

## **Working systemically with family violence: risk, responsibility and collaboration**

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In this article we describe a project which aims to ensure prevention and continued protection from violence for family members. We outline our theoretical approach to assessment and working with violence in family relationships and the associated ethical problems. We identify three recurrent themes: risk, collaboration, and responsibility. We focus on our work with couples, where the man is violent towards the woman. Within this discussion we identify other important clinical issues.

### **Introduction**

We wish to describe the ideas that inform a project interested in safety in family members' relationships and how people can live together safely in the aftermath of physical violence. We undertake both assessment and planned therapeutic rehabilitation with families following a risk assessment of low to medium probability of repeat violence.

The Council of Europe's (1986) definition of physical violence in the family informs our therapeutic work with families where violence has taken place:

Any act or omission committed within the framework of the family, by one of its members that undermines the life, the bodily or psychological integrity, or the liberty of another member of the same family, or that seriously harms the development of his or her personality.

We find this definition helpful for the following reasons:

- it invites us to think about responsibility for safety alongside responsibility for acts that harm others;
- it recognizes that acts of violence have psychological and relational impacts that are iterative over time;

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- it recognizes that acts of violence may be both historical and ongoing;
- it recognizes that acts of violence that might otherwise be defined as less severe, such as pushing or shoving, are important in terms of their putative effects;
- implicit in the definition of ensuing harm is the recognition of issues of power and control in acts of violence.

Space does not permit an extensive demographic survey of the problems of physical violence in couple and family relationships, but we wish to highlight a few points.

The British Crime Survey (1996) published by the Home Office, based on interviews with a sample of 16,500 people, found that 30% of violent crime was domestic assault, with 90% of women attacked by their male partners and 48% of men attacked by their female partners. In one-third of all incidents of domestic assault, the attacker was reported to be using drugs and/or alcohol. The assaults by women were reported to be less frequent, less severe and of less duration. Straus and Gelles (1990) estimate that one in eight women are physically assaulted by their male partner each year in the USA and they estimate that at least one in three women are physically assaulted over the course of their relationship. These data exclude 'marital' rape and psychological abuse.

Women are estimated to be more at risk of assault and murder if they leave their abusive male partner (Barnard *et al.*, 1982). One-third of reported physical assaults on women are estimated to occur during the contact 'handover' of children (McMahon and Pence, 1995). Adult partners who are violent are more likely as parents to physically abuse their children. Moffitt and Caspi (1998), in their review of the extant literature on this theme, estimate the risk to be between three and nine times greater.

These figures impel us to ask what the children are learning. Moffitt and Caspi (1998) estimate that about two-thirds of assaults between parents are witnessed by children. Some children are at risk for traumatic responses, and internalizing and externalizing problems, with worse behavioural outcomes for children linked to the frequency and intensity of the physical conflict between the parents (Sunderman and Jaffe, 1999). Browne and Herbert (1997), in their review of the effects on children of witnessing violence between parents, concluded that children may be taught aggressive styles of conduct, reduced restraint and increased arousal to aggressive

situations, distorted views about conflict resolution, and they are desensitized to violence. Researchers are beginning to assess the costs of domestic violence – economic, psychological and social – and note that a high proportion of victims of child maltreatment end up in the mental health system as adults (Ammerman and Hersen, 1999).

Aldarondo and Straus (1994) estimated that two-thirds of clients in couples/family meetings engaged in physical violence against their partners in the year prior to the initiation of therapy. Ehrensaft and Vivian (1996) found that of 60% of couples seeking therapy who had experienced physical violence, only 10% spontaneously reported the violence. It would seem that therapists do not tend to ask routinely about violent behaviour in their conversations with their clients.

### **Risk, responsibility and collaboration**

The three themes of risk, responsibility and collaboration are interwoven in our thinking about risk assessment and management when working with family members therapeutically in the aftermath of physical violence. We discuss each in turn.

#### *Risk*

A continuous programme of risk assessment is part of our strategic approach to risk management. Some of the families and family members we work with have been assessed by other agencies, such as (1) forensic psychology and psychiatry services and probation services when a family member has been sent to prison for their violent behaviour, or (2) social workers and expert witnesses in child protection cases. These families have often been through a lengthy legal process and are subject to intense and stressful scrutiny.

