family of origin issues
To increase parenting role

Couple:

To improve communication
To increase the level of mutual support
To explore differing perceptions about male/female roles

Intervention

Structure of Therapy

The possibility of Robin acting on her violent visualizations was discussed at length. Together we devised a safe plan of whom she could call if she needed help. With the plan in place, we were satisfied that this would offer enough relief to prevent her from abusing.

Because of the degree of emotional deprivation and neediness exhibited by Robin, joining with this family meant helping Robin to establish a healthy, trusting relationship with me as we began to look at the interconnectedness of her current and past problems. We agreed upon the following schedule: weekly individual meetings with Robin, with contact by phone as needed, and bi-weekly individual meetings with Matthew with the agreed goal of meeting bi-weekly with the couple once Robin and Matthew were feeling more comfortable.

Joining

Members in Family B were experiencing a high degree of stress and as a consequence were more open to intervention than would usually have been the case. In this situation the label of 'at risk' came from one member of the family who considered herself a potential abuser. Other family members were working hard to convince her that she was not 'at risk', but were doing so without the benefit of important information, that information being kept from the family by the 'at risk' member. This member labeled herself as 'at risk' because of her own abuse history, and her own thoughts and feelings. The

professional helpers that she contacted for service agreed with the 'at risk' label.

When I became involved with the system, I was able to use Robin's request for service and her worker's suggestion of more in-home support as an entry into the family. Immediately I was faced with Robin's acute stress and with her extreme rigidity and need for control due to her own deprivation. This was played out in her need to over explain and repeat any point she made. Her low self-esteem and victimization left her hearing comments as attacks or criticisms. She actively distorted most verbal and nonverbal communication. As an example, at one point when I commented on how attractive her son was, and she interpreted this remark as criticizing her for having difficulty with her baby. She reasoned that if I was saying that her child was attractive, he must also be easy to handle. Therefore, if she were having difficulty with parenting, it was because she was really hopelessly dysfunctional.

At the point of my entry into the system, Robin recognized her need for assistance, but had her own rigid idea of what this assistance should be. She felt it was pointless to meet as a couple, she was only willing to meet once a week, she was initially unwilling to talk about her mother, and she was convinced that her real problem was simply being house-bound. She was not yet ready to hear a reframe of the problem, nor was she able to easily establish a working relationship. Joining with this family meant helping Robin to first establish a healthy, trusting relationship with me, as we began to link her current difficulties with her experience of abuse. During these first initial visits much time was spent gathering information, trying to understand her perception of the world and helping her to get more in touch with the process

around her violent visualizations. Her experience had generally been that people were more interested in discouraging her from speaking about these episodes. She was at first puzzled that I seemed to want to know so much about them. It was also apparent that my seeking information in itself acted as validation for her. If it was okay to talk about these fantasies, and she was not the only person having these fantasies, then she must be more normal than she dared think.

A very important part of joining with this client, was challenging process on a moment by moment basis. Robin was very quick to become angry, offended, defensive, etc., but was also quick to deny that she was experiencing any of these emotions. I found that shifting back and forth between content and process, checking out the implied meaning of the verbal and nonverbal information that she communicated, was one way to help make her more aware of her own feelings and reactions, to stop these feelings from becoming a problem between us, and to challenge her distorted thinking and thus her need to employ these reactions.

As Robin and I developed a repertoire of healthy relating, we were able to use it throughout therapy when dealing with difficult issues, and when Robin felt threatened enough or worried enough to fall back into her old patterns. Joining with Robin has been an ongoing process. With each new issue, it has been necessary to check out our process level and discuss the verbal and nonverbal information being transmitted.

The joining process was ongoing until the fourth month of therapy, at which time enough process had been discussed to allow Robin to feel spontaneous in her responses to me. Two telling turning points were our

discussions about termination and her ability to joke about her inability to tell me what she wanted because it felt like it was wrong to do. While she was serious about thinking that she didn't deserve what she wanted, and felt guilty even saying it out loud, she could also see this thinking as distorted and joke about it.

In this family the problem of separating my treatment role from that of child welfare worker was not an issue as only treatment workers were involved. This was a case where prevention was early enough and successful enough for the family to avoid becoming known to the child welfare system.

Although the child in this family had never experienced abuse of any kind and was not in need of any special services, joining with Robin with the child in the home was initially a problem. Robin was threatened if her son showed any interest in me as she saw this as a demonstration of his preference for me over her. If he smiled at me, brought a toy to me, or wanted to sit in my lap Robin was convinced that it was because her mothering skills were less than adequate. Even comments made by others about how good her son was or how appealing he was, were interpreted as meaning that Robin had no right to have difficulties. To avoid this problem, I initially chose to meet with Robin during the baby's nap time. Once our relationship was a bit more established, I began coming later in the afternoon so that half of our visit was alone and half was when Robert was awake. We were then able to process parenting issues as they came up in our time together. Towards the end of therapy the situation had progressed to the point that Robin was able to enjoy Robert's attention to me as an opportunity for her to take a rest and for Robert to have

fun. She was also able to allow other adults to care for her children, and began to use a babysitter both inside and outside of the home.

Intrapersonal/Systemic Intervention

Meeting with the couple was a problem until Robin was feeling trusting enough of my intentions. Initially she was too defended, suspicious, and frightened to allow it. The first two times before the couple met, Robin and I rehearsed through role playing how the meeting might go. This seemed to help her feel ready to meet with Matthew. Our first meetings began with a very focused agenda of sharing differing perceptions of an episode that the couple had experienced together. From here we were able to discuss communication patterns between the couple and their differing perceptions about male and female roles in the family.

As Robin became more trusting of our relationship, she gained tools that she could use in the couple. She is now able to ask for help, to say how she is feeling, and to share some of her concerns around harming the children. Matthew is responding by showing more affection, spending more time at home, and helping more in the care of the children.

Helping Network

The helping network involved with this family was limited to treatment workers who shared a similar definition of the problem. As a consequence, the team acted in a unified manner, avoiding many of the problems encountered when helpers with very different roles come together to service a family.

The challenge to this helping network has been Robin's difficulty in joining and maintaining relationships with helpers. During my involvement with the family, I observed her reject 3 different workers. Generally, these rejections were forthcoming in the first several meetings and were based on Robin's distorted perception of these worker's lack of caring and/or understanding of her situation. This made it very difficult to maintain a team, as Robin seemed to be able to work with only one helper at a time.

As her primary therapist, I have attempted to address this problem. And although she is much more aware of her need to avoid connection and intimacy with others, and is able to assume responsibility for the way she sabotages these relationships, it continues to be an area in which she will require more work.

Outcome

Posttest

(1) At the termination of therapy, the B Family was asked questions to determine their own experience of the joining process: when they felt comfortable, when they did not, what they liked about the sessions, and their critiques of the therapeutic process.

Robin named four factors which she thought contributed to our successful joining. These were always being on time, listening carefully to her story and asking many clarifying questions, challenging her process and being flexible enough to offer nontraditional service. It is interesting to observe that during our joining process there were many moments when Robin was unconvinced that I did understand the magnitude of her difficulties, and when she became

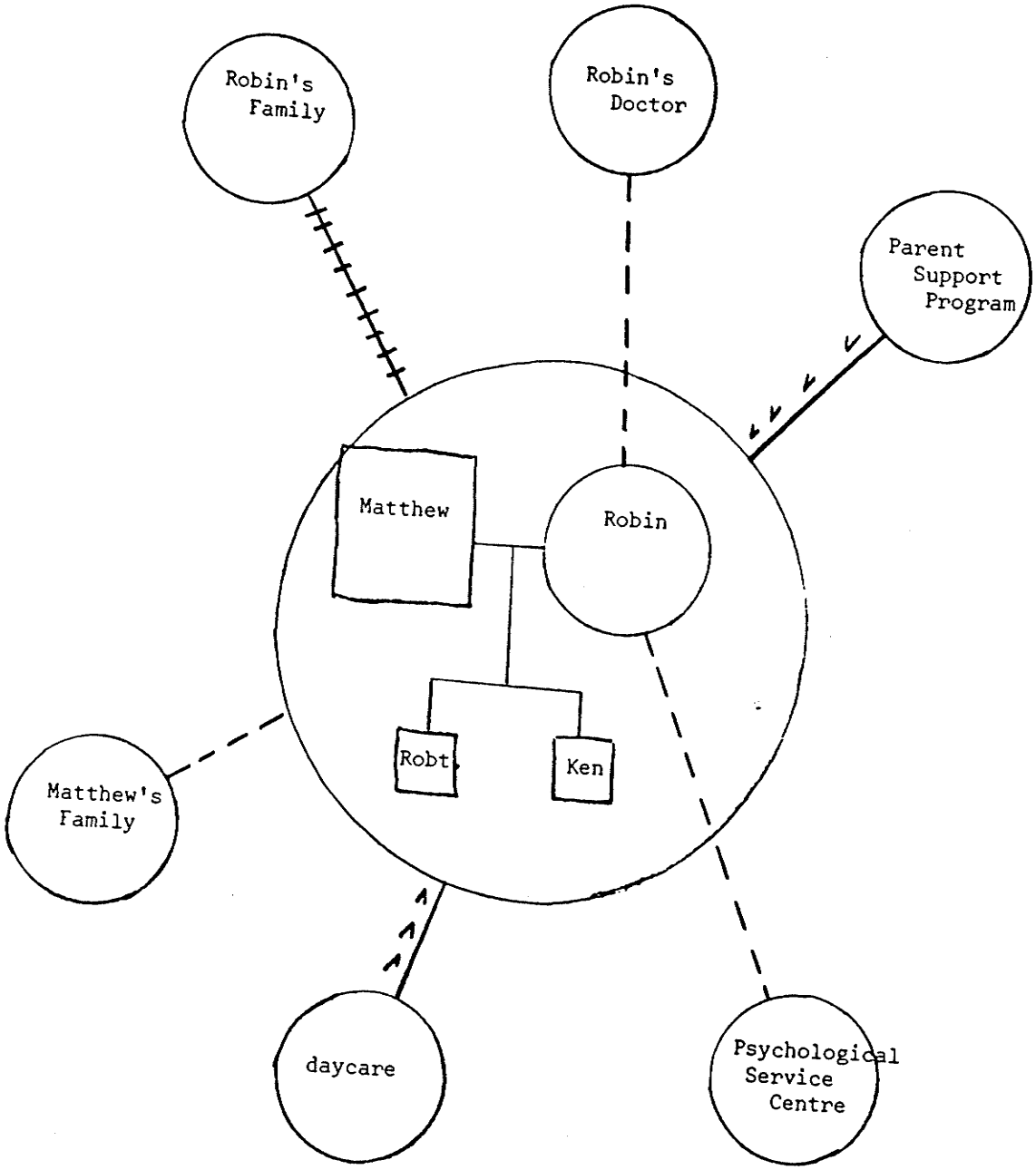
angry because I asked so many questions. I detected now in Robin a tendency to idealize our process, and to idealize my role as the only female who has ever been able to understand her.

Matthew felt that the most important factor in joining had been my ability to listen without always responding and offering solutions. Being able to talk about his difficulties and feeling that they were unconditionally accepted was a new experience for him. He also liked the way I asked questions and this had made him feel that I was really interested in understanding his situation.

Both Robin and Matthew were able to identify the new skills that they have mastered. Robin was now able to discuss her difficulties around dressing her children, and dealing with their whining and/or crying with other people. She had shifted her thinking and no longer forced herself to do things like bathe her children if she was experiencing strong panic sensations. Instead, she would ask for help and not feel like a failure as a mother. The episodes of rage and/or panic had greatly decreased. Robin was able to let other people help care for her children. She was able to use a babysitter. She recognized the importance of guaranteeing time for herself. She was much more flexible in her ability to change routines. She recognized how her presentation contributed to her difficulty with socialization. She has been able to establish a relationship of basic trust with me. She was better at communicating her needs, and in expressing her anger.

(2) Eco-Map

This is a new eco-map which tracks the system changes that took place in the course of therapy.



Matthew felt that he was better able to set limits with Robin. He was more direct in his communication. He was more involved with the family, and enjoyed his time with them. He was no longer impatient with Robin when she tried to talk about her rage. He had more empathy for her difficulties, and was more willing to support her.

(3) Goals

In reviewing the family goals that were accomplished during the course of treatment, the two most successful areas of gain for this family were improving communication and increasing the level of mutual support. Robin and Matthew were now much better at directly communicating their needs and expectations of one another. They were able to discuss problems without blaming and finding fault with each other. They sought clarification if they were confused, and as a consequence they were able to resolve many difficulties that in the past would have been insurmountable. Matthew was now able to provide more information when he and Robin discussed topics that in the past would have rendered him mute. Robin, on the other hand, was able to control her habit of over-explaining, which further encouraged Matthew to stay involved.

In reviewing the degree of mutual support now functioning in the couple, I observed that many changes had taken place. Matthew and Robin had purchased a second car to increase Robin's mobility. The children now attend home daycare 2 afternoons a week. Robin delivered the children and Matthew picked them up. On Saturdays Matthew looked after the children and

Robin was free to go out. The couple had also engaged an evening baby sitter, and they went out alone on the average of 2 or 3 times a month.

The biggest change that had taken place in this area was that Robin was now sharing with Matthew some of the difficulty that she still experienced around parenting. Matthew had responded very positively to this information. Together they had developed coping strategies for several problems. When Robin confided to Matthew that she was unable to bath Robert because she was afraid that she would harm him, Matthew began to bath Robert himself on a regular basis. When Robin explained the difficulty she had with anxiety on the days that the children were crying and/or whiney, Matthew made himself available by beeper, and has come home consistently within 30 minutes when Robin has phoned him for help.

As Robin felt supported she in turn increased her support of Matthew. She became much more tolerating of his many late work days. She no longer thought that he was purposely trying to stay away from home.

Although it had been difficult and slow going, Robin had finally established a trusting relationship with me and was generalizing many of the skills she had gained. In general her relationships outside of the home were more satisfying for her. She was distorting less, and checking out her perceptions more. She was speaking to more women, and had revised her perception of women as untrustworthy and malicious. She had begun to examine her own patterns of interactions and how these patterns had limited her ability to connect with others.

Robin continued to struggle with family of origin issues. These were mostly tied to the abuse that she suffered in her family. She was presently

working on deciding what kind of contact she would like to maintain with her parents. She was also developing relationships with both of her sisters for the first time.

Matthew had realized that some of the problems that he and Robin were having around male/female roles in the family, and his inability to spend any time with the children were patterns he had learned from his family of origin. He had increased his involvement with his sons, and was also in the midst of changing some of his ideas about how men show their caring for the family.

(4) Perception of Self as Abuser

At the termination of treatment Robin was asked to again rate herself as a potential abuser. Although she still struggled with feelings of wanting to hurt both of the children, these feelings had decreased. Robin was now able to feed the children, bathe the baby, and diaper the children without feeling that she wanted to harm them. When she did have difficulty, she asked for help from the people in her life who were most available to her. This was very different from her pattern of six months ago, when she forced herself to go through with whatever action was eliciting these feelings.

Robin was reasonably sure that she would never act on these feelings. She had a variety of back-up measure that she could employ if she started to doubt her own self control. These included paging Matthew, leaving the house, calling people to distract her, and going into another room and closing the door.

A major difference in her perception now was that she no longer thought that it was the behavior of the children which caused these feelings of wanting

to hurt. She said that the feelings generally came when she had an interaction with someone other than the children which left her feeling uncared for or unsupported. An example she gave was if Matthew had promised to come home at a certain hour and then called at the last minute to say he would not be home. This would be a time that Robin would then feel very angry and experience feelings of wanting to abuse. Since she had been able to target the source of these feelings as existing outside of her relationship with the children, she had felt much relief.

Conclusion

During the six months that I met with this family, we had approximately 30 session. In general I think that intervention was successful. In giving Robin and Matthew the FAM 3 again as an additional posttest (Appendix One), it supported my findings at termination. The couple had made many gains, especially in the areas of communication, role performance and affective expression. Some of their scores were still in the family problem area, and this supported my recommendation that long-term individual therapy for Robin as well as couple's work be continued.

For women like Robin, who have experienced such extreme and long term abuse, healing is a lengthy process. Our time together had played an important role in helping Robin to acknowledge the need for continued treatment. It had also helped her to gain enough basic trust to enable her to pursue other relationships in her ongoing therapeutic process.

At the time of my termination with the family, another worker from my program was introduced and began to work with the family. I had also

introduced a therapist from Psychological Services at the University of Manitoba for the purpose of seeing Robin individually. At the time that I left, however, Robin was not yet sure that she was ready to make the transition from in-home support to receiving therapy in an office. She and the therapist were continuing to talk about whether or not they would work together.

Chapter Seven

Family # 3: The C. Family

Wanda 22 years old (mother)
Joe 26 years old (father)
Angel 3 years old (daughter)
Andrea 2 years old (daughter)

Helping Network:

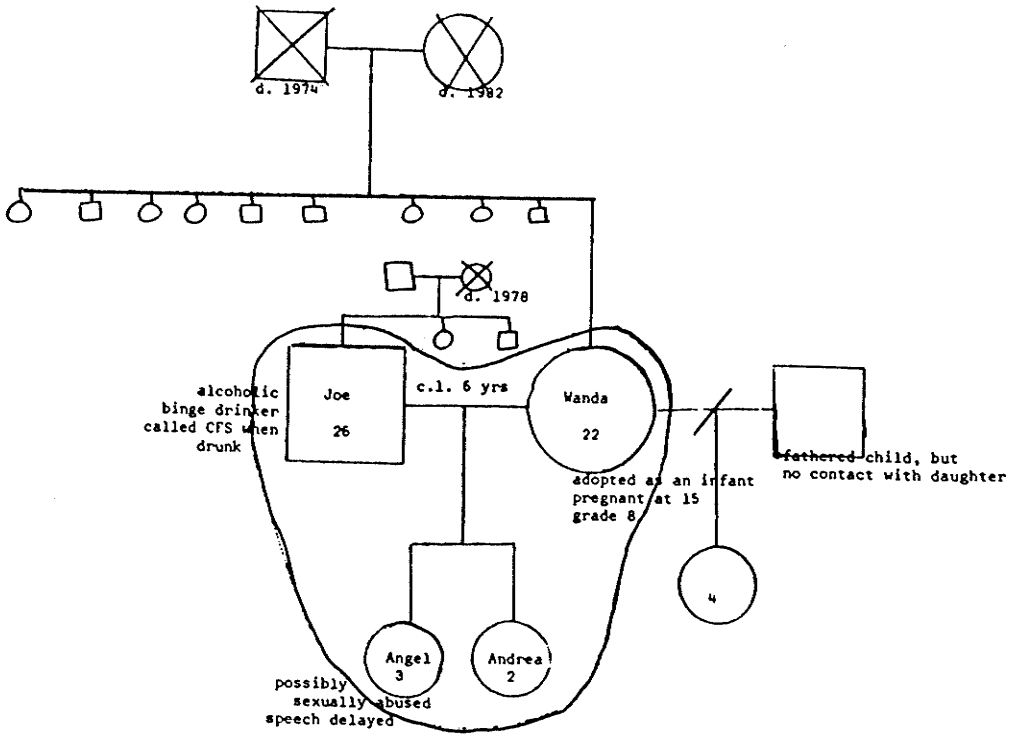
Child and Family Services worker
Foster mother
Parent Support Counsellor
Economic Security

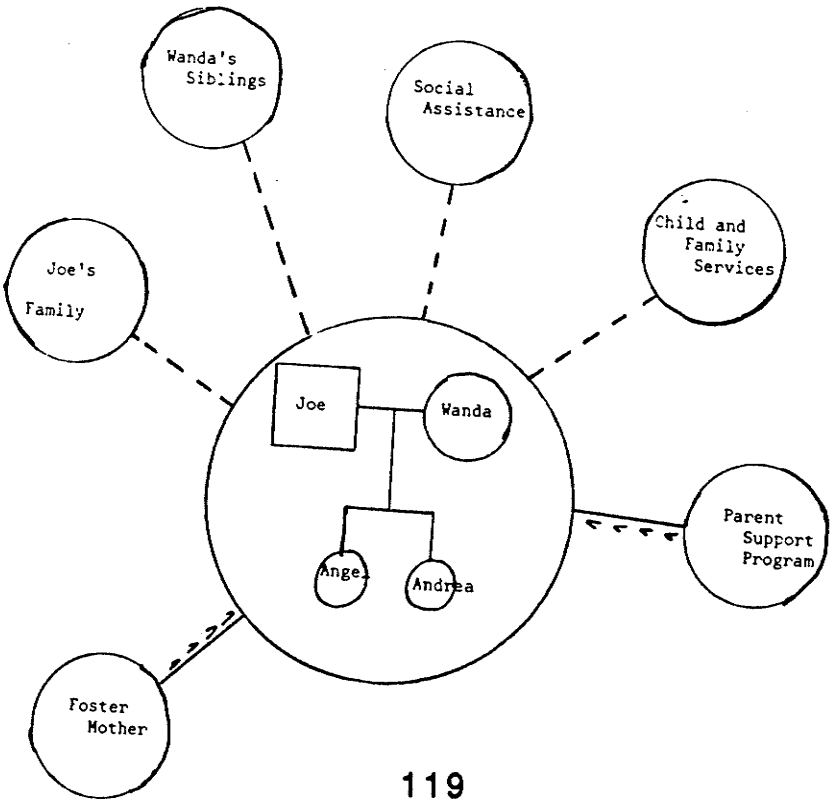
later involvement:
daycare

The family consisted of Joe, a young metis man from Waterhen, Wanda his 22 year old native, common-law wife and their two children Angel and Andrea. Joe and Wanda had been a couple off and on for 5 years. They described their relationship as generally okay. Their difficulties revolved around themes of jealousy and Joe's drinking. Joe was a heavy weekend drinker who typically binged from Friday through Sunday. When he was drinking he often did not return home at night.

Joe was the oldest of three children. His mother died when he was 15 years old. He didn't remember much about his family except that after his mother died he traveled from province to province with his father looking for casual labor. He also remembered drinking with his father on a regular basis.

C Family Genogram and Eco-Map





Important holidays and occasions were generally celebrated by binge drinking.

Wanda was adopted as an infant into the Smith family when her natural mother died. She grew up on the Peguis Reserve. The Smiths were a large family of ten children. Wanda's oldest adopted sibling was 25 years older than she was, the youngest one was 8 years older. Wanda was pregnant with her first child at the age of 14. This was shortly before her adopted mother died of a heart attack. After her adopted mother's death Wanda moved into Winnipeg and stayed with her sister Mildred. Wanda's child was adopted by Mildred at the age of 2. Wanda explained that this happened without much discussion simply because Wanda was too young and too involved with running around to really care for her baby.

This family was referred to the Parent Support Program by a child welfare worker at Child and Family Services. She had been involved with the family for approximately two months prior to the referral. The family had come to the attention of CFS because Joe, the father of the children, had telephoned CFS at 3 am on a weekend when he was drunk to say that his two daughters had been left in his care and he was unable to look after them. The children were taken into care that night. The next day the older child had complained of vaginal discomfort, and when examined by a doctor, showed some possible signs of sexual abuse. When the worker contacted the parents to discuss these developments, she was concerned with the parents inability to converse, their seemingly limited cognitive ability and their general level of disorganization. Although she felt fairly confident that if sexual abuse had occurred, the perpetrator was an unknown third party, she was concerned with

parental response. She assessed these children as at risk in a general sense for neglect and/or abuse. The children were apprehended on a six month order and placed with Wanda's older sister, Mildred.

Presenting Problem

At the time of my involvement, the CFS worker had met with the family three times to discuss the situation. She had explained to the family why the children had been apprehended, and what changes the family would need to make before the children were returned. She described her visits with the family as very frustrating and unsatisfactory as neither adult talked during any of the meetings.

The worker had very little information about the history of either of the adults in the family. She was becoming angry with the family because she felt that they knew what they had to do to get their children back, but lacked motivation to begin the work.

My first meeting with the family took place in their home with the CFS worker, the director of my program, Wanda and Joe and myself in attendance. My initial impression of the family was that they were shy, operated at a concrete level and had very different ideas from the CFS worker about what a family is, and how it functioned. Because of the gap in values between the two parties, I also suspected that the problems that the CFS worker had identified for the family (lack of stability in the couple's relationship, no discussion between couple about how to care for kids, no beds for the children, no plan for their care: daycare, nursery school, etc., and lack of

planning for who would babysit the children) were probably not issues that the family saw as problematic.

At this first team meeting, the family was unable to explain to me why the children had been apprehended. They were also very unclear as to what they had to do to get the kids back. I watched as the CFS worker made general protection statements to the family without specifically defining terms and assuming that the family shared her values and norms.

The presenting problem was the difficulty created by the gap in values between the child welfare agency and the family. My task was to find a way to close this gap so that each party understood the values and concerns of the other. In this situation the child welfare agency and the family clashed almost like two conflicting family members. My job was to educate, support and gather information in such as way as to bridge this gap.

Abuse History

In gathering information from this family over a period of weeks, no history of abuse was discovered. It appeared that this was not due to resistance or a need on Wanda or Joe's part to hide this information. It was very difficult to gather conclusive information from the family. Their ability to abstract, problem solve, reason and articulate was very limited. As a consequence questions had to be asked in a very concrete manner, and even so were often forgotten before they could be answered.

I suspected that Joe's life as a child was neglectful. I based this on his very limited ideas about what children need and how parents meet these

needs, what I observed about his life style and environment and his general level of socialization skills.

Wanda's situation was perplexing. She seemed to have grown up in a large supportive native family. Many of her siblings had stable families of their own and held responsible jobs. Yet Wanda also had very limited ideas about what children needed and how parents met these needs. She also seemed very present oriented, lived in a drab, unappealing and transient environment and lacked some obvious and important socialization skills.

Assessment

(1) Clinical Assessment

Couple:

weak boundaries and hierarchy
weak marital and parental subsystems
poor problem solving skills
focus on the present
family themes of aggression and helplessness
poor self-esteem
poor communication

Parenting:

when disciplining, no explanation of limits to children beyond saying 'don't'

lack of limits
lack of internalization of rules
adults overwhelmed and overburdened
fear of authority
poor idea of normal child development
role reversal between adult and child

(2) **FAM 3**

Joe was unable to read and so could not take the FAM 3 independently. When I attempted to read the questions to him and have him circle his response, he was unable to understand and answer most questions. He was so inarticulate and shy that it was impossible to glean whether this was resistance or simply inability.

Wanda was able to take the FAM 3 independently but was also unable to answer many questions, such as:

1. Family duties are fairly shared.
2. When I ask someone to explain what they mean, I get a straight answer.
3. You don't get a chance to be an individual in our family.
4. When I ask why we have certain rules, I don't get a good answer.
5. My family expects me to do more than my share.
6. Sometimes we are unfair to each other.
7. We never let things pile up until they are more than we can handle.
8. I never know what's going on in our family.

Because of these difficulties, I was unable to use the FAM 3 with this couple.

3) **MCN**

Wanda and Joe at times showed significant attachment to their children and they were able to be affectionate and to demonstrate positive interpersonal relationships with their children. At other times, when the children attempted to get their parent's attention, both Wanda and Joe displayed indifference and disinterest. These times usually occurred when either parent was watching the television (both Wanda and Joe watched a lot of television).

Wanda was moderately sensitive to the practices of good hygiene and was also generally aware of and practiced adequate nutritional standards. Joe was inconsistent in meeting and maintaining hygiene and nutritional standards. Both parents were inconsistent in maintaining adequate housekeeping standards and stability in the home environment. The home had a feeling of transience and was very sparsely furnished.

Wanda had the ability to recognize her own anger and generally did not direct it towards the children. Joe frequently withdrew when he was unable to cope and exhibited self destructive behavior in the form of binge drinking. Wanda was able to accept responsibility for herself most of the time, but in stressful situations displayed discomfort. Joe was inconsistent in developing and maintaining supportive relationships for extended periods of time.

Wanda was aware of most major hazards, but often neglected potential dangers by allowing the children to touch and manipulate many objects that could cause them harm. Joe could identify hazards and had information but consistently did not intervene when the children were in a dangerous situation. Wanda made inappropriate choices for babysitters depending on her stress level. Joe frequently used babysitters and inconsistently made appropriate arrangements.

Wanda generally identified when the children required medical care. Joe was unable to identify symptoms of illness or injury. Wanda was inconsistent in her health practices, but maintained minimum standards. Joe endangered his own health with poor health practices and demonstrated self destructive behaviors.

In the area of discipline, Wanda and Joe both attempted to correct misbehavior occasionally by yelling and spanking and got into power struggles with the children. Wanda was aware of the emotional needs of her children and did make attempts to promote emotional development. Joe was less demonstrative, and was inconsistent in his attention to the children.

In the area of Socialization, Wanda had the ability to accept support, but was inconsistent in her ability to ask for support. Joe did not reach out to others to build relationships. Wanda's communication pattern with her family was inconsistent. Relationships were adequate at times, but at other times she withdrew from the family. Joe had inconsistent contact with his family. Generally the time spent with them was during binge drinking episodes. Both Joe and Wanda needed professional support to improve their parenting skills. They were not resistant to this help, but were confused about why they might require it.

(4) Perception of Self as Abuser/Parenting Skills

Wanda and Joe felt that they were appropriate parents. Wanda thought that parenting was something that came naturally and that anyone could do successfully. She said that her parenting style was a combination of what she had observed in her sibling's families and what she learned through the Resources for Adolescent Parents Program that she took two years ago. She was skeptical of books about parenting and thought that the criticisms offered by CFS were excessive and unrealistic.

Family Themes

(1) The label of 'at risk' was coming from the professional helping system outside the family. This was a family whose values and life style clashed with those of the professionals assessing the family's capacity to parent. As a consequence, the helping system had found major deficits in the family's abilities. Some of these deficits were real, some were simply the product of one culture judging another culture. My task was to sort out which dangers were real and required intervention.

(2) The family was unable on their own to make the modifications in family structure and parenting style recommended by CFS because they did not see these changes as important or necessary. As a treatment worker I would not be able to help this family to change until the family understood why these changes were important. Together we needed to explore the protection issues targeted by CFS so that I could help the parents to understand the problems, and to take responsibility for solving them . This meant getting to know the family's world view, providing information and encouraging client participation.

(3) Because the adults in this family were shy, inarticulate, and concrete, communication between systems was a big problem. It was difficult to assess the family's skills if they were unable to discuss or exhibit these skills. In many ways the adults in this family functioned as if they were also deprived as children. It was important to find out what they really knew versus what they appeared to know.

Couple

To increase self-esteem
To increase level of trust
To help the couple understand the helping system's concerns
To empower the couple to take part in their own treatment plan
To improve communication
To help the couple develop plans for the future

Parenting

To help parents set limits
To develop a safe babysitting plan
To improve parent's knowledge of normal child development
To decrease role reversal between adult and child

Intervention

Structure of Therapy

In this family one could observe inappropriate parenting, lack of protection and a high level of family disorganization. Whether this was due to low intelligence, poor learning, or a history of abuse or neglect was unknown. Without communication, it was difficult to measure the degree of emotional deprivation that may have existed in the parents. I decided that regardless of the cause of the deficit, the approach would be to establish a trusting relationship with this uncommunicative, disorganized family through regular contact, which would create opportunities to problem solve with the family and provide for hands-on teaching.

Because the children were currently out of the home, the focus could be on meeting the needs of the parents and on gathering more information. For this reason I chose to meet twice weekly with the family. I met with the couple

this reason I chose to meet twice weekly with the family. I met with the couple whenever possible, arranging individual meetings with Wanda and arranging to work with the children with one or both parents present.

Joining

It was very difficult to measure the success of my attempts at joining with this family. When I was with the couple, Joe was almost completely mute and had great difficulty answering many of my questions. Wanda explained that Joe was very simple and easily confused. She joked that this was because of where he came from, that most of the people from his hometown were the same way.

Wanda though more verbal than Joe, also had great difficulty answering questions, especially abstract ones. Her affective expression was usually very limited, and she offered very few spontaneous verbalizations. This did improve a bit in our time together and towards the end of the six months Wanda was talking spontaneously with me. But her verbalizations were usually not related to a current topic, and tended to be concrete one-liners about events in her day.

Throughout my time with this family, my impression of the joining process was that it was not going well. It was therefore interesting to hear from the CFS social worker in the team meetings how much more communicative the family appeared to her. It was also interesting to note Wanda's faint hint of disappointment and anger at the point of termination. Except for these two communications, there were no noticeable indications that the family was interested in staying connected or working with me.

Intrapersonal/Systemic Intervention

During our individual sessions, Wanda answered questions about her childhood, her adopted family, and life events. She found these questions very unusual, and had great difficulty answering them. She seemed not to remember much about her childhood on the reserve. She could also tell me little about her adopted family. When we talked about her adopted mother and father, she barely knew the details of their deaths. She had difficulty remembering the birth dates of her own children, and had little to say about her relationship with Joe. She seemed to forget our conversations from visit to visit, in fact sometimes from moment to moment.

I was unsure of why it was so difficult for her to talk. She did not seem resistant in a hostile sense, but perhaps she was. I have worked with very few native families, and perhaps it was my ignorance of cultural issues which created this situation.

When I met with the couple the situation was worse. Even Wanda seemed a annoyed at Joe's lack of verbalizations. We spent long periods of time sitting in silence or discussing concrete topics such as preferred travel routes from the foster home to the couple's home.

When the children were in the home for day visits or overnights, much of my time with the family was spent modeling parenting skills, and attempting to strengthen the skills I observed in Wanda and Joe. I spent many hours playing with the children while drawing Joe and/or Wanda into the play. I attempted to expand on the routines and interactions at mealtimes and nap times and during playtime. While the children were very responsive, and Joe

and Wanda seemed to enjoy themselves, it was very difficult to measure what effect if any this approach had on long-term skill enhancement.

The Helping Network

In this case the active helping system consisted of the CFS worker and myself. The family's workers in Economic Security cooperated in supporting our decisions with funding for such things as accommodations, furniture, bus passes, etc.

The CFS worker and myself met regularly with the family in the family's home. These meetings were generally planned every 6 to 8 weeks. The CFS worker was very cooperative, and seemed to look to me for direction.

As a helping system, we were not especially successful in servicing this family. Whether this was due to cultural differences or the family's limited cognitive and social abilities, is still puzzling to me.

Outcome

Posttest

(1) At the termination of therapy, the C Family was asked questions to determine their own experience of the joining process: when they felt comfortable, when they did not, what they liked about the sessions, and their critiques of the therapeutic process.

Wanda said she liked to go out with me because otherwise she was usually bored. She said that although initially she had thought that the questions I asked were strange, she had become used to them and even enjoyed answering some of them.

She appreciated the help I had given her around finding a place to live, getting bedding for the children, and making sure she had enough money for food.

Her criticism of the treatment was that I had interrupted too many of her soap operas when I had come to visit. She wished that I could have come at different times.

Joe was basically unable to answer my questions about the joining process. He giggled, and stared into space. Even when I rephrased the question several times, he did not answer. I'm not sure if this was because he did not understand the questions, if he found them difficult to answer, or if he felt resistant.

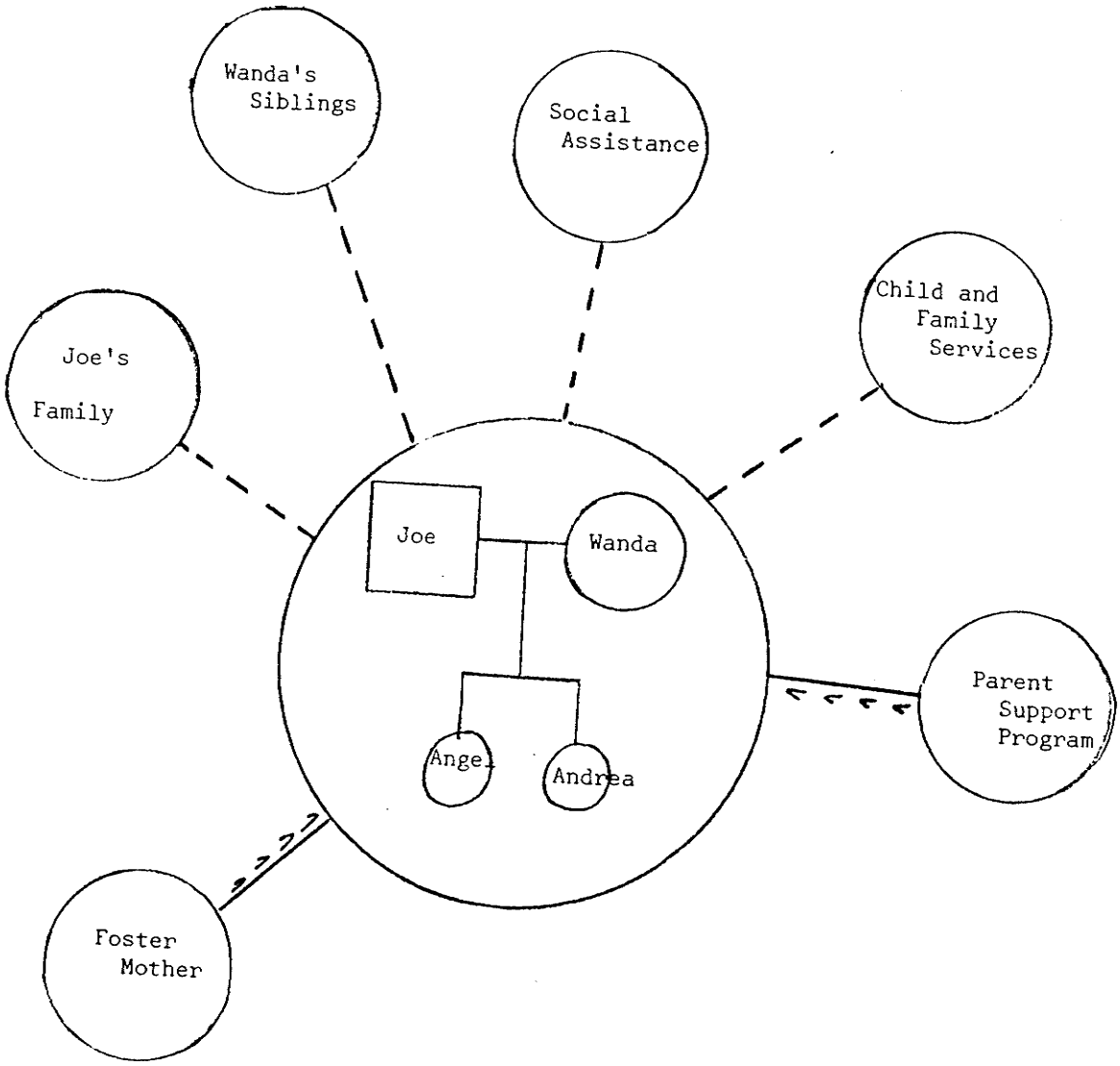
The Eco-Map on the following page tracks the system changes that took place in the course of therapy.

(3) Goals

Despite my uncertainly about the degree of joining that took place with this family, I did manage to accomplish several goals. After discussing many times the events around the apprehension of the children, and CFS's stance on the return of the children, the family finally understood why the children had been taken away, and what needed to take place before they would be returned.

Secondly, together the family and I made a list of the tasks that needed to be accomplished (new housing, new beds for the children with appropriate bedding, a plan for daycare, a transfer from city to provincial social

Eco-Map


Wanda's Siblings
Social Assistance
Child and Family Services
Joe's Family
Joe
Wanda
Angel
Andrea
Parent Support Program
Foster Mother

assistance), and worked on accomplishing them. In this way, the couple was able to plan for the immediate future.

The family also worked on several parenting goals. These included developing a safe babysitting plan for the future, and improving the couple's knowledge of normal child development. We discussed on several occasions the importance of keeping small children safe. We also talked about the effect that sexual abuse can have on children and how to protect them from such a risk. In addition to talking, I brought Wanda many easy to read pamphlets on child development.

At the time that I terminated with the family, I felt certain that both parents believed that their child could have been sexually assaulted and that they were prepared to better protect both their children in the future.

(4) Perception of Self as Abuser

At termination Wanda still considered herself an appropriate parent, although she now had concerns about Joe's abilities. Her solution to these concerns was to prevent Joe from caring for the girls on the weekend when he was likely to drink. Wanda remained skeptical of books about parenting and continued to employ yelling and spanking as her major management tools.

Conclusion

During the period of 6 months I met with this family approximately 30 times. Working with this family was a frustrating experience because it was so difficult to measure Wanda and Joe's level of understanding and involvement. I realized that in part this was due to the cultural differences between us.

While I looked for outward signs of affective expression as well as verbalizations to gauge our level of joining, Wanda and Joe communicated so little at the affective and verbal level that it was ineffectual to depend upon this information for feedback. I felt that I had no way to assess the couple's level of interest or understanding.

My experience was also the experience of other helpers in the system. Ironically though, despite this, perhaps I was in some way successful in joining with this couple. At our first team meeting, 3 weeks after meeting with the family, I was disturbed by the couple's lack of communication. I was surprised when the CFS worker congratulated me and wondered how I had managed to get the couple to talk so much.

From the beginning, in working with this family it was difficult to sort out cultural differences from protection issues. I knew that some of the concerns cited by CFS were simply the product of one culture judging another. The worker wanted each child to have her own bed, she wanted Wanda and Joe to have firm time frames for bedtime and meals, and she wanted the couple to share equally in the parenting of the children. These expectations were not a part of native culture. It was difficult for Wanda and Joe to understand their significance or to make changes in these areas to please their worker.

The continuation of other practices, whether a part of native culture or not, resulted in putting the children at risk. When the children were left indiscriminately with inappropriate babysitters, when Joe cared for the children when he was drunk, and when the children's needs for food, stimulation and nurturing were ignored, this placed the children at risk for abuse and/or neglect. These were the issues that I chose to focus on in my

work with the family. While I felt that some progress was made, it was also clear to me that the family would require long term, ongoing support. When I terminated with the family, I transferred the case to another worker in my office.