When our referral follows a previous forensic risk assessment which recommends family rehabilitation, we do not repeat the forensic assessment. However, we do continue the *process* of risk assessment, and in particular, we highlight the relational aspects of risk of further violence:

- *The contexts of violence.* We pay particular attention to how much is known about the contexts in which violence occurred and the frequency and severity of the violence. For example, did the

violence occur in the context of family living and/or did it occur at work, with colleagues, or socially, with friends and acquaintances? Did the violent behaviour include violence towards property and objects and the use of weapons? Does living in the 'goldfish bowl' of others' scrutiny make a difference? Such questioning provides information on people's understanding of social roles and rules and social rule violations and their sense of entitlement to use physical means to get their own way.

- *Management of anger responses.* We observe a person's ability to manage their anger responses when upset or frustrated in interaction with others.
- *Use and misuse of psychoactive substances.* We assess for the use and misuse of psychoactive substances. Where we find there is a problem we help with a referral to our community alcohol and drugs teams, and expect to work in collaboration with these services.
- *Empathy.* We attend to signs of empathy or lack of empathy for the person harmed by the violence, and pay careful attention to descriptions and observations of negative empathy, i.e. exploiting a victim's vulnerability to inflict further psychological harm. Dobash *et al.* (1999) and Dunford (2000) comment on the inability of violent men to reflect on their violence and its consequences. In the Dobash *et al.* evaluation study of British programmes for violent men, they noted that men who completed a programme successfully developed the ability to think about their violence and its costs to themselves, their partners, their children, and others.
- *Internal motivation for change.* Where there appears to be little internal motivation for change in relationships, and that motivation does not seem to develop over a period of continuous assessment, but rather seems to be a result of externally induced motivation for change (for example, by statutory or legal agencies) we are highly unlikely to undertake therapeutic work for rehabilitation. Where there is some internal motivation to change, we try and enhance motivation using motivational interviewing methods (Miller and Rollnick, 1991), adapted by us to be both systemic and suitable to working with violent behaviour, such as helping the man express concerns about a need to change, helping with the resolution to take action, using past and future questions to contrast hopes and aspirations for behaviour between then and now, and exploring the costs and benefits of current behavioural choices.

We work with safety in relationships as our first priority, before we agree to consider broader therapeutic aspects of the work with the couple. We agree a safety plan with our referrers and the couple during our initial meetings; this includes a place of safety for women and children if needed, and an agreed network of informed and helpful professional, community and extended family members who will support the safety work. Often our work with a couple is part of a safety plan that includes other interventions.

We agree no-violence contracts (Carpenter and Treacher, 1989; Goldner *et al.*, 1990) with the perpetrators of violence. Once the no-violence contract has been established and seems to be holding, as reported by all concerned parties at our regular review meetings, we extend it to include other forms of psychological abuse, such as coercive and intimidatory behaviours. The pro-feminist work on violence in intimate partner relationships carried out by the staff of the Duluth Domestic Abuse Intervention Project (1987) has drawn our attention to behaviours of 'emotional terrorism' that form the context for acts of violence, and that may well continue within a relationship once actual physical violence has ceased. These behaviours that serve to humiliate, shame and degrade the other may sometimes also be initiated by the recipient of violent behaviour as part of self-defence, and buttressed sometimes by a sense of entitlement as a victim of physical abuse. At this point we are then able to extend the therapy contract to look more carefully at past issues and how they impact on the present and the hopes for the future, widening the scope and context of questioning, explanation and possible solutions.

If the no-violence contract is broken, we do not keep information about repeat violence confidential. Family members are aware of the moral position we take around violence, our beliefs about violence and safety in relationships and our reasons for doing this work. We always try to talk to family members about our use of social control procedures. We do not try to repeatedly shore up the no-violence contract. We may well try one more time, with the agreement of all parties, but it might be that we need to refer the perpetrator back to a men's group or offer more individual work around anger management, and offer the woman individual support. It may be possible to resume couples work at a later stage, if all participants agree and the man has shown he can prioritize safety. Liaison between all parties is crucial in effective safety planning and in the timing of the different interventions available.

### *Responsibility*

We have been influenced by the work of Goldner and colleagues at the Ackerman Institute (1990, 1998, 1999), Jenkins (1990), and Jory *et al.* (1997) and Jory and Anderson (1999) in their attempts to hold the tension in therapeutic work between the responsibility for violent behaviour on the one hand and the explanation for violence on the other, in such a way that the explanation is not used by the perpetrator to minimize or deny their violent intent and action. In our assessment we look for some acknowledgement that there is a problem, accountability for behaviour, responsibility for keeping oneself and others safe, and a recognition of how relational factors may contribute to the problem, without recourse to the consistent blaming of others. The parenting assessment and risk management procedures developed by Reder and Lucey (1995) and Fitzpatrick (1995) in the context of child protection are helpful to us as they similarly emphasize the different aspects of accountability and responsibility.