Chapter Eight

Family #4 The D. Family

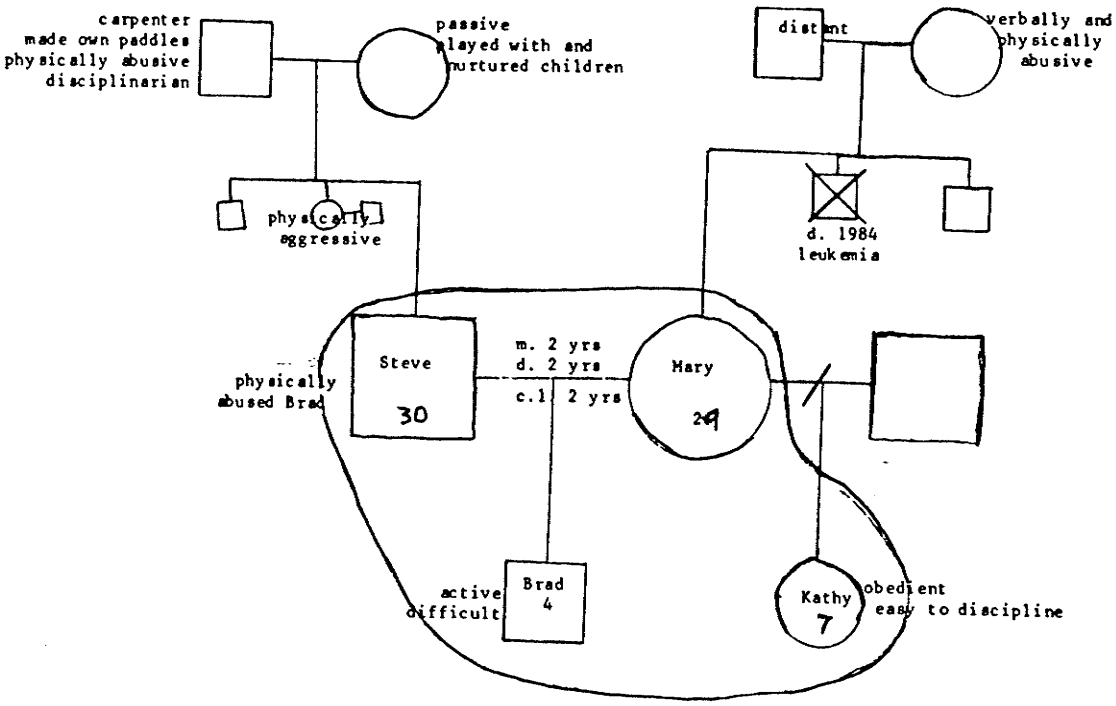
Steve 30 (father)
Mary 29 (mother)
Kathy 7(daughter)
Brad 4 (son)

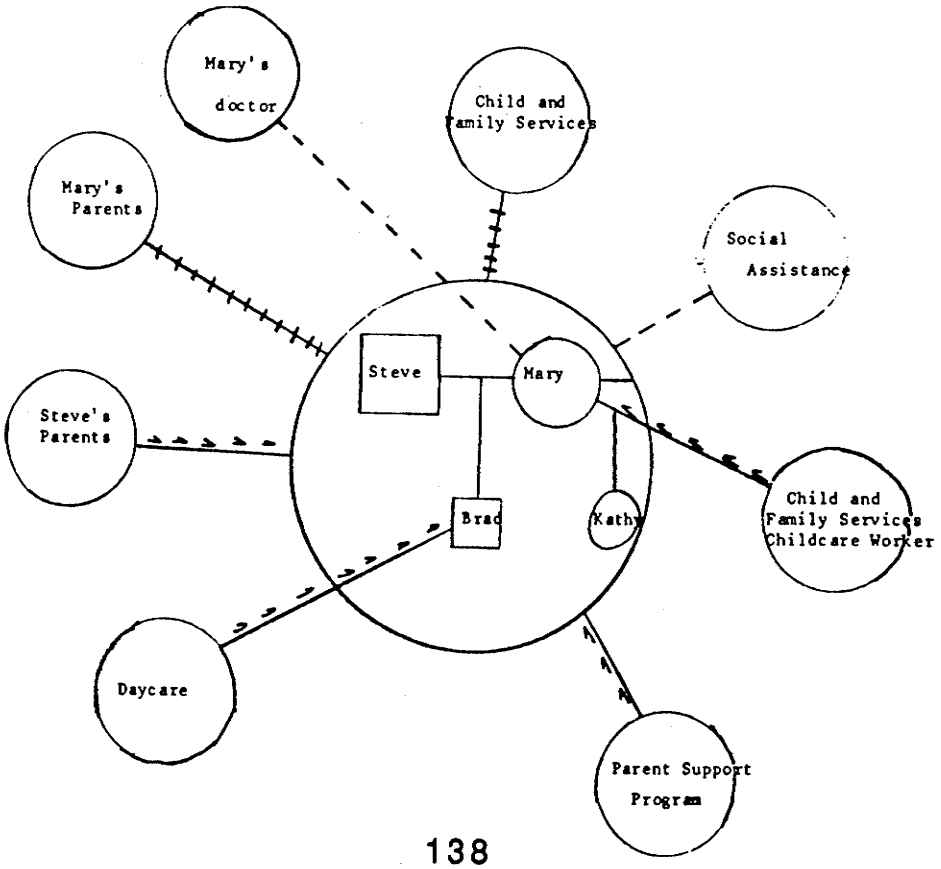
Helping Network:

Child and Family Services Worker
CFS Childcare Worker
Daycare
Parent Support Counsellor
Social Assistance

The family consisted of Steve, a 30 year old carpenter, Mary his 29 year old common-law wife, Kathy, Mary's daughter by another partner and Brad, Mary and Steve's 4 year old son. Mary and Steve had been a couple on and off for 6 and 1/2 years. They first came together when Kathy was an infant. Their courtship lasted 2 months. They lived together for 6 months, and were married for 2 years. Separated and divorced for two years, they had now been living as common-law partners for the past two years. They both described their relationship as rocky. Their difficulties seemed to revolve around the themes of balancing intimacy and independence, and disagreements about how to raise the children. When the couple argued, they were unable to resolve conflict. These disagreements generally ended with Steve storming out of the house or threatening aggression or with Mary withdrawing emotionally.

The D Family Genogram and Eco-Map





Steve was the youngest child in his family. He had one older sister and one older brother. His father was a tradesman, his mother remained at home to care for the family.

Steve remembered his father as the disciplinarian in the family. All the children were afraid of him but respected him. He made his own wooden paddles. He rarely played or socialized with the children. Steve did remember going into the garage with his dad to learn about building. This was the only pleasant time he remembered sharing with his father. He remembered his mom as the parent who played with him, comforted him and gave him affection. He said that even now he could never do anything to hurt his mom, because when he was younger she always used to cry when she was upset with him.

As a child Steve was allowed very little personal freedom. He could not stay at school to play with other children, nor could he have children over to his house. He was not allowed to participate in extra-curricular sports and activities. Steve left home when he was 18. He says he could no longer tolerate the many restrictions imposed upon him by his father. He met Mary after living on his own for 2 years. He remembered their early courtship as difficult because they always had to worry about babysitters, and had little time to themselves.

Mary described her childhood as unhappy. She was the oldest of two children. She described her mother as verbally and physically abusive. Her parents had frequent arguments. Mary's personal freedom was also very restricted. She was not allowed to play with other children. She was expected to work after school in her parent's personal care home. She spent

a lot of time with her mother who always seemed to be angry and unhappy. She took her frustration out on Mary in the form of physical and verbal abuse.

Mary left home at the age of 15. She worked and lived on her own for 3 years. At the age of 19 she moved in with a boyfriend and became pregnant soon after. When she gave birth to Kathy, her parents were very drawn to their new grandchild. They have continued over the years to seek contact with Kathy. They seem to have no interest in Brad. In the past year Kathy has been forced to sever contact with her parents because the tension between Steve and her parents had become intolerable. Steve and Mary's father had exchanged blows during arguments over Kathy. Mary's parents felt that Mary and Steve were unable to offer Kathy the quality of life that she deserved. They wanted the little girl to live with them. They had attempted to abduct Kathy from school. It had been necessary for Mary and Steve to contact Kathy's school around this issue.

Presenting Problem

This family was referred to the Parent Support Program by a child welfare worker at Child and Family Services. The family had come to the attention of CFS when the director of the daycare that the children attended called to report that Brad had appeared at the daycare with an injury that he said his dad had inflicted. Apparently the injury had occurred when Steve had punished Brad for helping himself to breakfast before the rest of the family was awake.

Steve was very angry that CFS had become involved. He interpreted this as a threat to his right to control and discipline his own children. When the

CFS worker visited the family Steve was too angry to discuss the situation rationally. The worker was forced to make the agency's mandate to protect children very clear to the family, and to outline what kinds of behaviors and discipline would not be acceptable in the future.

Mary was relieved to have CFS involved. She was the first to admit that she was not pleased with the style of discipline she and Steve dispensed on the children. She had observed that as the children got bigger, they seemed to require harsher discipline and she worried that in time she and Steve might accidently seriously injure the children. She also realized that the children were becoming fearful rather than respectful, and that they did not seem to be internalizing family rules.

Mary was also worried about her relationship with Steve. She felt that because of a variety of pressures, they were once again near break-up. She thought that many of the problems with the children stemmed from the conflict between the couple. She wanted marital therapy for the couple as well as help with developing a new style of parenting.

Steve was receiving pressure from CFS and from Mary to try marital counselling and to make some major changes in his parenting. Although reluctant, he agreed to try working with a counsellor from our program.

My first meeting with the family took place in their home with the CFS worker, the director of my program, Steve, Mary and myself in attendance. My initial impression of the family was that they had very different perceptions of the problem and that Steve in particular was not comfortable with sharing information which he considered personal with outsiders.

After a long discussion. The issues that the couple opted to work on were: (1) their tendency to have very different perceptions of most of their conflicts, (2) their inability to resolve conflict, (3) unresolved issues around separating and coming together , and (4) developing a new style of parenting which worked and was agreeable to the child welfare agency.

Abuse History

As is frequently the case with adults abused as children, neither Steve nor Mary had labeled the harsh treatment they had received from their parents as abusive. They both, and especially Steve, believed that because they were bad children, their parents had been forced to beat them and isolate them as a matter or course. They labeled this treatment as punishment for misdeeds.

Steve remembered that his father's beatings left welts and bruises. Because of the pain, it was often difficult for him to go to school the day after a beating. He said that no school official ever questioned him about the marks. He remembered feeling very angry towards his father, and promised himself that he would leave home as soon as he could.

Mary remembered being verbally insulted and belittled. She was expected to work in the personal care home everyday after school and on weekends. She was slapped and beaten by her mother for minor infractions. Her father although aware of this treatment, never interfered.

Mary left home at the age of 15 to escape further maltreatment. She quit school, got a job and lived on her own for 3 years with minimal contact with her family.

Previous Intervention

I985--- Mary contacted Children's Aid Society in Saskatchewan 6 months after she left Steve. She was feeling very tense and anxious and felt unable to take care of the children on her own. She voluntarily placed the children in foster care for 2 months. She saw a therapist for 8 months.

I986--- Mary again saw a therapist for 6 months to work on individual issues.

I987--- While Mary and Steve were in the process of reuniting, Mary once again contacted Children's Aid Society and voluntarily placed the children in foster care for 2 months. During this time she commuted to Winnipeg to visit Steve and discuss their future plans.

Assessment

(1) Clinical Assessment

Couple:

low level of mutual support
weak marital subsystem
poor differentiation
poor problem solving skills
focus on present
family themes of aggression, helplessness and abandonment
poor self-esteem
poor communication
frustrated dependency needs

Parenting:

parents as regulators
triangulation of a child
inconsistent limits
adults overwhelmed and overburdened
uncontrolled aggression
fear of authority
power struggles between adult and child

violent response to stress
inability to empathize with children
poor idea of normal child development
child's behavior perceived as willful and disobedient

(2) Fam 3

The FAM 3 was taken by Mary and Steve. FAM 3 profiles for the D family are located in Appendix One. On the general family scale Steve rated high for defensiveness which indicates a possible distortion of the FAM profile. This may mean either artificially depressed scores or a distortion in the shape of the profile. This was not surprising given Steve's tendency to employ projection. Generally, the results of the FAM 3 supported my clinical observations. Steve and Mary had difficulty communicating in a clear, direct manner. They both often misunderstood the other's communication, yet lacked the ability to seek clarification. As a consequence they were unable to resolve most arguments.

The FAM 3 identified the couple's struggle with role integration. As was obvious in our session, there was a lack of agreement regarding male/female role definition. Mary frequently felt that she was doing everything for the children and in the home, while Steve had lots of time for recreational activities. This resulted in a low level of mutual support in the couple.

The FAM 3 supported my observation of the family's poor problem solving abilities. Mary and Steve were unable to accurately identify problems or generate or implement solutions. Minor stresses in the family tended to precipitate crisis. The family's inability to problem solve left them very present oriented.

Finally, the FAM 3 targeted difficulties in the area of differentiation which were also observable in our session. The marital subsystem was weak. Family members were in competition for nurturance and need fulfillment.

(3) MCN

Mary showed significant attachment to the children, and demonstrated sensitivity, responsiveness and empathy. Steve was ambivalent about his relationship with Brad but was willing to discuss his feelings. He participated in minimal interactions with both children. Mary actively pursued positive interpersonal relationships with both children. Steve demonstrated negative feelings and withheld affection because he believed his children will be spoiled.

Both parents were sensitive to the practices of good hygiene and were aware of and practiced adequate nutritional standards. Both were able to provide adequate housekeeping standards and stability for the children in the home environment. In the area of Capacity to Meet Own Needs, Mary was inconsistent in her ability to recognize her own limitations and resists help offered. Steve frequently withdrew when unable to cope and exhibited self-destructive behavior. Both Steve and Mary were inconsistent in developing and maintaining supportive relationships for extended periods of time. Mary was able to accept responsibility for herself most of the time, but had a tendency to accept responsibility for Steve as well. Steve, under stress used projection, blame and criticism as a way to distance his anger.

In the area of Environmental Supervision, Both Mary and Steve were able to identify hazards and protect the children. Both were also able to provide

age-appropriate supervision of the children. Both were able to identify when the children required medical care, they could anticipate the need for maintaining an adequate standard of health care.

Mary occasionally resorted to spanking to correct misbehavior, and got into power struggles with the children. Steve had unrealistic expectations of the children and rationalized the use of physical discipline. When angry, he would strike the children and consistently react to the children with hostility. Mary was aware of the emotional needs of children and attempted to promote emotional development in her children. Steve's responses were unpredictable, he responded from his own emotional needs.

Mary had the ability to accept support, but was often dependent on friends. She was inconsistent in her ability to ask for support. Steve was able to build superficial relationships, but lacked the ability to build lasting relationships. Because of conflict between Steve and her family of origin, Mary had no contact with her family. Steve's communication pattern with his family was inconsistent. Relationships were adequate at times, but frequently there were mixed messages regarding expectations. Mary had a need for support, and was able to use professionals for this purpose. Steve denied his need for support, and was resistant to professional intervention.

(4) Perception of Self as Abuser/Parenting Skills

Steve felt that he was an appropriate parent. He described his own style of parenting as similar to what he learned in his own family. Steve thought that he should be able to discipline his children in any manner that he saw fit. He thought that children must be made to fear and respect an authority figure,

because otherwise they would have no reason to behave. He minimized and denied the severity of the injury that he inflicted on his son. If inconsistencies in his reasoning were challenged, he became angry and defensive, unable to resolve for himself how he could maintain control over his children without the use of harsh corporal punishment. He personalized challenges to his parenting skills, and reacted with quick and aggressive anger, which was demonstrated as an inability to rationally discuss the issues, poorly focused anger, and impulsivity. He thought that Mary was a push-over where the children were concerned. Whenever she intervened in his disciplining of the children, he became angry, removed his support and insinuated that she would be unable to follow through on her own.

Mary was dissatisfied with Steve's and with her own method of disciplining the children. She suspected that there was a better way, but she had been unable to find it on her own. She was afraid of Steve's anger both for herself and for the children. She saw him as potentially abusive. She saw herself as also potentially abusive, if she was under enough stress. Stress for her was generated by marital conflict. When she was in this state, she described herself as unable to tolerate any mischievous behavior from the children.

Family Themes

(1) The problems presented by the family seemed to have existed for 6 and 1/2 years, beginning when these two young adults first came together to form a couple without working out some of the complications involved in courting and establishing a new relationship with a small baby. This had

been an ongoing pattern with the couple. They have never been able to address and resolve the various conflicts that they have experienced. At times these conflicts have been intense enough to end in temporary separation, yet when they have come together again they have chosen to deny and minimize their problems rather than attempt to discuss and resolve their differences. The current episode of conflict seemed to have started soon after their latest reunion. Each buried episode of unresolved conflict had acted as a foundation upon which the next episode was built.

(2) Both adults in this family had experiences in their respective families of origin which rendered them unable to develop a clear, separate sense of self. Steve was playing out the role of rebellious adolescent as he struggled to maintain a balance between his own individuation and his role of father and husband in his family. Mary attempted to keep Steve connected to the family by blaming, attacking and using guilt, rather than through direct communication of her needs. The learning that Steve received in his family of origin about the roles that men, women and children play added to his present confusion and put him in conflict with his partner, his children and outside helping systems.

Mary was also a product of the observations and learning she did in her own family of origin. Steve and Mary's struggles set up a certain circular complementarity between the couple. As Steve distanced himself from Mary in an attempt to exercise individuation, Mary pursued him as a measure of her commitment to the family. This gave both of them an opportunity to perpetuate old myths about men and women and about families. Poor self-esteem, poor

communication and poor problem solving abilities compounded the family of origin issues.

(3) The unfinished business between the couple, their unresolved individual issues, and their dysfunctional interactional patterns, interfered with the couple's present ability to discuss, problem solve and agree on important issues involving the children. As a consequence these two parents were in the habit of responding independently with contradicting styles and ideas of parenting.

Goals

Individual:

To increase self-esteem
To increase self-differentiation
To explore unresolved abuse issues
To explore how these issues influence the current family

Couple:

To increase level of mutual support
To strengthen the marital subsystem
To improve problem solving skills
To help the family plan for the future
To improve communication

Parenting:

To take parents out of the role of regulator
To improve limit setting
To decrease the power struggles between adult and child
To increase ability to empathize with children
To improve knowledge about normal child development
To change perception of child's behavior

Intervention

Structure of Therapy

Although the adults in this family had important family of origin issues which needed to be addressed, it was my assessment that these could be addressed in conjoint couple sessions. The children were not currently in any real danger. I contracted to meet weekly with the couple to work on my targeted goals.

Joining

Mary was very concerned about Steve's method of disciplining Brad and she recognized that the couple had many difficulties. She was anxious for service and therefore very cooperative. Steve did not think his method of disciplining needed any attention. He was in fact, very angry and resistant to the idea of having a stranger in his home to help with private family matters. He explained that Brad was a very oppositional child who required very consistent, firm disciplining. He felt that unless he was really hard on Brad, he would grow up to be out of control.

Joining with this couple was initially quite a challenge. While Steve made it very clear that he was not interested in making any changes, Mary was equally clear about wanting changes.

In the first two sessions, I spent most of my time discussing the differences in Mary and Steve's perceptions of their difficulties. I asked many clarifying questions, and together we traced this difference in perception to their respective families of origin. I drew genograms of each of their families. In

addition, I spoke neutrally about my experiences with the child welfare system. While I empathized with Steve's anger and feeling of lack of control over his family, I also discussed CFS's role as a child welfare agency mandated to protect children. We discussed what CFS might do if the abusive behavior continued. I introduced this information as a treatment professional who although not a part of the child welfare system, had worked with enough CFS workers to know a bit about their process. We went over this material several times, and by the end of the second session, Steve was visibly less resistant.

Both Mary and Steve had grown up in physically and emotionally abusive families, but they also both minimized the maltreatment they had received. Much time was spent listening to their stories, and validating their experiences. It was interesting to observe how they both competed for my attention, and how easily offended they became if they perceived that I was siding with one or the other. It struck me that although they were eager for my nurturance, as a couple they were unable to nurture each other.

We discussed the connection between family of origin learning and present difficulties. Once Steve and Mary had a family or origin context for their present difficulties, Steve no longer felt he was being blamed or labeled as a bad parent. It was at this point that I felt the family became invested in continuing treatment.

Intrapersonal/Systemic Intervention

Because I met Mary and Steve in their home, it was easy to have informal time with the whole family, to get to know members and to observe

dysfunctional interactions. My time with the family began to include direct intervention, and hands-on teaching opportunities. There were many times when I became a coach during family arguments or when Mary tried to set limits with the children and needed help following through. Both Steve and Mary acknowledged that the small changes that the family tried worked. For the first time Steve seemed receptive to a gentle reframe of the problem as one affecting the entire family.

By this time, the separation between myself as a treatment person and CFS as a monitoring agency was clear to the family. The family had begun to recognize on their own that my style was very different from that of CFS. They spoke candidly to me about their worries, which for me was a measure of the success of my joining with the family. Steve was even able to admit that he acted out of anger and was often overly harsh with Brad.

Together the family and I worked on couple and parenting issues. Besides expressing a desire to learn new behavior management techniques, Steve and Mary also wanted to improve their communication and to strengthen the marital subsystem.

We worked together on these issues for 4 months. At this time, Steve felt that the couple had accomplished enough to terminate, Mary disagreed. The end result was that Steve opted to discontinue the couple meetings. I contracted with Mary to work on individual issues for 8 meetings.

The Helping Network

From the beginning of this case there was a reluctance on the part of the CFS social worker and the CFS childcare worker to meet as a team with the

family present. Given the tension between CFS and the family, I felt that to meet without the family was to compromise my position as an advocate for the family. I decided therefore, not to meet with the team unless the family could be present.

Unfortunately, CFS was never able to agree to my terms, and as a consequence the team never met. Because of this case, as a program we have decided that in the future all referring workers must agree (1) to attend regular team meetings and (2) that the family will be invited to all meetings.

Outcome

Posttest

(1) At the termination of therapy, the D Family was asked questions to determine their own experience of the joining process: when they felt comfortable, when they did not, what they liked about the sessions, and their critiques of the therapeutic process.

Steve talked about the difficulty of talking to a stranger about personal family problems. He felt that it was somehow wrong to share personal information with outsiders. He said that he had struggled with this throughout the treatment process. He was careful to let me know that his dilemma had nothing to do with me. He had found me easy to talk to and he said that he had liked that I had asked many questions and had seemed genuinely interested in understanding his side of things.

He said that he had felt just the opposite when he met with the CFS worker and that it had taken him several sessions before he was convinced that I was different.

He appreciated the help that I had given the family and he felt that he had changed his attitude toward Brad because of what he had learned in our sessions. He now realized that he had been controlling his son with fear, and he expressed a desire to change this. He acknowledged that this was a departure from the way that he had been raised. He was even able to say that perhaps his parents had been too harsh on him as a child. And that maybe he too had been too harsh on Brad.

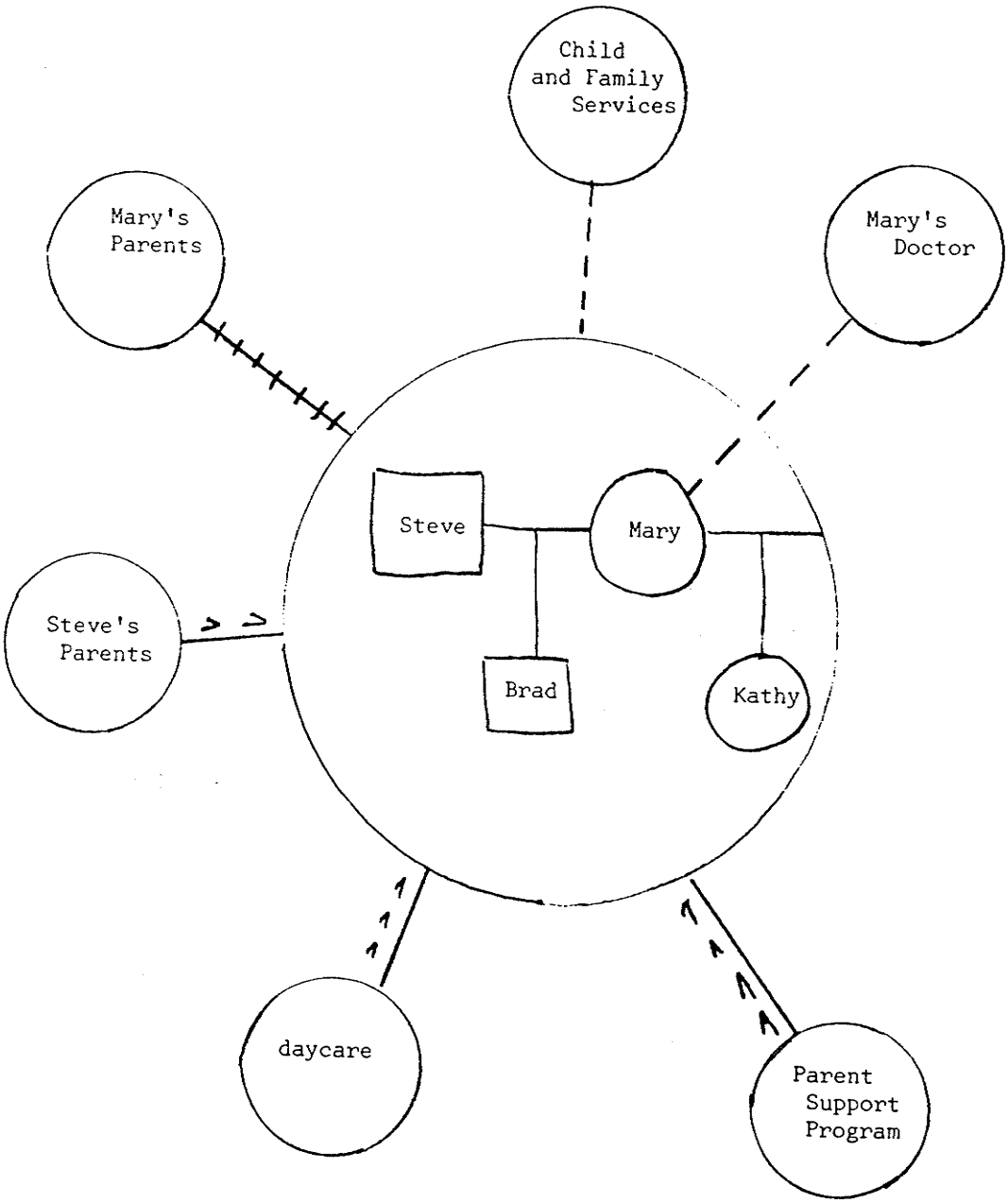
Mary said that she had felt respected and listened to in our sessions. She said that initially she was afraid that I would come down too hard on Steve, as she felt the CFS worker had and that Steve would refuse to participate. She was pleased that I had not taken sides or gotten into arguments with Steve.

Mary said that through our sessions, she had learned to stop trying to please everybody and do everything. She was now taking time to do things that she wanted to do. And she was generally more relaxed. She observed that this change in her seemed to affect everybody in the family. Steve was willing to do more around the house, and the children were minding her much better.

A new Eco-Map that tracks the helpers involved with the family at the time of termination can be found on the next page.

(2) Eco-Map

This is a new eco-map which tracks the system changes that took place in the course of therapy.



3) Goals

In reviewing the goals for the couple that were accomplished during the course of treatment, the most successful areas of gain for this couple were improving communication and increasing the level of mutual support. Steve and Mary were now much better at directly communicating their needs and expectations of one another. They were able to discuss their problems without blaming and finding fault with each other, and to resolve their difficulties in most instances. Mary was no longer frightened or stopped by Steve's verbal aggression, and as a consequence, Steve relied on this as a method of control less and less.

Instead, both Mary and Steve shared more information with one another, and sought clarification if they were confused. They now understood that negotiating required perseverance and effort. Prior to treatment, they had been unable to resolve their most minor conflicts. Now they were tackling some of the bigger issues in their relationship, such as having friends of the opposite sex, and learning to balance individual time with family time.

In reviewing the degree of mutual support now functioning in the couple, I observed that many changes had taken place. Steve was now caring for the children two nights a week to allow Mary time for herself. He was also actively participating in meal preparation, shopping and doing laundry. Steve was pleased to observe that as he participated more in these activities, Mary complained less about the times he went off with his friends. In addition, he felt closer to his children, and had begun to see Brad less as a difficult child and more as a child who enjoyed being challenged and busy.

Many changes had taken place in Steve and Mary's parenting style. Mary had learned to set appropriate limits, and to follow through with these limits. This had in turn decreased the number of power struggles with the children. As Steve had observed the positive results of Mary's new skills, he too had begun to imitate her methods. He talked about the closeness he now felt with the children. He acknowledged that in the past he had been overly harsh with the children, and had not been especially sensitive to their strengths and interests. Now he was making more of an effort to understand them, and as a consequence everyone was getting along much better.

Both Mary and Steve had a better awareness of how their individual abuse experiences had influenced their current family difficulties. We had spent many hours mapping their families and discussing their childhood experiences. Together we made the connection between what they had learned in their families about male/female roles, and how this learning had been perpetuated in their present family. Covering this material served to help differentiate them from their families of origin, as they began to discover that they could actively choose to accept or reject family myths. This process was also self-esteem building, as both Mary and Steve began to take more responsibility for changing the patterns and interactions in their present family.

(4) Perception of Self as a Potential Abuser

Steve could now admit that he had not been an appropriate parent. He described his old style of parenting as similar to what he had experienced as a child in his own family. Steve no longer thought that children must be made to fear and respect an authority figure. He could recognize the difference

between disciplining children out of anger or out of a desire to direct and teach. He was embarrassed about the severity of the injury that he had inflicted on his son. He said that it was now possible for him to maintain control of his children without the use of harsh corporal punishment.

Although he was now more in control, he still reacted with quick and aggressive anger, which was demonstrated through impulsivity. Now, however, he allowed Mary to point this behavior out to him when it occurred, and he was trying hard to learn to be more thoughtful and less impulsive.

Mary was pleased with her own new method of disciplining the children. Although she was still concerned about Steve's anger both for herself and for the children, she was able to confront him when she felt uncomfortable. This made her feel more secure in her ability to control the situation to avoid violence. She no longer saw herself as a potential abuser. If she was under stress, she was able to seek help from Steve or to prevent herself from directing it to the children.

(5) Conclusion

During the six months that I met with this family, we had approximately 25 sessions. When I gave the couple the FAM 3 again as an additional posttest (Appendix One), it supported my observations at termination that the couple had made many gains especially in the areas of communication, role performance and task accomplishment.

Although it had been very difficult for Steve to share information about the private dealings of his family with an outsider, in our final session, he was able

able to talk about this difficulty and to acknowledge that the experience had been beneficial for the entire family.

Because of the couple's gains in parenting skills , the case was closed by CFS. As Mary was interested in continuing her individual therapy, before I terminated with the family, I helped Mary make contact with a therapist at the regional office of Health and Community Services.

Chapter Nine

Case #5: The E Family

Astrid 38 years old (mother)
Cara 6 years old (daughter)
Lena 5 years old (daughter)

Helping System:

Economic Security Worker
Play Therapist's for each child
Parent Support Counsellor
Montessori School

At the time of referral the family consisted of Astrid, a divorced 38 year old mother and her daughters, Cara and Lena. All three were bright, attractive and creative. Astrid had been divorced for 3 years, after being separated for 1 and 1/2 years. The girls had been both physically and sexually abused by their father during his regular visitation with them. The abuse lasted at least 18 months, and possible longer. When Astrid realized what was happening she pressed charges. Although Astrid herself had been subjected to countless hours of terrifying brutality at the hands of her ex-husband, she described watching her own children recover from their abuse as one of the most difficult things she had ever had to do. She has had to cope with night terrors, sexualized behavior, phobias, eating and sleeping disturbances and a variety of bizarre acting-out behavior from her daughters. Having been a physically and emotionally abused child herself, these episodes with her children brought her own memories of childhood abuse flooding back. In

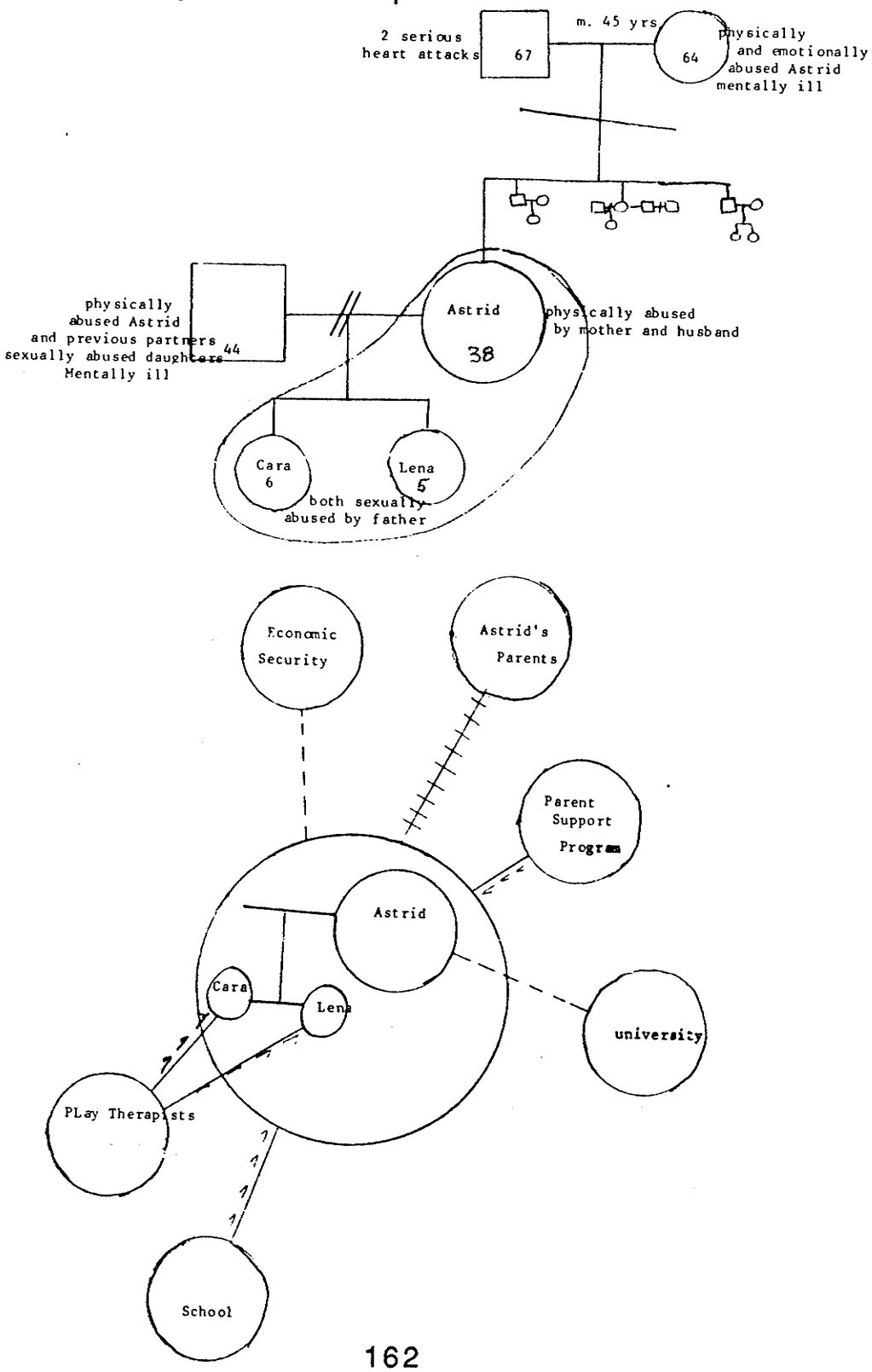
addition she felt tremendously guilty because she was not able to protect her children. An Eco-Map of the E Family can be found on the following page.

Presenting Problem

This family was referred to the Parent Support Program by Cara's therapist. She was concerned by Astrid's behavior and level of distress when she brought the girls to therapy. Each week when she arrived, Astrid would pour out her worries and confusion to the therapist. The therapist was concerned about Astrid's ability to parent and to protect her children from further abuse. She was also concerned that given Astrid's background of abuse, her consistently high level of anxiety, and her seeming inability to handle the difficult behavior that the girls were displaying, that she too might become abusive.

My first meeting with the family took place in their home with the director of my program, Astrid, Cara, Lena and myself present. The meeting was chaotic and confusing. Astrid spoke nonstop while the children simultaneously bombarded us with toys and questions, climbing into our laps, jumping, running and demanding attention. Astrid seemed at a loss as to how to control the situation. She was indecisive and ineffectual. Her childrenignored her. She smiled and looked apologetic. All three were in competition for our attention. The level of noise and of chaos was irritating and draining. We discussed what was happening with Astrid and she requested our help. We contracted with her to begin working on setting limits with the children.

The E Family Genogram and Eco-Map



Abuse History

Astrid, the oldest of four children was severely physically and emotionally abused by her emotionally disturbed mother until she left home at age 20. When she was a child, the abuse was carried out in secret when other family members were absent. Astrid was regularly beaten, kicked, slapped, tied and locked up, denied food, clothing and the use of the bathroom. After an especially bad episode it was common for Astrid's mother to lock herself in her bedroom for up to several days complaining of a variety of somatic disturbances. During these times, Astrid, being the oldest was expected to assume care of her brothers and sister. Her father never supported nor interfered during these times.

When Astrid met her husband they dated for several years. He became abusive soon after they were married. For four years she was brutally physically and emotionally terrorized. Her husband had psychotic episodes and attempted suicide several times. She left when she realized that things were not going to change.

From an early age Astrid was groomed to become the target of her mother's aggression. Although she appeared to be a victim, in reality she was one of the family's strongest members, and consciously made a decision at an early age to sacrifice herself to protect her mother. She remembered that even as a small child she perceived her mother as very emotionally fragile and dependent on the nurturing of others for survival. She consciously chose to never fight back when her mother attacked her. During these times, Astrid would tell herself that unless she took the abuse without complaining, her mother would crack and go crazy. She perpetuated this role with her

husband. She saw herself as his protector. Even when he was extremely abusive towards her, she focused on what she identified as the 'lost child' inside of him.

Assessment

(1) Clinical Assessment

Individual:

poor differentiation
poor problem solving skills
family themes of aggression, helplessness
poor self-esteem
poor communication
feelings of guilt
frustrated dependency needs

Parenting:

weak parental subsystem
parent as regulator
inability to set limits
overwhelmed and overburdened
power struggles between adult and child
poor idea of normal child development
in competition with child for love

(2) FAM 3

The FAM 3 was taken by Astrid. Cara and Lena were too young to participate in the assessment. FAM 3 profiles for the E Family are located in Appendix One. The FAM 3 targeted difficulties in the areas of Communication, Affective Expression and Role Performance. This was consistent with my clinical observations.

This was a family in which communication was used for the purpose of side-tracking one from action. Everyone talked all of the time, but no one listened. In my first session with this family Astrid and her children competed for my attention by simultaneously talking the entire meeting. The resulting chaos was quite amazing, and even more amazing was my observation that no one in the family seemed to mind.

The family had also not managed to develop an acceptable level of role integration. This was reflected in the FAM 3 assessment. Members lacked agreement regarding role definition. Neither child had internalized the family rules or had evolved an independent role in the family. Astrid acted as the regulator of everyone's behavior. But at the same time, she was very inconsistent in this role. As a consequence the boundary around the parental subsystem was very blurred.

Finally, the FAM 3 supported my observation of disturbances in affective expression. Astrid tended to communicate with the children in an overly intense style. This was especially obvious when the children committed some minor infraction or when Astrid perceived that they were in danger.

(3) MCN

Astrid showed significant attachment to the children and demonstrated sensitivity, responsiveness and empathy. She actively pursued positive interpersonal relationships with each child. She was sensitive to the practice of good hygiene and was aware of and practiced adequate nutritional standards.

Astrid was unable to acknowledge that she was ever really angry or that there were ever times that she required help. She accepted responsibility for self without conflict, but had managed to maintain few trusting relationships.

Astrid identified hazards and protected the children almost obsessively. She was worried each time either child attempted any display of climbing, jumping etc. She often frightened the children because she communicated her fear for their safety by yelling suddenly. She was very conscientious in her provision of supervision.

Astrid identified when the children needed medical care. She anticipated the need for maintaining an adequate standard of health care, and had an ongoing satisfactory relationship with one provider.

In the area of discipline, Astrid attempted to correct misbehavior occasionally by spanking and often got into power struggles with the children. She was aware of the emotional needs of her children, and made attempts to promote emotional development.

Astrid was able to maintain some relationships, but generally had a sense of isolation. She sought new relationships but showed discomfort when attempting this.

Her family of origin was intrusive and controlling. She continued to return to the family to draw them in to the situation. Astrid used the help of professionals inconsistently. At time she would accept assistance. At other times, when she needed help she would deny it.

(4) **Perception of Self as Abuser/Parenting Skills**

Astrid described being a parent as one of the most difficult jobs she had ever attempted. She was constantly trying to go against her training, to be nurturing and supportive of her own children. She was unable to set limits she said because for her the slightest hint of negativity or anger made her fear that she was as unreasonable and as frightening as her mother was. Her fear that she would abuse her children as she had been abused by her mother, fostered a relationship with her children which was built on a lack of proper hierarchy. The end result was that the children were out of control.

Family Themes

(1) Because of her own abuse, this woman had difficulty developing clear boundaries between herself and the other systems with whom she must interact. This was demonstrated with her children as difficulty in setting limits, having time apart from them, and in meeting her own needs. In her family of origin Astrid remained the deflector of her mother's pain and deprivation and thus an undifferentiated extension of her as she pretended that the abuse never happened, continued to allow her mother to verbally abuse her, and was sometimes immobilized by the need to protect her mother. Out in the world, Astrid's difficulty with maintaining boundaries was played out by her need to indiscriminately share information about herself with casual acquaintances, by the repeated pattern of inappropriately coming to the aid of others at the sacrifice of herself, and by her inability to assert her own opinions and needs. All of these actions were perpetuated by the fundamental lessons

about relationships and interactions that Astrid was taught through out her childhood, as a consequence of the abuse.

(2) Astrid's inability to form clear boundaries combined with her low self-esteem and poor individuation to result in her inability to trust her own opinions and decisions. This became a serious problem when it put her or her children at risk in the world. In these situations Astrid struggled to choose between what she was taught as a child (compromise yourself to fulfill the needs of others) and what would provide safety and stability for herself and her children.

(3) As all parents do, Astrid functioned as a model and a mirror for her children, who were learning about the role of women in the world. When she modeled that women were indecisive, self-sacrificing, and powerless, her children were internalizing these lessons. Because of their painful experience with victimization through their own abuse, they were especially vulnerable to the role of victim.

(4) As is common for many victims of abuse, Astrid confuses firmness and strength with anger, negativity and violence. For her to display anything stronger than kind concern was to risk loosing control and becoming abusive. Because of this, she was unable to set limits or show the strong assertive side of herself. This meant she constantly set herself up for failure and to be taken advantage of as a victim.