The development of personal and parental agency around safety and problem-solving in the aftermath of violence is part of our approach to risk management. We ask questions to encourage the couple to think about the effects of violence on their children. We often talk to parents in role: 'As a father, what do you want your son/daughter to learn about how men and women get on?'; 'As a father how will you teach your daughter to keep herself safe?'; 'As a father how will you hold yourself responsible to your children for your violence towards their mother and towards them – how will you talk to them about it when they are older?' Developing the couple's own sense of agency for problem-solving around their own relationship, responsibility for safety and their relationship with their children is the plank on which we build a rehabilitation plan and on which getting their children back from the care of Social Services may depend.

### *Collaboration*

We aim to be transparent in our therapeutic and rehabilitative work with family members. Thus we are clear with them about our own moral position around the use of violence in family relationships, our use of social control procedures and in our use of reflecting processes (Andersen, 1987; Friedman, 1995; Smith and Kingston,

1980). We always work together with family members, whether seeing them individually, in relationship or as a group. We do not use a screen. Harnessing the therapeutic potential of multiple observers and multiple perspectives, we develop our ideas in conversation with each other in front of the family, inviting them to comment and add to what we have said; the therapist invites reflections from the in-room consultant on what transpires between the family and therapist, and all participants are encouraged to adopt the roles of both listener and speaker and to comment on the differences and similarities in perceptions. The in-room consultant uses the role to acknowledge success where it may have been overlooked, i.e. in the written documents, to ask questions and offer suggestions, to introduce new ideas and to ask confrontative and challenging questions in ways that facilitate constructive problem-solving. We have few rules, which include always being brief, not using too many ideas, being tentative and always encouraging our clients to comment on our ideas.

Collaboration is assessed in part by the ability of family members to see professional workers as potentially helpful and in part by their ability to co-operate with professional workers. Collaboration and co-operation in our view lie at the heart of good risk assessment and risk management strategies. Previous professional attempts to tell family members to change their behaviour have not always been productive, so, if we cannot establish a context for co-operation through our attention to the therapeutic alliance and our processes of transparent working, we do not proceed.

## **Our working context**

### *The referral process*

We do not accept referrals direct from the general public, but through Social Services, the Courts, Probation and our local NHS Trust. Some family members may well have voluntarily given up their privacy by consenting to lengthy observation and interrogation in the context of custody disputes and other childcare proceedings. Other families that we work with are referred through our NHS Trust contract and they have not been assessed for risk nor do they have experience of such intense scrutiny. The cases that are referred to us, from whatever source, are always problem-saturated and never without risk.

We are a small, independent agency, working without the protec-

tion and support of a large statutory agency. Our minimum sufficient network for therapeutic rehabilitation is a triangle, formed by ourselves, the family members and our referrer/referring agency. Our referrer forms the stable third in our therapeutic triangle, sharing and managing the risks of doing this work. Often we are working with a complex network of statutory and other agencies. The stakes are high for the family members and other professional stakeholders who want the violence to stop and for whom rehabilitation depends on the cessation of violence. Much of our work with referrers involves supporting social workers who carry the strain of thinking about the children and their needs.

We have an initial meeting with the referrers and subsequently hold regular reviews with family members and our referrers every six sessions, in which we review progress, identify the risks and responsibilities for all participants in the process and the interconnected nature of those risks and their management. We use in-room consultation at all times in our project. Clear and close co-operation for all parties is essential. The assessment of the ability to co-operate with professionals and see others as potentially helpful is part of our risk assessment strategy with family members. Equally, if the referrer/referring agency was reluctant and uncommitted to the process of rehabilitation, perhaps forced into agreeing with rehabilitation as part of a Court decision, we would be cautious in proceeding, and use our initial meeting and review meetings to identify the dilemmas and how they affect decisions, actions and relationships throughout the network. Our regular review meetings are the forum within which we agree the criteria for ending our work and within which we evaluate the outcome of work for all concerned. Subsequently, we hold regular follow-up reviews and offer relapse prevention work as necessary, as a means of monitoring the continuing helpfulness of our work to the overall safety of family members.

We are always dealing with both written texts, often legal, and spoken language. These documents will be signed and witnessed in a process that is seen to give them the status of incontrovertible truth. As some of our clients are non-literate, we seek to understand their struggle with the words written about them.