Goals

Individual:

To teach alternative to operating from crisis to crisis

To increase self differentiation
To strengthen boundaries
To re-align hierarchy
To improve problem solving skills
To improve ability to plan for the future
To improve communication skills
To explore abuse

Parenting:

To decrease role as regulator
To improve ability to set limits
To decrease power struggles between adult and child
To improve concept of normal child development

Intervention

Structure of Therapy

Because the children were already well supported with daily school and weekly visits to individual therapists, I began with weekly visits with Astrid and bi-weekly visits with Astrid and the children. During our individual time together, Astrid and I worked primarily on the targeted individual goals. During the visits which included the children, I had an opportunity to address parenting goals in a hands-on activity oriented approach.

Joining

In this case the referral came as a result of the children's play therapist's concern about Astrid's high level of disorganization and distress. Knowing the family's abusive background, and the difficulty of the present situation, she was concerned that (1) Astrid was unable to protect her children from further abuse, and (2) that Astrid might physically abuse the children. When the therapist discussed making the referral to our program with Astrid, she framed

it as an opportunity for Astrid to have someone to speak to about the children's abuse.

I entered the family system as someone who could help Astrid sort out how to handle the very difficult behavior that her children were exhibiting as they worked through their abuse. Upon entry, I was at once faced with Astrid's obvious deprivation. Her own abuse history was manifested in her extreme need to talk continually and without stopping. She had a need to over explain and repeat every point she made. She would give example after example to back up a single statement. During the first three to four sessions she spoke almost exclusively of her own abuse. She recounted episode after episode. She presented in a near hysterical manner, one moment sobbing, the next moment starting again to speak at a frenetic pace. She seemed to need to hold my attention, yet disbelieve that she had the power to do so. She startled very easily and was easily distracted. I felt that it was important to hear her story with a minimum of interruptions. I asked only clarifying questions. I wanted to convey to Astrid that I thought that her story was important, in this way I hoped to validate and empower her. I also suspected that after she had the opportunity to tell her story on her own terms, that she would be more receptive to intervention.

Joining with this family meant helping Astrid to first establish a healthy, trusting relationship with me, as we began to link her current difficulties with her past experience of abuse. During the first 5 to 6 sessions I focused on gathering historical information, trying to understand her perception of the world and making gentle connections between her difficulty in parenting and her experience of abuse as a child.

In this family, separating my role as treatment worker from that of child welfare worker was not an issues as only treatment workers were involved.

Intrapersonal/Systemic Intervention

Every other week I met Astrid with her children. During these informal activity times, I began to get to know the children and to observe many dysfunctional interactions between parent and children. My time with the family included direct intervention and hands-on teaching opportunities. I helped Astrid set limits with the girls and follow through with those limits. Because the children were displaying a lot of sexualized behavior, I helped her to interpret and redirect this behavior.

We talked many times about how children internalize the behavior and attitudes that their parents model for them. Astrid began to realize how she over protected her children and encouraged dependency. As she became more confident, she modeled this new attitude for her children.

Together we worked on strengthening boundaries and hierarchy, improving problem solving and communication skills. Astrid learned new behavior management skills and began to see her daughters as separate, autonomous beings. It was interesting to observe that as Astrid began to treat her children as competent and capable, the sexualized behavior stopped.

As an example, at the termination of one session spent with the entire family at the local Parent Child Drop-In Centre, Cara began to throw a temper tantrum because she did not want to leave. In the past Astrid had seen Cara's oppositional behavior only as embarrassing. Generally in a situation such as this Astrid would have felt that because her child was crying, everyone was

judging her as a bad parent. In this particular instance, instead of giving into Cara because she was crying, Astrid told Cara that they were leaving, that she needed to get her boots on, and that Astrid would be waiting for her outside of the centre. She spoke to Cara in a neutral yet nurturing tone and then stepped outside. Cara stopped crying immediately, put her boots on and joined her mother outside also.

The Helping Network

The helping network, with the exception of social assistance, was limited to helpers who shared a similar definition of the problem. As a consequence, the team acted in a unified manner, avoiding many of the problems encountered when helpers with very different perceptions come together to service a family.

The biggest challenge that faced the team was Astrid's habit of individually calling up each member in a perceived crisis. At these times as she repeated her story to each helper, she seemed to need their involvement on an emotional level. After this had happened twice, the team came together with Astrid present to discuss how best to handle this situation. Together we evolved a method of redirecting which we planned to employ the next time this happened. It was interesting to note that it never happened again.

Outcome

Posttest

(1) At the termination of therapy, Astrid was asked questions to determine her own experience of the joining process; when she felt comfortable, when

she did not, what she liked about the sessions, and her critiques of the therapeutic process.

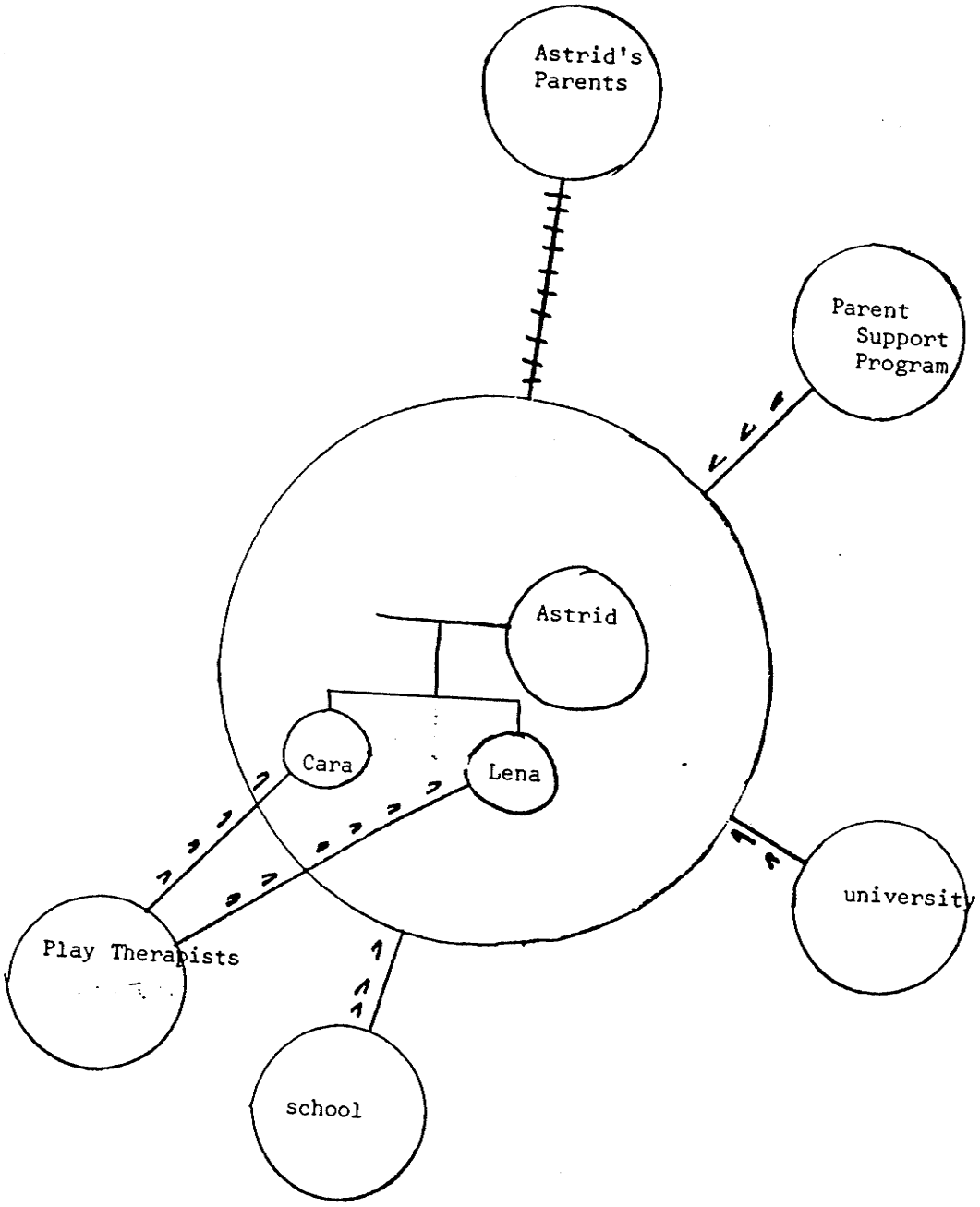
Astrid named four things that she thought had contributed to our successful joining. These were asking many clarifying questions, believing her stories of abuse, challenging her in a honest yet gentle way, and offering nontraditional service.

Astrid explained that when I asked questions to gain more information about something, it made her feel understood. She felt immensely grateful that I cared enough to clarify what she was saying. It helped her to feel that I believed that she was abused as a child. She said that having the opportunity to talk about her abuse had really helped her to realize that it had happened and that it was not her fault. During our time together she had remembered many long forgotten instances of abuse. Although these were difficult memories, she also expressed a certain relief in being able to talk about these episodes.

She also appreciated the way in which I had challenged and confronted her on a process level. She felt my caring was unconditional and talked about feeling as if I had been the caring nurturing parent that she had never had as a child.

(2) Eco-Map

This Eco-Map tracks the changes in the system during the course of therapy.



(3) Goals

In reviewing the parenting goals that were accomplished during the course of treatment, it was obvious that Astrid had gained many new skills. She had worked hard to strengthen the boundary around the parental subsystem, and in the process had also re-aligned the family hierarchy. She was now more able to set firm limits with the twins, and was delighted to observe that in most instances the children complied easily with the new rules. As the children's behavior improved, Astrid began to see them as strong and creative. She no longer worried that they would be traumatized by their abuse, and she recognized her ability to teach and model the kind of behavior that she wanted the children to emulate.

She trusted the children to make more choices, and as a consequence, gave them more independence. This freed up her time and she was able to pursue more of her own interests. She began to enjoy school and to feel more confident in her academic ability. Small frustrations no longer provoked crisis. She was able to problem solve and think her way through most difficulties.

Astrid and I spent many hours discussing the connection between her own childhood abuse and the patterns that had evolved in her present family. Astrid came to realize that she had been severely abused as a child probably because her mother was emotionally disturbed. No longer feeling responsible for her own abuse was very freeing for Astrid. Although for a time she was very angry with her parents for the maltreatment she experienced, in time she was able to accept their limitations as parents, and to also absolve herself from the responsibility of protecting them.

(4) Perception of Self as Abuser

Astrid still described being a parent as one of the most difficult jobs she had ever attempted. But she was now able to set limits without fear that she in any way resembled her abusive mother. She understood the importance of strong boundaries between subsystems and an appropriately aligned hierarchy. Her children were no longer out of control, and Astrid did not feel that she would abuse them.

(5) Conclusion

I met with this family approximately 25 times. I think that intervention was very successful. At termination, Astrid and her daughters were engaging in many more adaptive interactions then when treatment first began.

For women like Astrid, who have experienced such extreme and long term abuse, healing is a gradual and long term process. Although Astrid decided not to continue with treatment, I suspect that she has much work ahead of her. Perhaps in the future she will again decide to seek professional help. I think that if this does happen, the skills that Astrid developed in our time together will enable her to pursue other therapeutic relationships.

Chapter Ten

Evaluation

This section will focus on the evaluation component of this practicum. I will discuss the process of joining with each family, my strategies for intrapersonal and systemic intervention, issues involved in coordinating the helping system and my own personal learning which took place as a result of this practicum.

Joining

As I expected, all five families entered treatment at different levels of readiness. For me as a clinician this meant entering the system and joining with each family in a highly individualized way. It was important to consider whether a family's label of 'at risk' came from inside or outside of the system. This influenced the way in which I defined my role and the way in which I was able to join with the family.

Families who's label of 'at risk' came from inside the system, while cautious and generally rigid about retaining their own definition of the problem, were at least anxious for service. Families who's label of 'at risk' came from outside the system, were either in disagreement with the label, and therefore, closed and suspicious to service, or were oblivious to the implications of the label, and therefore unprepared for service. In these situations, joining was a longer process and required more attention to listening to the family's story and challenging process.

In general, I found that three important factors influenced the joining process. These three factors may not be unique to multi-agency at risk to abuse families, but given the characteristics and issues of this population, I suspect that they are crucial in successfully joining with this clientele. The three factors are: (1) listening to the family's story, (2) challenging process, and (3) offering more intense, nontraditional service.

Listening to the Family's Story

Even families with an outside label of 'at risk' were willing to share their story. Many of these families had never before been asked to discuss their perception of the presenting problem, to talk about family history, to describe what had been tried by other helpers, to say what they thought had been effective, and what had not. As a joining helper, tuning into the family's perception of the world seemed to me to be one way of fostering acceptance and respect (Coppersmith, 1985). For the families, this process seemed to serve as validation and empowerment. I noticed that even the most reluctant family became visibly less defensive and resistant as they shared information (Buck, 1984). I suspect that for the deprived adult in these families, asking them to share their story was an important act of nurturance. They had not only the unfamiliar but pleasant experience of being listened to, but also of being an expert on the material they presented.

Taking the time to gather information through this format also gave me the opportunity to model for the family that: (1) before one can problem solve, one must gather information, and (2) operating impulsively and emotionally when

under stress is less beneficial than slowing down and methodically surveying the situation.

Listening to a family's story was a process that generally took one and sometimes two complete meetings. During this time I also constructed genograms and eco-maps with the family and questioned the family about intergenerational connections. Sometimes the FAM 3 and MCN measures were given during this time. After several sessions at this stage, the family was usually ready to move on to the next stage.

Challenging Process

I found that if I continually shifted between the content and process levels, checking out family member's verbal and nonverbal responses in a neutral and nonjudgmental way, that it became possible to make covert, dysfunctional processes overt. This served several purposes: (1) to make members more aware of their own feelings and reactions, (2) to challenge distorted thinking, and (3) to provide an opportunity to discuss and practice new adaptive interactional skills.

Again and again I observed how difficult it was for these abused and deprived adults to be in touch with and acknowledge their emotional reactions and responses to events, or to risk being vulnerable. After so many years of being abused, each of these adults had learned to protect themselves by losing touch with their own needs and with the pain they had once experienced because these needs were denied. By challenging process, in some cases on a moment by moment basis, individuals began to replace old interactional styles with new more adaptive styles. By checking out the

implied meaning of the verbal and nonverbal information that these clients communicated, it became possible to help these people become more aware of their own feelings and reactions (Kroll, 1988). This process also stopped these feelings and reactions from remaining unspoken and from becoming a problem between us. By challenging process, cognitive distortions were dealt with as they appeared. Throughout this process I consciously tried to present as neutral and matter of fact. I was very aware of how hard it was for this population to scrutinize their own dysfunctional interactions. I wanted to create an atmosphere of unconditional acceptance in which clients would feel able to discuss these difficult issues. I suspect that this was what allowed the adults in these families to establish a healthy, trusting relationship with me.

Offering Nontraditional Service

The level of deprivation and victimization experienced by the adults in these families left them unable to postpone gratification, to think beyond the present, or to put their own needs aside for the benefit of the family (Buck, 1984). This resulted in such problems as the family's inability to keep regular appointments, to travel to the therapist, to sustain involvement between appointments scheduled farther apart than once or twice weekly, or to carry out homework assignments.

With traditional servicing (family meets therapist for one hour weekly in therapist's office, relying on discussion and verbal enactment) the responsibility for contact and direction generally rests with the family. With the multi-agency at risk to abuse population, this traditional format is unsuccessful (Kaplan, 1986). Such families require a different, more extensive intervention.

Here, I had the opportunity to re-parent the adults, to demonstrate the rewards of postponing gratification, to teach how and why one plans for the future, and how to empathize and care for others. Much of this was accomplished through talking, but the families also needed to learn through observing my actions and modeling (Buck, 1984). Thus, my work often included helping the family deal with other helping agencies (economic security, housing, health care, etc.). This was done through phone contact, or actually going with the family to a particular agency. I also made myself available to meet more often with a family, or met for longer periods of time if they required more intense intervention. And I always met with the family in their own environment. These were the concrete ways through which the members of the family begin to learn that they were cared about, believed in, supported and respected. For some adults abused as children, this was their first opportunity to experience a relationship which offered this quality of interaction.This nontraditional approach to treatment is discussed in the literature as necessary if one acknowledges the unique special needs and concerns that face this population (Janzen and Harris, 1980; Kaplan, 1986).

When the families in my practicum felt supported, believed in and respected, they became ready to take more responsibility for the course of their own therapy. At this point a shift in focus became possible with the family able to participate in a more equal partnership with the therapist.

This was the point in therapy that marked successful joining. With each case the amount of energy and time spend prior to arriving at this point varied. Thinking back on the process of joining with each family, the degree of deprivation and the origin of the label of 'at risk' did influence the amount of

time required for joining, and the areas of emphasis. In families resistant to service it was necessary to spend extra time listening to their story and discussing their perception of past interventions. From there we could discuss the nature of my role, and the impact that an involuntary relationship with child welfare had on the family. By the time we had reached this point, it was possible for me to challenge process and to begin my intervention.

For the extremely deprived adults in these families, joining turned out to be an ongoing process. Because of the severity of their own abuse and the resulting mistrust and patterns of dysfunctional interaction, establishing a working relationship with these people required more work in the form of listening to stories and challenging process. This did get easier as our time together progressed, however. By the fourth month of treatment even the most damaged parent was feeling comfortable and happy about the work she and her family had accomplished.

Intrapersonal/Systemic Intervention

As discussed elsewhere in this practicum paper, most abusive parents were themselves abused as children (Buck, 1984). As a result, these adults became locked in an intergenerational cycle of abuse. All of the parents in my practicum struggled with feelings of being unloved and unlovable, and to varying degrees looked to their child as a source of reassurance and nurturance, almost as if he/she was expecting the child to assume the role of loving parent. In each case, the child was unable to meet these needs because they were in direct competition with the child's own need for nurturance and love. The parent perceived this as once again being thwarted

in his/her attempt to be nurtured. Given a personality which allows aggression to be expressed impulsively and without control, the result could have been child abuse.

This is the intergenerational connection. When a child is made to feel innately bad, when the first intimate relationship that child has teaches a sense of worthlessness, this experience influences all future attachments. The deprived adults in these families were very much oriented towards satisfying their own needs. This affected their ability to parent and to establish relationships with other adults.

As parents these adults had difficulty maintaining appropriate boundaries and hierarchies. This was demonstrated as difficulty in setting limits (either too harsh, or too lenient), role reversal between parent and child, and enmeshment. The emotional relationships of these adults with other adults were generally inadequate, volatile and minimally supportive (Buck, 1984). Unable to receive gratification from these relationships, there was an increased expectation of nurturance from their children.

As all parents do, these parents acted as models for their own children, teaching important information about interacting with others, roles, values, handling stress, self-esteem, and affective expression. Thus, the dysfunctional learning of one generation was transmitted to the next through daily direct and indirect interaction.

In this practicum, intervention was designed to simultaneously address the current system's problems, as well as interpersonal issues connected to abuse. The damaged adults in these families were able to work on system's issues only when they as individuals were supported and nurtured. Without

individual attention, these adults entered the family session with maladaptive and rigid perceptions about the role of children in the family, relationships, parenting and the role of outside helpers. In the family context it was impossible to address these issues while remaining neutral and equally supporting other members. The very act of equally supporting other members left these damaged adults feeling slighted, blamed, neglected and in competition with family members.

With individual support to nurture and establish a trusting relationship, it became possible to change the rigid and maladaptive perceptions of the parent. With individual support and validation, these parents were able to scrutinize the interactional patterns in the family, and to broaden their perception of the problem from child focused to an inclusion of the entire family and its interactional patterns.

As these parents felt nurtured and validated and began to internalize new skills for maintaining adaptive relationships, they also began to model these new skills for their children. Parent-child relationships improved, hierarchies and boundaries became stronger and clearer. Children felt more stability and protection from the parental system, and anxiety and acting-out behavior decreased.

An additional interesting outcome was that as families improved functioning and became more aware of the intergenerational connection between abuse and maladaptive learning, they chose to associate in a different way with their families of origin. They saw them less frequently, depended on them less in times of stress, and accepted their limitations in terms of their ability to nurture and support.

With the exception of Family C , all of the other families after four months of treatment were aware of the changes that had taken place. Parents were able to articulate change at both the individual and systems level, children were aware of system changes. All agreed that these new changes improved individual and family functioning.

Family C was the only family that remained in the pre-phase of intervention. This was a cognitively limited family who had great difficulty understanding why they had been labeled 'at risk' for abuse. Neglect and poor parenting skills had been practiced in this family for several generations. As a result the behaviors that were being externally labeled as 'at risk' were considered appropriate internally.

Coordinating Helpers

In this practicum I viewed the outside helping system and the family as one system. I mapped the system to identify significant members and relationships. I gathered family history and organized network meetings for the purpose of defining the problem, learning about past interventions, and defining the roles of the various helpers involved with the family.

In working with other helpers I learned that each helper has his/her own unique perception of the family and its problems. These differing perceptions often cause contradicting, overlapping and confusing service to the family (Coppersmith, 1986). Further, when one is dealing with autonomous agencies who are used to acting unilaterally, creating a team atmosphere can be challenging to say the least. The concept of coming together as a team

with the family present to discuss concerns and problem solve, was foreign and unfamiliar for many of these agencies.

As an example, when the CFS worker fired the A Family's childcare worker without first consulting with the family or with the team, as already discussed, some important treatment goals were compromised. The family was confused as to why the worker had been fired and also began to worry that other helpers could leave just as suddenly. Because two of my major goals with this family were to empower them to participate in their own treatment plan and to replace operating from crisis to crisis with planning and problem solving, I organized a team meeting with the family and all members present. CFS was very reluctant to attend the meeting. They did not want to discuss the firing of the worker. I organized the meeting and set the agenda. I explained that the purpose of the meeting was to problem solve with the family how to address the issues that had been created by the firing. I worked hard to establish an atmosphere in the meeting in which all members of the team felt comfortable discussing the firing and its impact on the family. We did not blame or argue. Although CFS had been very reluctant to attend the meeting, in the end we were all able to work together to problem solve how best to help the family deal with the loss of the worker. The meeting was an important therapeutic process for the family. It helped to both empower them and to reinforce that people can come together to work out differences. In this situation, the helping system was able to model for the family how to accomplish these tasks.

Often times it was necessary to spend almost as much time joining with the team as with the family. I had to work especially hard to convince team

members that including the family was useful and productive. Many team members were in the habit of using meetings to focus on family pathology. It was necessary to replace this thinking with a new concept of team meetings; coming together to problem solve in the present context, focusing on the strengths of the team and of the family (Levin, Raser, Niles and Reese, 1986).

As stressed by Erickson, Rachlis and Tobin (1973), team meetings had an important socializing effect. They were a time for members to meet all players, to get to know individual concerns, and to share information first-hand. For the families it was an interesting though sometimes very difficult experience. They were able to meet the helpers, and to discuss, confront and challenge them as equal members of the treatment team. This was an empowering experience. With each meeting, families got more familiar with the process and thus better at participating and contributing to their own treatment goals.

Including the helping network in the family system succeeded in widening the conceptual base for understanding the family, its problems and solutions. As I attempted to conceptualize helpers and family as one system, I learned about the complex interpersonal dynamics that had evolved between the family and its multiple helpers. A developing respect for these dynamics enabled me to conceptualize the family and the system as nonpathological. I saw that systems develop around problems in an attempt to solve them (Levin et al, 1986). Everyone, including the family, was simultaneously trying to solve these problems with techniques generated by their own unique perceptions, and methodologies. All members of the team brought useful information and skills that helped solve the problems.

Personal Learning

In retrospect, I am aware that through this practicum I have gained a better understanding of the multi-agency at risk to abuse population. I also have a much clearer idea of the necessary intervention process with this population: what's effective, what is not, what is available in the community, and what is needed. As an example, I am very aware now of how delicate the joining process can be with individuals who have never had the opportunity to experience a relationship built on basic trust. I know that the process of joining will be longer and will require such techniques as challenging process on an ongoing basis, and offering nontraditional services as a way to facilitate joining. I know that in working with this population, one must be prepared to first meet the dependency needs of the adults in the family, before attempting to work with the family as a whole. As a therapist, one must also be prepared to teach basic socialization skills and to act as a model for these clients.

As I have become better acquainted with the helping system, I am aware that few services exist for this population. With the exception of our program, I know of no other in-home long-term counselling program. Instead these families are serviced by agencies who are often unable to extend themselves in nontraditional ways.

Because of weekly supervision which has included practical learning as well as broadening my theoretical base, I have improved and added to my clinical skills. I have learned about myself, and now have a better idea of my particular areas of strength and weakness. I am much more aware of my need to rescue families. I am aware that in this need I sometimes become involved in 'fixing' rather than slowing down and helping the family to generate its own

solutions to the problems. But, I also recognize my strength in being logical and methodical. I am good at working in an organized and specific way. Again, to balance this, I need to develop my ability to pull back and observe the big picture.

Structurally and clinically, I am aware of several weaknesses in the practicum. The most glaring of these problems is the need for more thorough assessment measures. While the FAM 3 was an adequate tool for assessing family functioning, the MCN Scale was not a detailed enough nor objective enough measure of capacity to parent. In several instances it failed to discern at risk to abuse parents. The measure was not rated for reliability. There were other measures which would have measured parenting skills better. In addition, the assessment component of the practicum would also have been enhanced by tools capable of measuring individual deprivation, and self esteem.

If I had chosen a less eclectic systemic approach with my families, I could have had the benefit of learning one model of family therapy well. Instead, although my clinical skills have improved as a result of this practicum, I remain a generalist, rather than a specialist in any one model. An added advantage to practising one model of family therapy, is that I could also have chosen a family assessment measure that utilized the same model, and thus chosen and administered a stronger assessment/intervention package.

I also would like to comment on the nature of systemic intervention, and the type of systemic intervention which I was able to incorporate into my treatment process. Originally I had conceptualized that treatment would be systemic intervention focused on the family as a system engaged with the

helping system. Although I did look at circular and intergenerational patterns in the various families to see how they contributed to the dysfunction, and did think about how the structure of the family may have perpetuated its difficulties, much of my systemic intervention was focused at the individual level due to the high degree of need exhibited in the adults that I saw. To address these needs, I chose to focus on individual growth issues rather than the family as a whole. I chose to work through deeper issues with these abused adults but to do so from a systemic perspective. Although I could have broadened my systems component by focusing more on the immediate presenting problems and then emphasizing the family's process at the interactional level, I sensed that the adults in these families required a more intense, individual focus. Because the population was highly dysfunctional and unable to articulate problems, or make choices about what the format of therapy should be, I made the choice to pursue deeper individual issues with these clients.

As a new clinician, it was at times difficult to be as assertive as the situation required. As a result family members who were hesitant to attend sessions were not always pressed and couples reluctant to meet were allowed to postpone sessions. At the time, the combination of fear of loosing the family and the difficult nature of the population, left me unable to always assert my position as therapist. If I were to do this practicum again, I would be more assertive because I now better understand that working with families to elicit change means shaking up the system, doing the unexpected and the unfamiliar.

Chapter Eleven

Clinical Implications

For family therapy to be a practical approach in the treatment of at risk to abuse multi-agency families, certain modifications become necessary. While this model offers the opportunity to reframe child abuse as a family problem, the therapist must carefully assess the degree of deprivation and need in the adults in the family and consider how this may impact on the therapy situation. Some parents will have experienced enough deprivation to be in competition with their children for the attention of the therapist. They will resent the presence of the children, and perceive any attention the therapist directs toward them as demonstration that they, the adults, are undeserving and unlikable (Janzen and Harris, 1980).

Difficulties in joining with the family may arise if the adults in the family have experienced abuse and/or neglect to the extent that they have not previously had an opportunity to experience at least one healthy relationship. If adults in the family lack an idea of how to relate and establish healthy contact with another, they may project suspicion, mistrust and lack of confidence into the therapy session. When this happens a variety of problems arise. Other family members may be forced to sabotage the sessions to prove their loyalty, power struggles may ensue, or the degree of distorted thinking on the part of the damaged parent may be such that he/she perceives joining efforts as threatening. In these cases joining may be a long or ongoing process, leaving the therapist feeling cautious about the degree of challenging and confrontation that is possible.

It may be necessary for the therapist to initially begin by focusing on the adults in the family, gaining trust, enhancing self-esteem, and nurturing before these adults have the energy and interest to learn about and include their children (Buck, 1984). Without this extra step, such parents may be unable to put aside their own deprivation for the benefit of the family. An alternative to meeting alone initially with the adults might be individual sessions conducted concurrently with family sessions.

Because of the family's preference for action over cognition, and for the concrete over the abstract, the therapist may need a more nontraditional, direct approach in the form of in-home counselling and educating (Kaplan, 1986). Attempting to discuss family issues in an abstract manner or relying on enactment when a family has difficulty communicating can be frustrating. Being present in a family's home can be a valuable opportunity for direct observation of dysfunction patterns. It can also provide opportunity for direct modeling of new methods of coping and problem solving in the moment of conflict.

Another necessary modification comes in the amount of recognition that the model gives to the environment and to the influence of family of origin. In working with at risk to abuse multi-agency families, the therapist assumes an important teaching role, giving the parents the clear message that their current parenting skills are not satisfactory, and that they must change quickly because of the risk to the child. In such work it becomes crucial to help the family challenge the learning about relationships and child rearing that they have picked up from their environment and in their family of origin. In breaking the intergenerational connection of abuse, families must clearly

understand the myths and beliefs that have been passed from one generation to the next, perpetuating dysfunctional patterns.

Given the nature of the population and their tendency towards impulsivity, the need for immediate gratification, and chronicity of problems, the therapist joining with such a family must proceed slowly, carefully assessing the family simultaneously on a content and process level. He/She must be aware if the parents have a need to vent their frustration and anger with the child. If this need is extreme, the parents may need to meet with the therapist without the child present. The child may also have a similar need to vent his/her own feelings of frustration and anger towards his/her parents.

The therapist must not expect that the family members are at a stage where they are able to articulate a presenting problem. Initially they may not be aware of their need for service. This is dependent on whether the label of 'at risk' comes from inside or outside the family system. Assessing the origin of this label is an important consideration for the therapist as it dictates how he/she will join with the family.

If abuse has been an intergenerational problem, parents in the present generation may have some very maladaptive ideas about what constitutes a good relationship, normal child development and parent and child roles. In this situation the therapist may enter the family only to find that a common agreement between therapist and family about societal values and norms is nonexistent. The therapist may observe the family involved in harmful and unacceptable practices. There may be an immediate need to stop these interactions in the name of protection and safety. Chastising the family and challenging these practices alone is not enough. Because of the related

abuse issues (low self-esteem, a feeling of powerlessness, no model for healthy relationships), such families experience this as blame or criticism. If the family is feeling defensive, joining will be difficult. Therefore, intervention must simultaneously be aimed at supporting the adults while preventing further risk to the children.

Unfortunately when an at risk to abuse family becomes known to the helping system it is usually because the family is already in crisis. Observing inappropriate parenting that continues to damage children, while at the same time planning intervention that is neutral and nonjudgmental is difficult for most workers, and especially those not familiar with this population's issues. In addition to a nonblaming attitude, therapists working with this population must have a practical knowledge of the available services in the system which can support the children in these families while the family as a unit is being serviced.

Finally, the family therapist working with at risk to abuse multi-agency families must be prepared to extend him/herself in a manner that exceeds traditional contact. The level of deprivation and victimization experienced by the adults in these families, is typically realized as an inability to postpone gratification, to plan for the future, or to put one's own needs aside for the sake of the family. Such characteristics may result in the family's inability to keep regular appointments, to travel to the therapist, to sustain involvement between appointments spaced longer than once or twice weekly, or to carry out homework assignments.

With such a family, the therapist truly has the opportunity to re-parent the adults, as he/she goes about teaching from the ground up the rewards of

postponing gratification, how and why one plans for the future, and how to empathize and care for others. Much of this teaching is done through talking, but the family also needs to learn through the actions and modeling of the therapist. Thus, if the therapist is willing to extend contact to include helping the family deal with other helping agencies (economic security, housing, health care, etc.), if he/she is willing to meet more often with a family, to meet for longer periods of time, and to meet in the family's environment, these are the concrete ways through which the members of the family begin to learn that they are cared about, believed in, supported and respected. For some adults abused as children, this may be their first opportunity to experience a relationship which offers this quality of interaction.

If these families are able to pass through a stage where they feel well supported, believed in and respected, as treatment continues, it is quite natural for a shift in focus to occur when the family is ready to begin to take more responsibility for the course of their own therapy. It is at this point that the therapist can extend less as the family extends more. The family now has the ability to enter into a more equal partnership with the therapist and will require less intense intervention.

Conclusions

Ideally a therapist working with this clientele needs special knowledge and understanding about the characteristics of the population. One must understand the nature of abuse, its causes and its impact on the development of healthy relationships. One must also understand the relationship between

abuse and 'multi-agencyism', as well as respect potential gaps in learning, values and norms between worker and client.

Because of their experiences, at risk to abuse multi-agency families typically need more intervention, support and education than do families who are able on their own to rally their strengths and approach the helping system. In our current system, at-risk to abuse families typically enter at the child welfare level and have their most frequent contact with front line child welfare workers. These workers are the most overworked and the least clinically trained in our social service hierarchy. It is unfortunate that our least experienced, trained and supported workers must work with such a complex and challenging population. As these workers have neither the time, the energy nor the experience to implement an intensive therapeutic plan, contact with such families is out of necessity sporadic and inconsistent. Ironically, rather than breaking the pattern of intergenerational abuse, the present system helps the family to perpetuate its role as victim as it is acted upon and buffeted around in a confusing and inconsistent manner by the very agencies who are mandated to help.

It is my conviction that the population of at risk to abuse multi-agency families can be a rewarding and responsive population to service, if treatment is aimed at their unique issues and needs. These families may initially require more intervention and cooperation between helping systems, but if these services are forthcoming, the hidden strengths and potential of these families can at last be realized.

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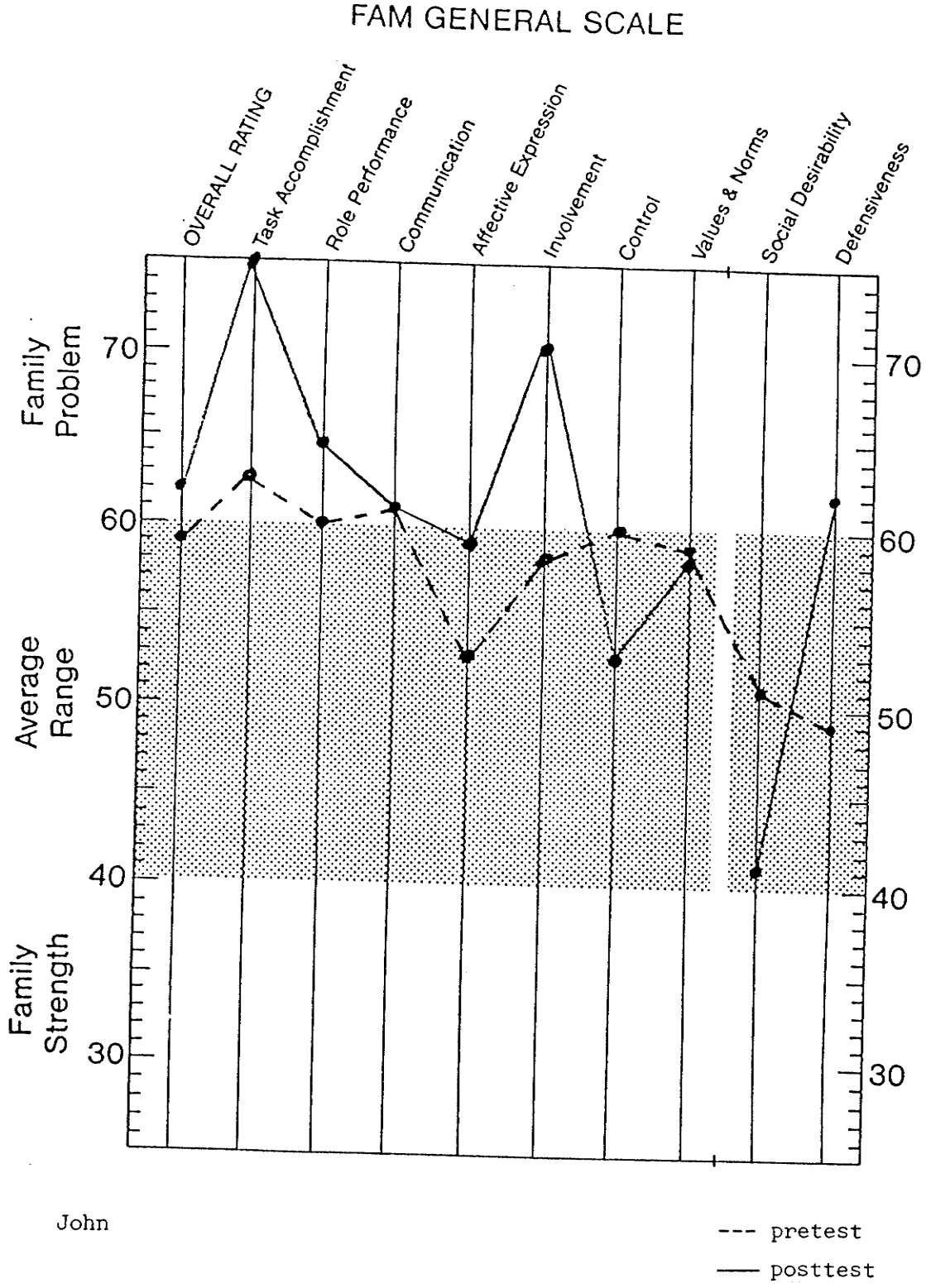
Appendix One