### *The clinical process*

As family therapists, our systemic framework allows us to draw deliberately on both family systems thinking and on theories from

other disciplines, integrating them in therapeutic formulation. We are informed by ideas of pattern and process in relationships, of the intergenerational transmission of attitudes and beliefs towards violence, of intergenerational and life-cycle experiences and the context of the referral (Vetere, 1998). Feminist informed sociopolitical critiques of power in interpersonal relationships (Burck and Speed, 1995) provide the context for drawing on object relations ideas when thinking about intimate attachments, internalized representations of self and others, and the dilemmas and binds that underpin violence in family relationships (Akister, 1998). Social learning theory helps us unpack the gendered constructions around masculinity and femininity, while paying attention to the family and social processes that acculturate children (Browne and Herbert, 1997). Finally, we weave Novaco's (1993) work in developing a cognitive-behavioural approach to anger management and arousal regulation into both our risk assessment and risk management approaches.

We agree with Goldner and her colleagues (1990, 1998, 1999) in the Ackerman Violence Project that we need multiple theories to understand the complexity of the situations, dilemmas and binds within relationships, past and present, where violence, coercion and abuses of power intersect with attachments and dependence. In addition, we would add the need to describe and understand the complexity of immediate family-extended family relationships and family-agency relationships using multiple theories. We would accept also the notion that we as therapists are organized by and subject to the same cultural prescriptions, proscriptions and stereotypes as the family members we work alongside, and thus find multiple theories helpful both in grounding our practice in formulations and in holding ourselves ethically accountable to our referrers and to family members.

We are interested in the wider familial context of our clients. Obviously, court mandated work is not voluntary, so the ideas and beliefs family members have about their position at that particular moment can be powerfully influenced by their recent history and that of their extended families. These experiences will have formed and informed their view of themselves, their understanding of their position within their families, within their communities and within the legal system. In addition, the effects for family members of living within the goldfish bowl of constant watching is experienced in a number of ways, such as the cognitive and emotional effects of stress, the undermining of parental authority, and sometimes rever-

sals of existing power differentials in family relationships. For example, couples often struggle to negotiate a reweave of power and control within their relationship when the mother is required by social services to 'blow the whistle' on her partner's behaviour for the protection of the child, while also trying to re-establish their couple and parental relationship. Their ability to work with us, and often the other agencies, can rest on our capacity to be even-handed in hearing all points of view, and forming an understanding of what is important for family members, even though it might be a Court mandated piece of work. Thus, we would want to know if they understood where they were in the legal process, if they understood what changes were required of them, if they had a sound relationship with their solicitor, and to whom they looked for advice and guidance. Some families look to their social worker or referrer, but others appear to be at war with their social worker or referrer. In their extended family, we are interested in who they have talked to, how they are helpful, who wants them to stay together, who wants them to part, and whether they have discussed these different views themselves, and what they think their children and other family members wish for the future.

In cases where the father has been to prison for his violent behaviour, and his partner has continued to live at home with the children, we will ask in detail about their different experiences. It may be that it has strengthened their resolve to stay together and achieve change, it may have made them realize that a future together is not possible, or it may be there are dominant and justifying explanations that are not publicly discussed. We often find a complementary pattern where the man will diminish his responsibility for his violent actions and the woman will agree or otherwise tolerate that description, and where the woman will diminish her own competence and her understanding of events, and the man will agree with her description. Our responsibility to the couple is to work slowly and try to create a culture of respect and equity, in which he takes responsibility for his actions and she becomes more confident in her own abilities.

As part of our assessment process and the safety plan, we ensure women have resources to keep themselves and their children safe. Too often we notice that women who are traumatized by repeated and enduring violent assaults are deemed, within the legal system, incompetent to care adequately for their children and meet their needs for safety.

**Some guidelines for clinical practice**

We do not attempt therapy or rehabilitation with family members whom we believe to be at high risk of further violence. When working with couples, for example, there needs to be an agreement that both partners wish for and are committed to finding a way to live together safely. For example, we would not work therapeutically with a couple where the woman is afraid to meet or be in the room with her male partner. Bograd and Mederos (1999) suggest that a woman's willingness to discuss her partner's violence in his presence is an important indicator of whether a conjoint treatment approach is possible.

We do not offer confidentiality in our work with families in the aftermath of violence or where violent behaviour is suspected; rather we negotiate confidentiality on a continuous basis. We explain this to people when we first meet them, along with the safety and risk management implications for our stance. If we are worried that someone is at risk from harm or likely to harm others, we will inform the appropriate statutory and legal authorities. We tell family members that we will try to discuss our concerns with them before informing others, but that we will not offer confidentiality. Similarly, if a woman confides in us during an individual meeting about her partner's violent behaviour towards her, we do not force disclosure in the couple's meeting if we consider that unprepared disclosure will place the woman at further risk. We had thought initially that our stance would offend and dissuade people from using our service. Instead it seems to have had the opposite effect, in that our clients tell us they are pleased to know where they stand with us and that they find us straightforward in our approach.