The A Family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Task Accomplishment
Role Performance
Communication
Affective Expression
Involvement
Control
Values & Norms
Social Desirability
Defensiveness
Family Problem
Average Range
Family Strength
70
60
50
40
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John
--- pretest
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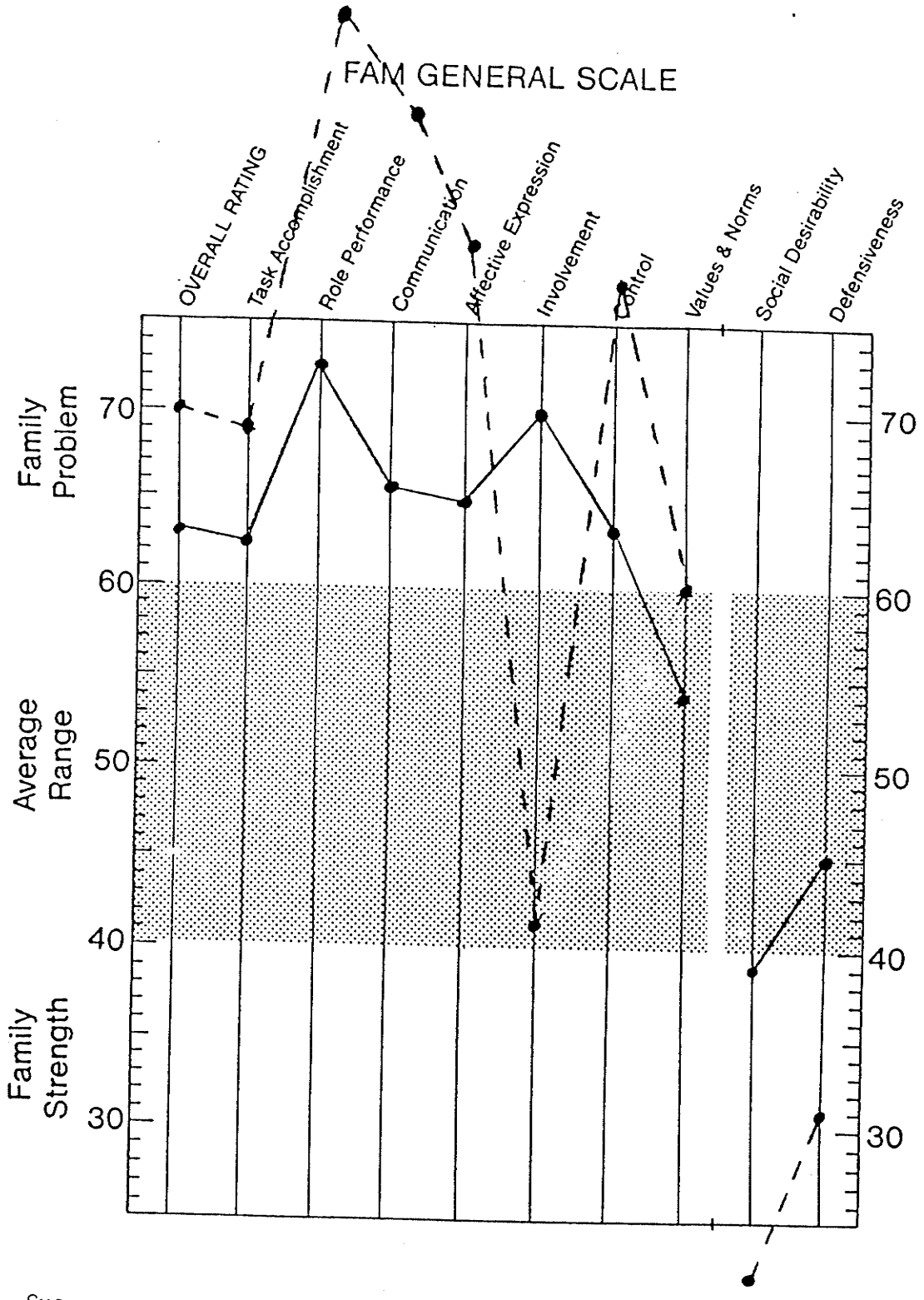
The A Family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Sue
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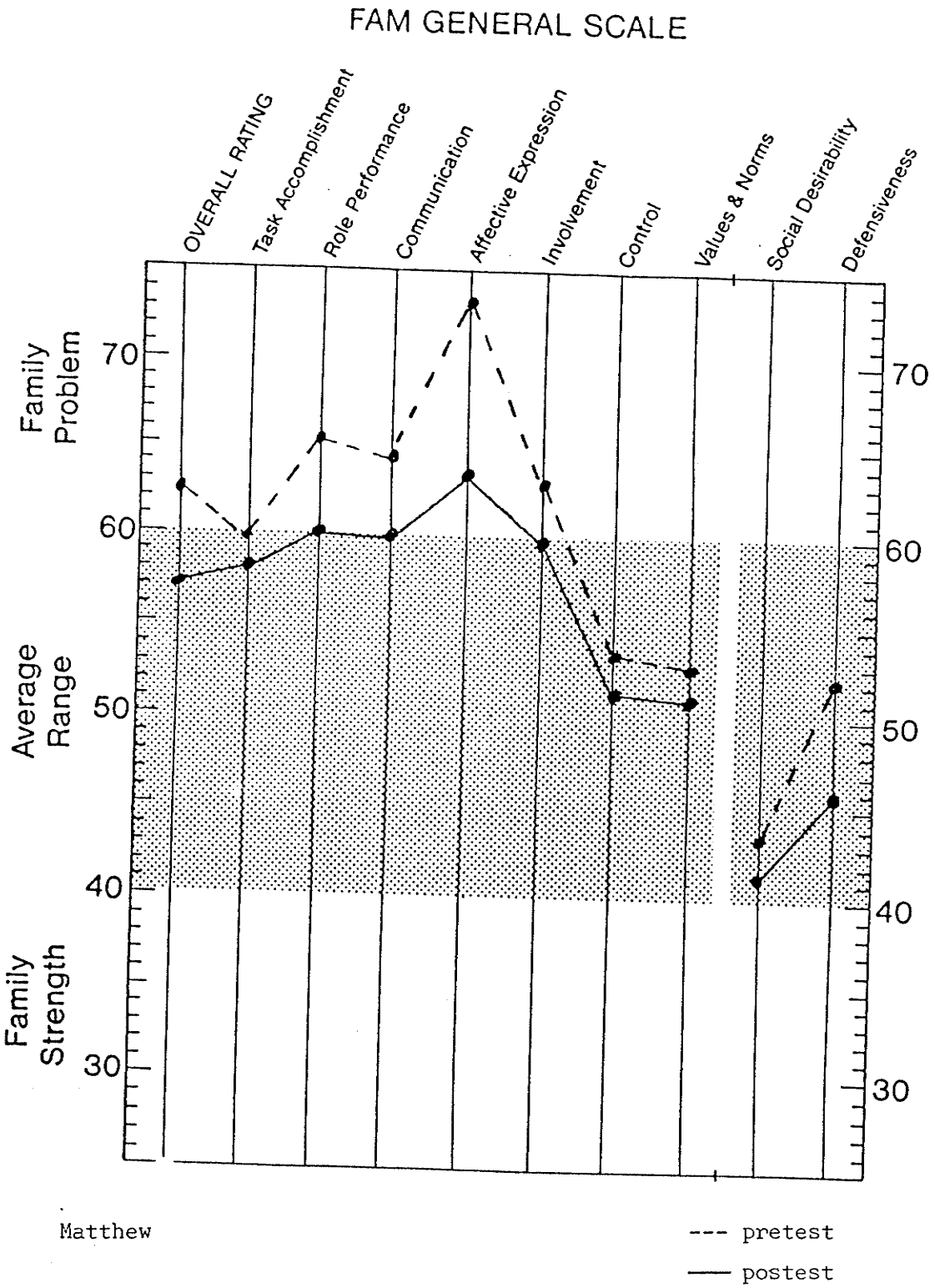
The B Family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Matthew
--- pretest
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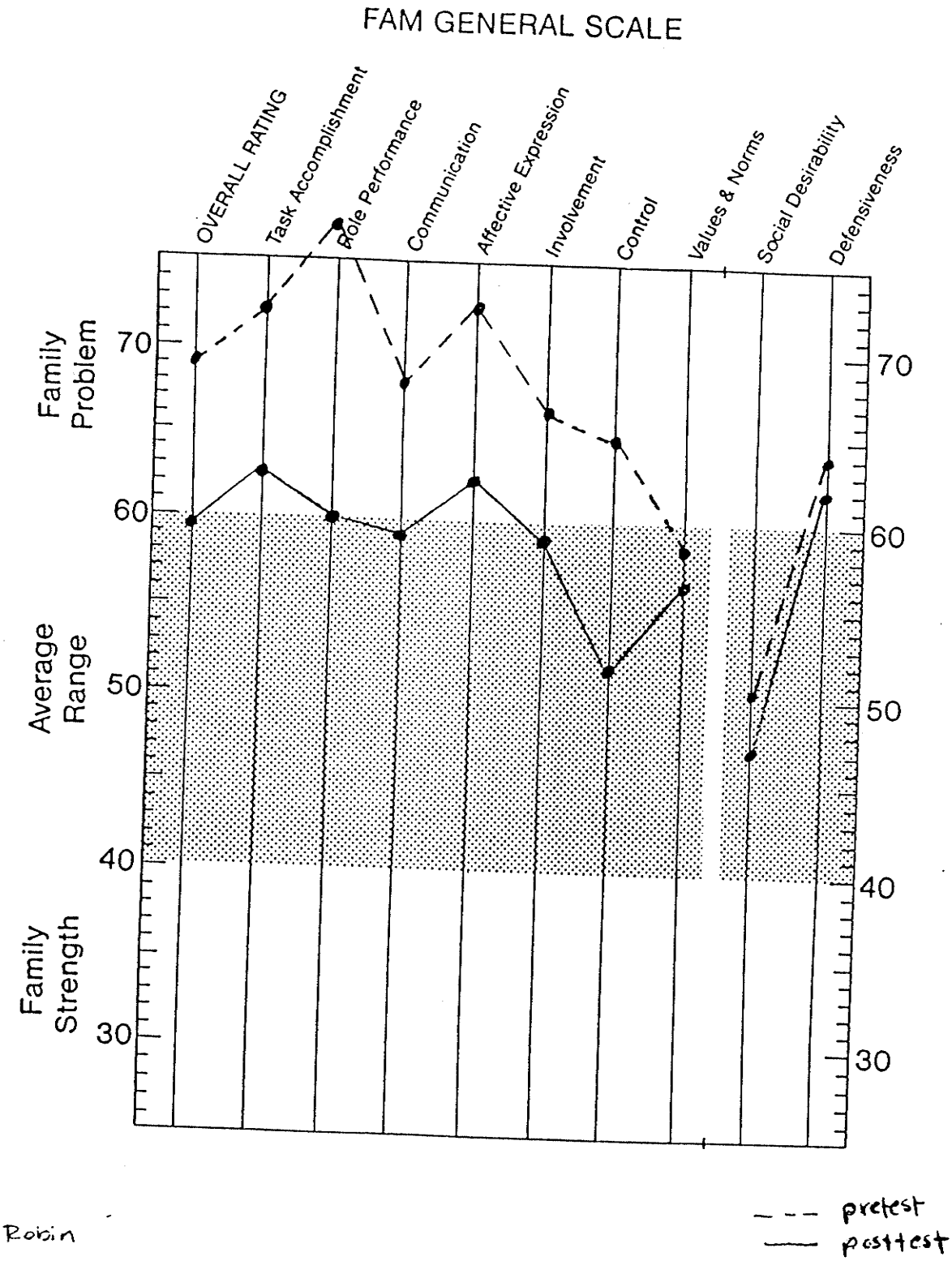
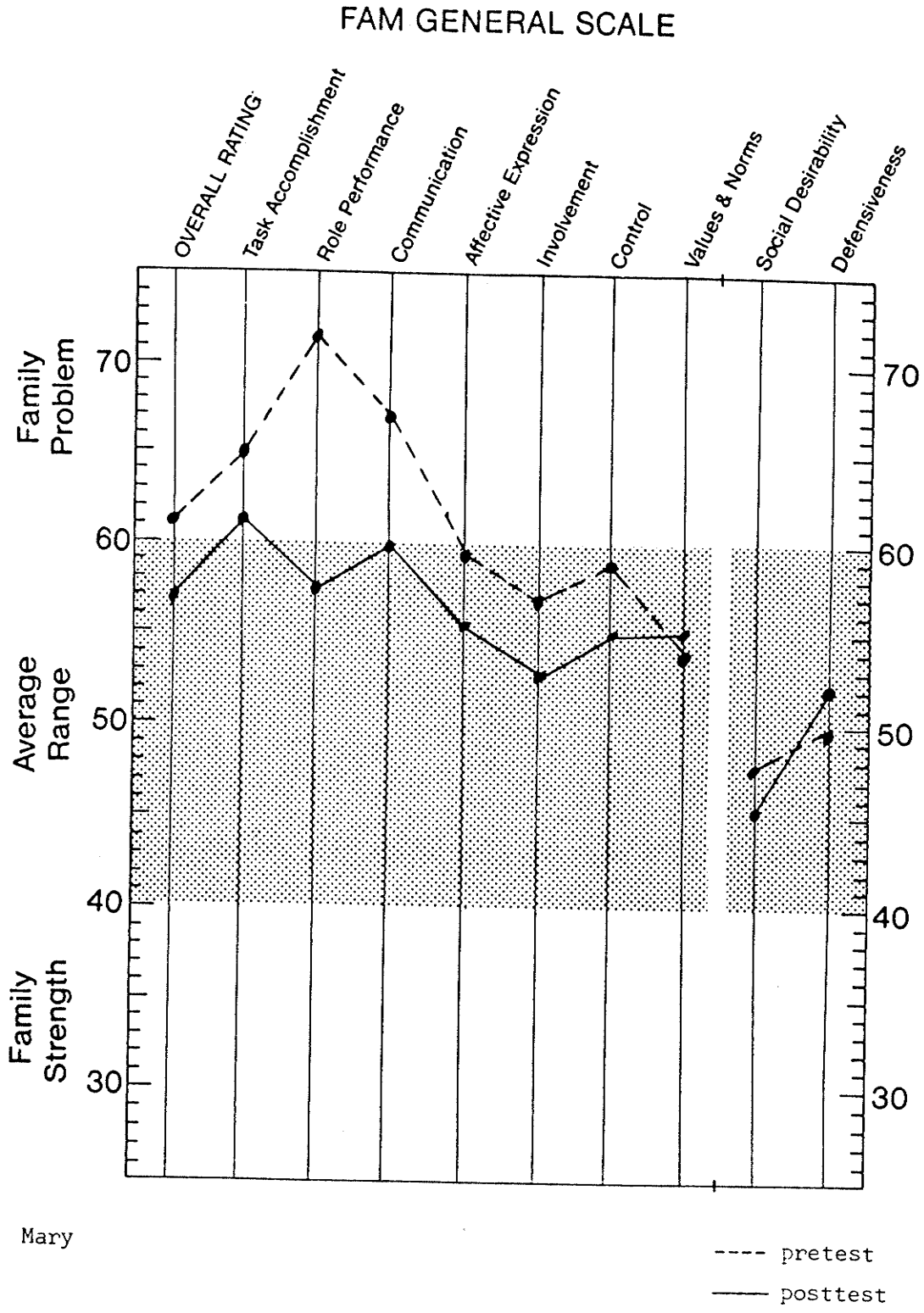
The B Family



Robin

The D Family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Mary
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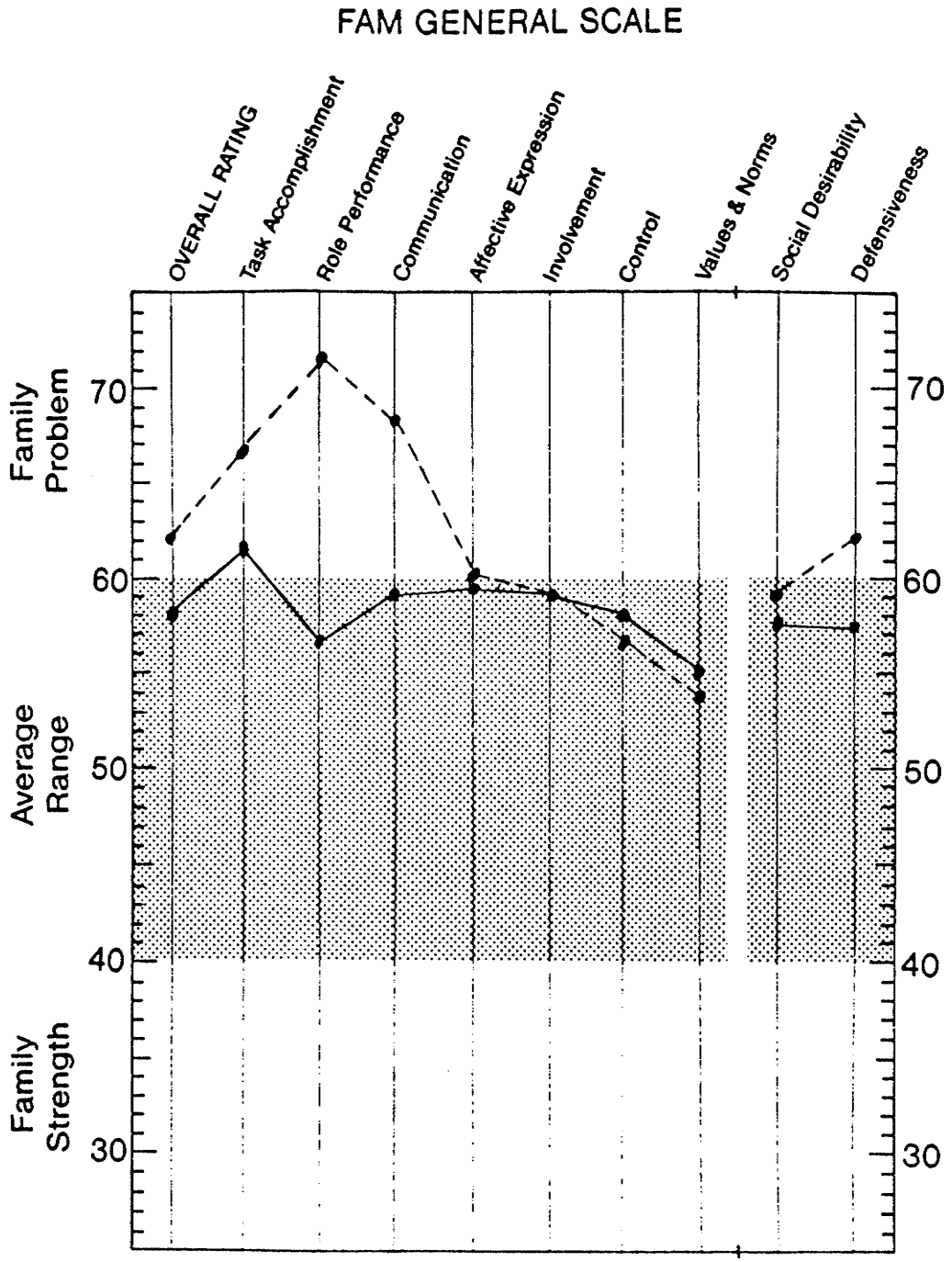
—— posttest

The D Family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Family Strength
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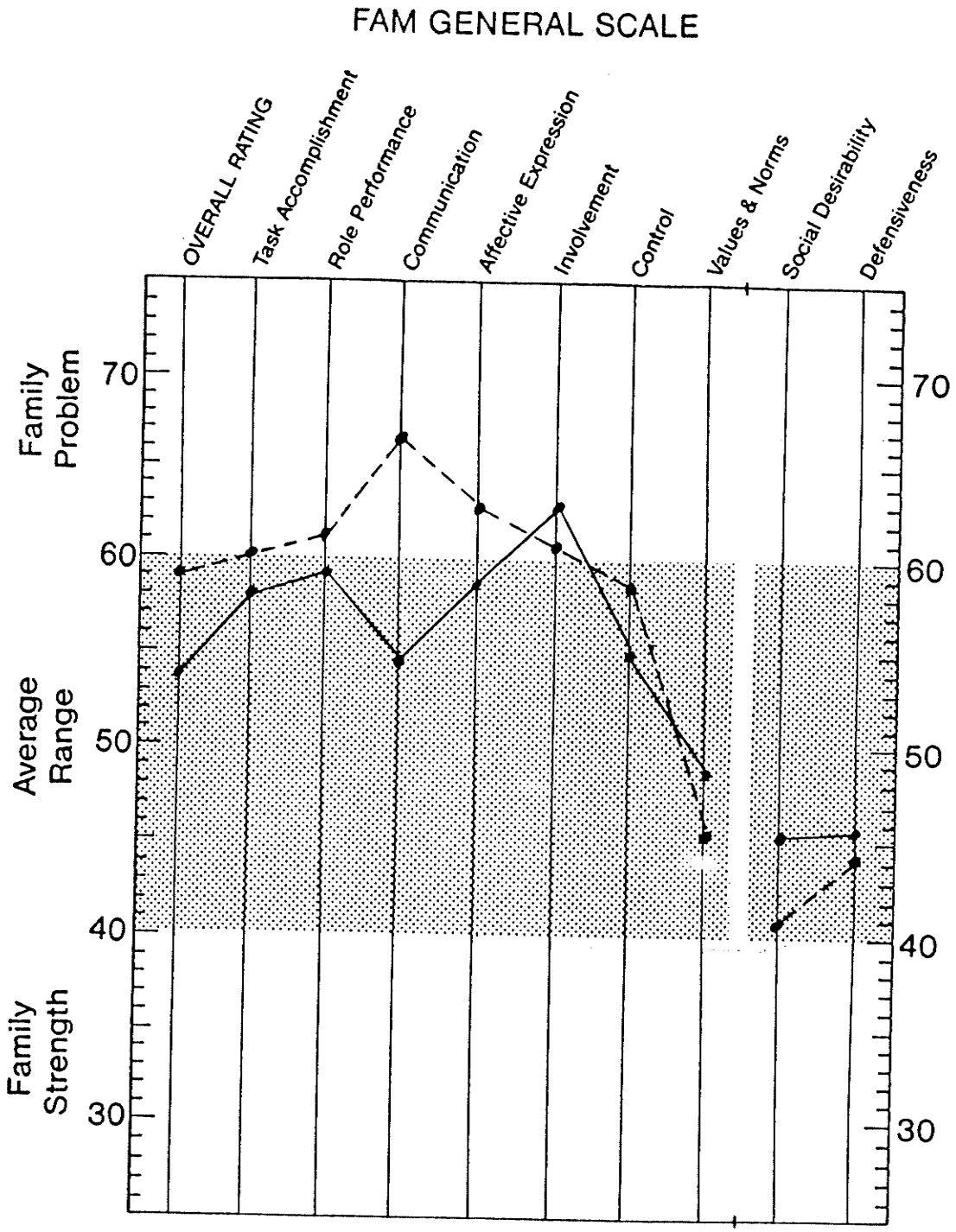
Steve
---- pretest
—— posttest

The E Family



Astrid

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Appendix Two

GENERAL SCALE

Directions

On the following pages you will find 50 statements about your family as a whole. Please read each statement carefully and decide how well the statement describes your family. Then, make your response beside the statement number on the separate answer sheet.

If you STRONGLY AGREE with the statement then circle the letter "a" beside the item number; if you AGREE with the statement then circle the letter "b".

If you DISAGREE with the statement then circle the letter "c"; if you STRONGLY DISAGREE with the statement then circle the letter "d".

Please circle only one letter (response) for each statement. Answer every statement, even if you are not completely sure of your answer.

Please do not write on this page.
Circle your response on the answer sheet.

1. We spend too much time arguing about what our problems are.
2. Family duties are fairly shared.
3. When I ask someone to explain what they mean, I get a straight answer.
4. When someone in our family is upset, we don't know if they are angry, sad, scared or what.
5. We are as well adjusted as any family could possibly be.
6. You don't get a chance to be an individual in our family.
7. When I ask why we have certain rules, I don't get a good answer.
8. We have the same views on what is right and wrong.
9. I don't see how any family could get along better than ours.
10. Some days we are more easily annoyed than on others.
11. When problems come up, we try different ways of solving them.
12. My family expects me to do more than my share.
13. We argue about who said what in our family.
14. We tell each other about things that bother us.
15. My family could be happier than it is.
16. We feel loved in our family.
17. When you do something wrong in our family, you don't know what to expect.
18. It's hard to tell what the rules are in our family.
19. I don't think any family could possibly be happier than mine.
20. Sometimes we are unfair to each other.
21. We never let things pile up until they are more than we can handle.
22. We agree about who should do what in our family.
23. I never know what's going on in our family.
24. I can let my family know what is bothering me.
25. We never get angry in our family.

Please do not write on this page.
Circle your response on the answer sheet.

26. My family tries to run my life.
27. If we do something wrong, we don't get a chance to explain.
28. We argue about how much freedom we should have to make our own decisions.
29. My family and I understand each other completely.
30. We sometimes hurt each others feelings.
31. When things aren't going well it takes too long to work them out.
32. We can't rely on family members to do their part.
33. We take the time to listen to each other.
34. When someone is upset, we don't find out until much later.
35. Sometimes we avoid each other.
36. We feel close to each other.
37. Punishments are fair in our family.
38. The rules in our family don't make sense.
39. Some things about my family don't entirely please me.
40. We never get upset with each other.
41. We deal with our problems even when they're serious.
42. One family member always tries to be the centre of attention.
43. My family lets me have my say, even if they disagree.
44. When our family gets upset, we take too long to get over it.
45. We always admit our mistakes without trying to hide anything.
46. We don't really trust each other.
47. We hardly ever do what is expected of us without being told.
48. We are free to say what we think in our family.
49. My family is not a perfect success.
50. We have never let down another family member in any way.

Appendix Three

Part II:

Intensive Services Help Prevent Child Abuse

JOAN VELASQUEZ/MARY LOU CHRISTENSEN/
BARBARA L. SCHOMMER

Although the Special Families Care Project was designed to focus primarily on intervention, a method of evaluation was decided upon at the beginning. The following three questions were to be examined: Can intensive, early intervention with high-risk mothers result in reduced incidence of abuse, neglect, and out-of-home placement? Do infants who remain with these high-risk mothers attain normal growth and development? Can professional intervention improve parenting skills and a parent's ability to develop a supportive network?

Twenty-three mothers of newborn infants who had participated in the Special Families Care Project were assigned to the treatment group. All had experienced four or more of the family-background indicators used by the project in identifying women at high risk of abusing or neglecting their children (1). Thirty-two mothers of newborns were assigned to a comparison group. These mothers also had experienced four or more of the family-background indicators and had been referred by their physicians to a public health nurse during the two years prior to the study. (See Part I for a list of the family-background indicators.)

Mothers in the treatment group received intensive health care services (between two and four hours of contact with nurses and social workers every week for a minimum of 18 months). Mothers in the comparison group received more traditional, less intensive health-related services, generally at two-week to four-week intervals. The comparison-group services focused on teaching mothers about infant growth and development, feeding patterns and practices, maternal concerns, health, and attachment between mother and infant. In most instances, comparison-group services were terminated between 9 and 18 months after they were initiated, the average being 13 months.

The ages of mothers in both groups ranged from 16 to 25 years old. The vast majority were unmarried, and all had delivered no more than one month prior to receiving services. Excluded from both groups were mothers who were severely mentally ill or mentally retarded.

Although random assignment of subjects to concurrent treatment and control groups would have produced more credible results, this alternative was neither possible nor desirable. To determine the effectiveness of the project, the project's staff members had to be prevented from discussing their services with the health care professionals who provided more traditional services. Otherwise, the differences between the services received by the treatment and the comparison groups would have gradually become less distinct and interferred with legitimate testing of the treatment approaches.

Some Positive Statistics

To evaluate whether the Special Families Care Project had been more effective than the less intensive health-related services in reducing the incidence of child abuse, neglect, and out-of-home placement, a search of the intake files and computerized information systems of the Ramsey County

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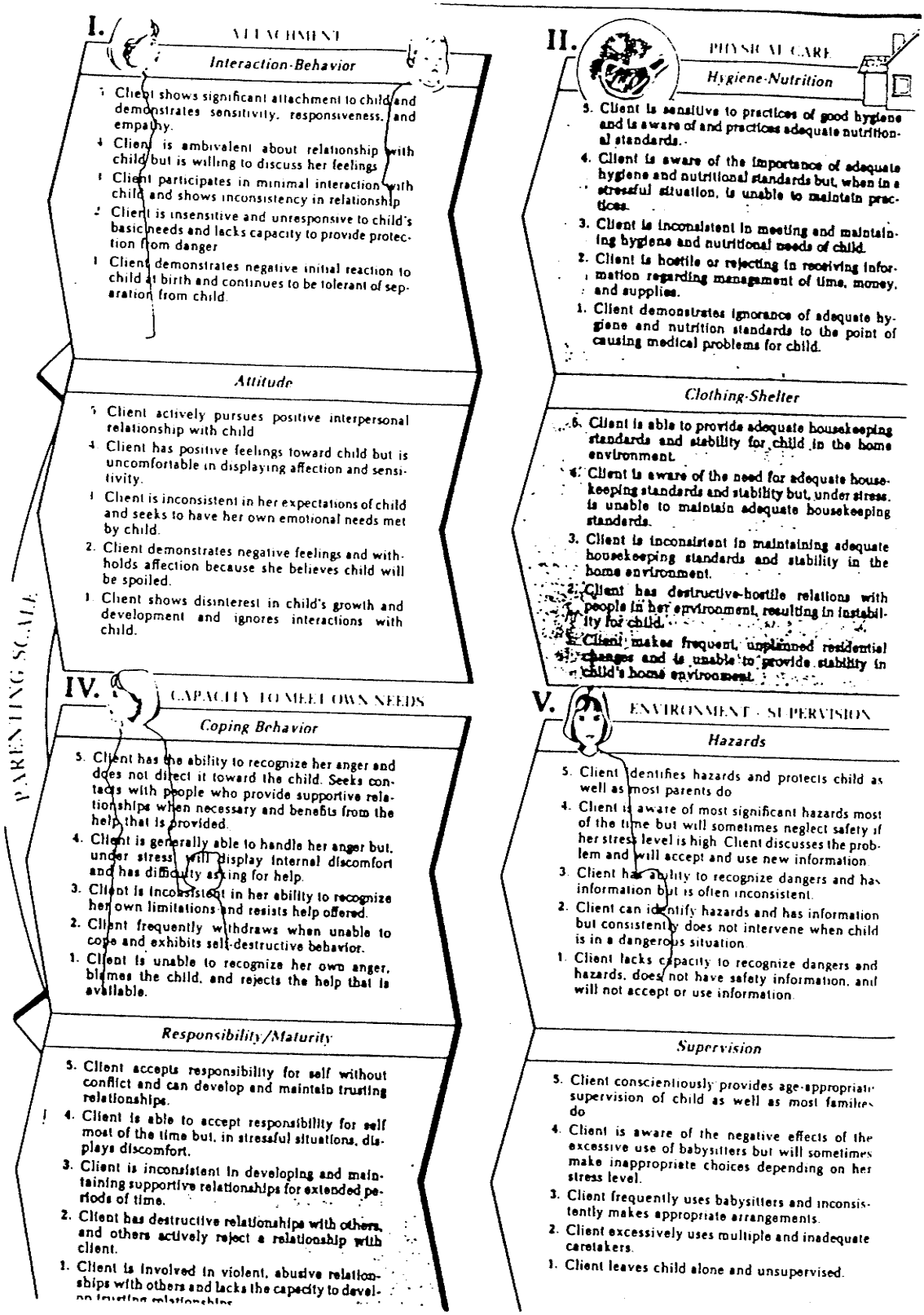
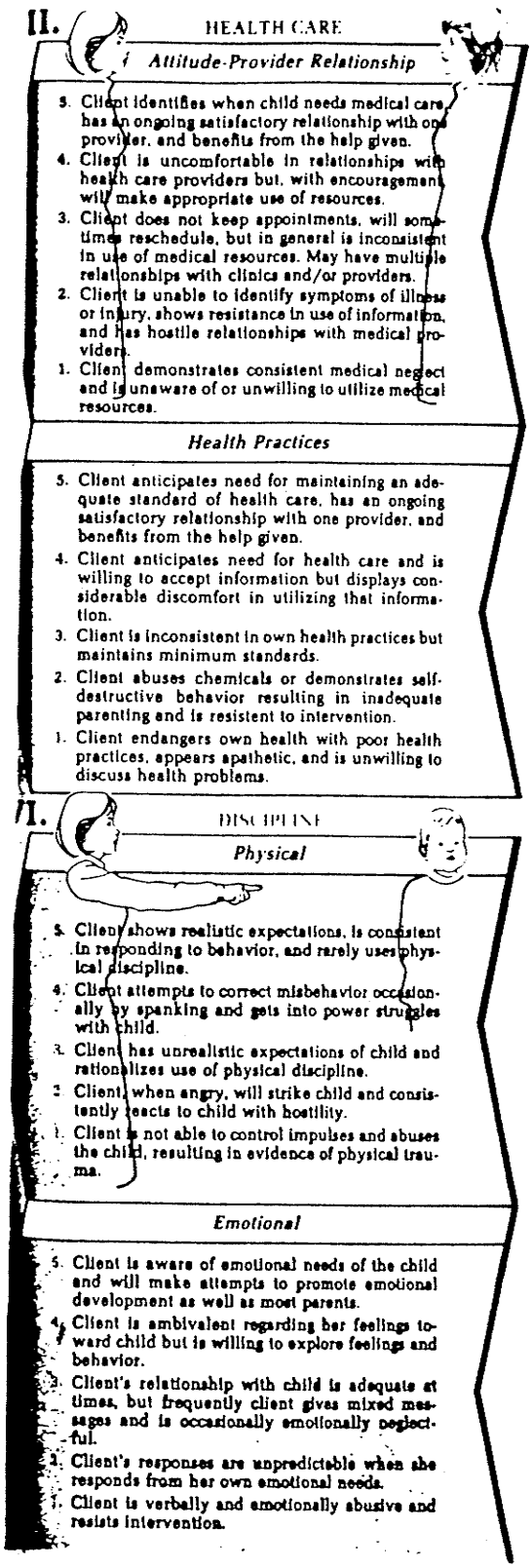

PARENTING SCALE
I. ATTACHMENT
Interaction-Behavior
7 Client shows significant attachment to child and demonstrates sensitivity, responsiveness, and empathy.
4 Client is ambivalent about relationship with child but is willing to discuss her feelings
1 Client participates in minimal interaction with child and shows inconsistency in relationship
2 Client is insensitive and unresponsive to child's basic needs and lacks capacity to provide protection from danger
1 Client demonstrates negative initial reaction to child at birth and continues to be tolerant of separation from child.
Attitude
7 Client actively pursues positive interpersonal relationship with child
4 Client has positive feelings toward child but is uncomfortable in displaying affection and sensitivity.
1 Client is inconsistent in her expectations of child and seeks to have her own emotional needs met by child.
2. Client demonstrates negative feelings and withholds affection because she believes child will be spoiled.
1 Client shows disinterest in child's growth and development and ignores interactions with child.
II. PHYSICAL CARE
Hygiene-Nutrition
5. Client is sensitive to practices of good hygiene and is aware of and practices adequate nutritional standards.
4. Client is aware of the importance of adequate hygiene and nutritional standards but, when in a stressful situation, is unable to maintain practices.
3. Client is inconsistent in meeting and maintaining hygiene and nutritional needs of child.
2. Client is hostile or rejecting in receiving information regarding management of time, money, and supplies.
1. Client demonstrates ignorance of adequate hygiene and nutrition standards to the point of causing medical problems for child.
Clothing-Shelter
5. Client is able to provide adequate housekeeping standards and stability for child in the home environment.
4. Client is aware of the need for adequate housekeeping standards and stability but, under stress, is unable to maintain adequate housekeeping standards.
3. Client is inconsistent in maintaining adequate housekeeping standards and stability in the home environment.
2. Client has destructive-hostile relations with people in her environment, resulting in instability for child.
1. Client makes frequent, unplanned residential changes and is unable to provide stability in child's home environment.
IV. CAPACITY TO MEET OWN NEEDS
Coping Behavior
5. Client has the ability to recognize her anger and does not direct it toward the child. Seeks contacts with people who provide supportive relationships when necessary and benefits from the help that is provided.
4. Client is generally able to handle her anger but, under stress, will display internal discomfort and has difficulty asking for help.
3. Client is inconsistent in her ability to recognize her own limitations and resists help offered.
2. Client frequently withdraws when unable to cope and exhibits self-destructive behavior.
1. Client is unable to recognize her own anger, blames the child, and rejects the help that is available.
Responsibility/Maturity
5. Client accepts responsibility for self without conflict and can develop and maintain trusting relationships.
4. Client is able to accept responsibility for self most of the time but, in stressful situations, displays discomfort.
3. Client is inconsistent in developing and maintaining supportive relationships for extended periods of time.
2. Client has destructive relationships with others, and others actively reject a relationship with client.
1. Client is involved in violent, abusive relationships with others and lacks the capacity to develop trusting relationships
V. ENVIRONMENT - SUPERVISION
Hazards
5. Client identifies hazards and protects child as well as most parents do
4. Client is aware of most significant hazards most of the time but will sometimes neglect safety if her stress level is high. Client discusses the problem and will accept and use new information.
3. Client has ability to recognize dangers and has information but is often inconsistent.
2. Client can identify hazards and has information but consistently does not intervene when child is in a dangerous situation.
1. Client lacks capacity to recognize dangers and hazards, does not have safety information, and will not accept or use information.
Supervision
5. Client conscientiously provides age-appropriate supervision of child as well as most families do
4. Client is aware of the negative effects of the excessive use of babysitters but will sometimes make inappropriate choices depending on her stress level.
3. Client frequently uses babysitters and inconsistently makes appropriate arrangements.
2. Client excessively uses multiple and inadequate caretakers.
1. Client leaves child alone and unsupervised.



social services department was made. Two of the infants in the treatment group (9 percent) compared with 13 infants in the comparison group (41 percent) experienced one or more occurrences of abuse, neglect, or out-of-home placement (chi-square = 5.73, $p < .01$).

More specifically, no infant in the treatment group compared with six infants in the comparison group (19 percent) experienced abuse. Only one infant in the treatment group (4 percent) compared with four infants in the comparison group (12.5 percent) was neglected. Two infants in the treatment group (9 percent) compared with seven infants in the comparison group (22 percent) were placed in foster care homes at some point before age two.

The one infant in the treatment group who was neglected had a psychotic mother whose psychotic episodes recurred after she stopped taking her medications. The mother was committed to a psychiatric hospital, and her infant was then placed in a foster care home. The other child in the treatment group who was placed in a foster care home had not been neglected and was placed voluntarily at the mother's request.

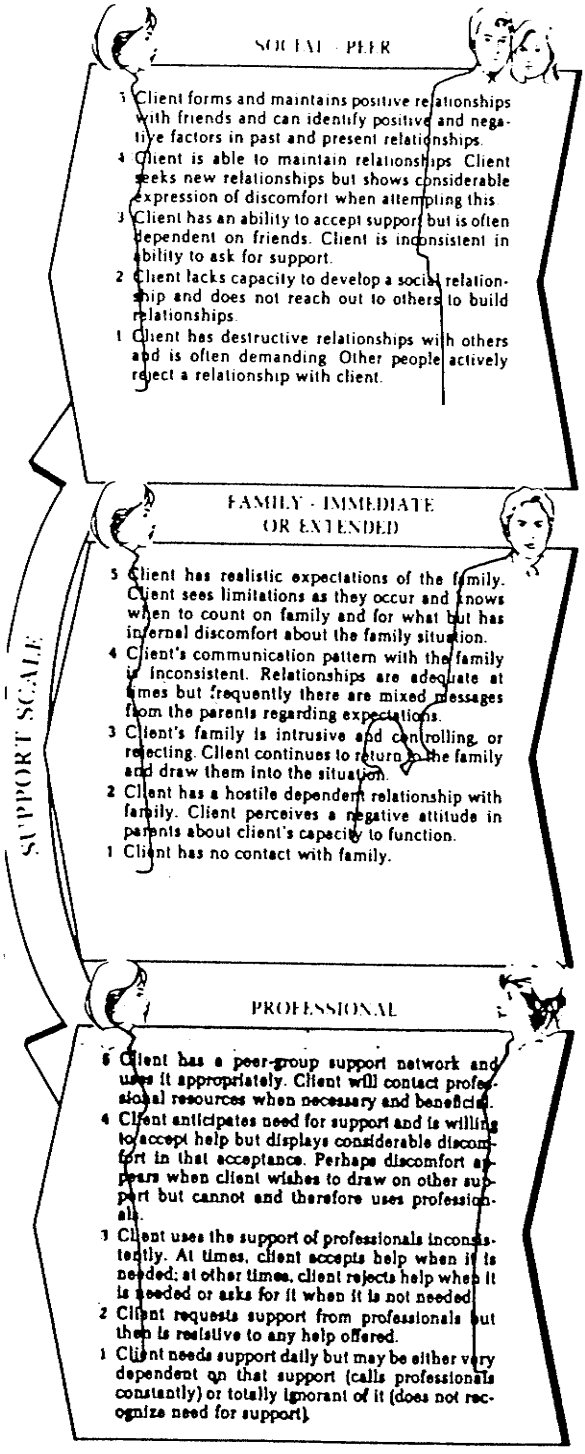
Data supporting these findings were highly reliable and complete. By law, all suspected cases of child abuse or neglect had to be reported to the social services department, and a permanent record of all confirmed incidents was maintained.

Moreover, the chances of abuse or neglect of an infant in the treatment group not being reported were highly unlikely since staff members of the Special Families Care Project visited these children regularly. Unreported cases of abuse or neglect would have been much more likely in the comparison group since health care professionals were not intensely involved with these children.

More Encouraging Results

The Special Families Care Project also was successful in accomplishing its second objective: the promotion of normal growth and development of the infant. Growth rates for infants in the treatment group were measured quarterly; growth rates for the majority of infants in the comparison group were measured at intake and closing. The standard set for an acceptable growth rate for both weight and height was a drop of no more than 25 percentile points on the Mead Johnson Growth Grid from one quarter to the next and no measurements below the fifth percentile at any point during the infant's first two years.

All of the infants in the treatment group achieved normal growth rates; none experienced a decrease of more than 25 percentile points or were below the fifth percentile at any time measured. By contrast, three of the infants in the comparison



group (9 percent) experienced a decrease of more than 25 percentile points or were below the fifth percentile in either height or weight.

To measure infant development, the Denver Developmental Screening Test (DDST) was used. It not only provided a standardized means for measuring infant development but also permitted evaluation of the four developmental areas (social language, fine motor, and gross motor skills) that the project desired to measure. Further, the DDST is a practical tool that is easily and inexpensively administered. It is used routinely in public health nursing practice for assessment and teaching as well as for planning care.

Infants in the treatment group were screened quarterly; infants in the comparison group were screened at intake and closing. None of the infants in the treatment group failed on any of the DDST's four scales. However, seven infants in the comparison group (22 percent) failed on one or more of the scales, with four of the infants (12.5 percent) failing on all four scales. Because infants in the comparison group were followed for a shorter period of time than were infants in the treatment group, further developmental delay might have occurred among infants in the comparison group prior to their reaching age two but was not recorded.

A Few Unsettled Questions

The results on improving the mothers' parenting skills and their ability to develop and use supportive networks were less definitive. Two scales were developed by the Special Families Care project to measure improvement in these areas (see charts "Parenting Scale" and "Support Scale"). Both scales consisted of various dimensions, each of which had five descriptive statements. Prior to their use in the project, the reliability of the two scales had been examined on an exploratory basis with child-protection workers using a test-retest method at two-week intervals (Spearman's rho = .9).

Only mothers in the treatment group were rated on the scales. Ratings were made quarterly. The project's staff members selected the descriptive statement in each domain that best described the mother at that point in time and gave the mother the numerical rating assigned to the statement. Scores on these scales at intake and discharge were compared to determine whether positive, negative, or no change had occurred over all and in each domain during treatment.

Since the parenting and support scales had been developed for the Special Families Care Project they were not used for the comparison group. As an alternative, two independent raters read the charts of comparison-group mothers and judged whether general parenting skills at intake and

closing had improved, remained the same, or declined. The same method was applied to rate the mothers' use of a positive support network.

The raters of the comparison-group mothers held master's degrees in social work and had at least five years of clinical experience with families and children. Interrater reliability was considered adequate (Spearman's rho = .91).

Independent raters' judgments of changes in parenting skills indicated that seven out of 22 mothers in the comparison group improved their parenting skills while receiving nursing services. (Ten of the mothers had been rated as having acceptable parenting skills at intake and therefore could not have shown improvement on this measure). None of the comparison-group mothers' parenting skills declined.

Because of staffing changes, only 14 of the treatment-group mothers were consistently rated on the parenting scale, and four of these mothers had been rated as having acceptable parenting skills at intake. Six out of ten mothers' parenting skills improved. However, five of the treatment-group mothers' parenting skills declined. Those whose skills declined nearly always were rated as worse on the discipline dimension.

The project showed that the incidence of child abuse and neglect as well as out-of-home placement can be reduced.

Similar results occurred in examining the mothers' support networks. Independent raters' judgments of comparison-group mothers indicated that seven out of 22 improved on the support scale. (Ten of the mothers had been rated as having an adequate support system at intake.) Three of the comparison-group mothers declined on this scale.

Again, data were consistently available for only 14 of the treatment-group mothers, two of whom had been rated as having an adequate support system at intake. Eight out of 12 mothers improved on the support scale. Two of the mothers in the treatment group declined on this scale.

Because data were not consistently recorded in a large percentage of cases and because different measures were applied to the treatment and comparison groups, drawing conclusions about the data is difficult. Further, the measures applied to the treatment-group mothers were more stringent and more sensitive to change. Also, because mothers in the treatment group were rated over a longer period of time than their counterparts in the comparison group, they had more opportunity to demonstrate change in either a positive or a negative direction.

Despite these limitations, some information can be gained. A higher percentage of treatment-group mothers than comparison-group mothers improved their parenting skills, although the treatment group also had a higher percentage of mothers whose parenting skills declined. One of the reasons for this somewhat contradictory finding is that some treatment-group mothers who parented their infants in an acceptable manner did less well with parenting the children as toddlers (particularly in regard to discipline). Most comparison-group cases were closed before infants reached the toddler stage.

Longer-term follow-up data are needed to determine whether parenting skills change substantially in all significant areas after intervention is completed. Since the challenges presented by toddlers may be more likely to provoke impulsive, aggressive behavior by mothers, continued intervention may be necessary with high-risk mothers, including those who appear to be adequately parenting their infants.

Results regarding the mothers' support networks suggest that a higher percentage of treatment-group mothers than comparison-group mothers were able to develop and use positive supportive relationships with family and friends. Further, although these data must be cautiously interpreted, they indicate that the Special Families Care Project may have been more successful in assisting mothers to draw needed support from others, including the project's staff members, than in consistently improving the mothers' parenting abilities.

Penny Wise, Pound Foolish?

The Special Families Care Project showed that the incidence of child abuse, neglect, and out-of-home placement can be reduced, thereby enabling children to grow and develop normally within their own homes. Unfortunately, the resource-intensive services provided by the project are too costly to be delivered to all new mothers.

This cost, however, must be weighed against the extensive costs of treating and placing abused and neglected children as well as the emotional costs to those involved. The fact that 41 percent of the infants in the comparison group of this study were abused, neglected, or placed in foster care homes strongly supports the argument in favor of providing intensive services to families at highest risk for child abuse or neglect.

REFERENCE

1 SCOTT, W. J. *Attachment and Child Abuse: A Study of Social Indicators Among Mothers of Abused Children*. Minneapolis, University of Minnesota, 1974 (Unpublished doctoral dissertation)