Contextually, our work builds a bridge for interpretation between the written documents and the spoken word, yet it places us in a position of authority and power. Understanding this context provides us with an opportunity to think about time and future. For example, we can ask ourselves and the family, 'What if the accounts in these documents never get challenged?' or 'In the future, how will you manage to talk to your children about the stories in these documents?' These are poignant areas of our work, moving as they do between experiences and accounts of failure, shame and responsibility.

We are often asked how we would know if people were lying to us. In our thinking, lying has its consequences; for example, if we

observe that people seem too interested in their own performance, or engage in extreme impression management, or display discrepancies in their verbal reports or between their verbal and nonverbal behaviour, or there are discrepancies between the verbal accounts and the written reports, we proceed with caution and question systemically around the effects of what we are noticing.

We use a mix of behavioural, cognitive and systemic problem-solving methods to help family members who use violence to maintain their no-violence contracts. We work with the worst and/or last episode of violence and track the escalation into physical violence, identifying the proximal and distal risk factors, while paying special attention to the particular triggers for violence and their interconnection, such as thoughts, feelings and physiological arousal, often contextualized by entitlements, power imbalances and lack of respect in relationships. Early solutions to the escalation of conflictual interactions between the couple might include time-out strategies, where both partners agree, so that one will walk away from the escalation of conflict and the other will agree not to pursue.

### *Language in the clinical process*

Since we regard violent behaviour as a strategy of social control and intimidation within relationships, we are interested in the relationship between the use of language and volitional behaviour. Language is one of a number of power bases or personal resources that family members draw on in order to maintain influence (Williams and Watson, 1987). When assessing for therapeutic rehabilitation or for a court assessment, we listen carefully to how family members talk about their responsibility for violent behaviour; for example, whether their use of words minimizes or diminishes the acts of violence (Hearn, 1994), or the responsibility for those acts. Paradoxically, the experience and expression of anger and violent behaviour are often described as 'losing it', not 'gaining it', or as a strategy used when a person might feel at their most helpless. The work of the feminist linguists has been helpful in thinking about the complexity of language use in our work (Spender, 1980). Social order may be said to be reproduced and partly maintained through language, so it is interesting to consider how these language patterns, linguistic rules and social expectations come to be believed and accommodated in particular ways by men and women, including ourselves as therapists. For example, the words available

to talk about violence may reflect family rules about whether it is even permissible to talk about violence, either for men or for women.

We explore and unpack the complex weave of power and control, stereotypical gender experience and expectations, and the beliefs and assumptions that are implicit in our individual language use. Holmes (1992) suggests that women and men talk about the social world in different ways, while also talking in ways that illustrate solidarity and connection. Understanding the influences of stereotypical gendered speech patterns, while at the same time challenging the meaning of these stereotypical patterns, allows us to listen in a different way to women and to men, so that they maximize their potential for change, even though some social and family rules appear to oppose change.

Intergenerational transmission of meanings and beliefs is often grudgingly acknowledged as being unchangeable. In talking about violent behaviour in therapy and assessment, we are listening in detail for language that promotes and accepts responsibility for violent behaviour from the perpetrator and language that acknowledges the right of safety and a sense of agency on the part of the victim. Combination talk, including some responsibility and excluding some responsibility, is often complicated. The problem is that it can allow acknowledging responsibility and a change in behaviour and belief to slip away into entitlement again. Individual phrases, such as 'I only pushed her' or 'I just shoved', permit minimization.

A family we worked with illustrates family rules about language, patterns of connection and the courage it takes to want change. In this family there was a dominant view that 'we take care of our own'. Paradoxically, this view did not recognize that there were two parallel gendered stories, neither of which took into account any responsibility or understanding of the lived experiences of the others. In sociopolitical terms, this 'we take care of our own' was born out of privilege on the one hand and family secrecy on the other. The Limb family consisted of grandparents, their two adult daughters and one adult son. These adult children were married, and two daughters had children. Historically the grandfather had been violent to his wife and this had been witnessed by their children. The two daughters had married men who were violent towards them, and their son was violent towards his wife. It was the son's wife who went to her GP and came with her husband to see us. There seemed to be a family assumption that the men did not talk and did

not need to talk about their violence towards their wives. When the women were hurt, they would go to their mother, or mother-in-law, who would look after them. The women only talked about their experiences of violence to each other, and in terms of their own behaviour that provoked the men, or in terms of closeness, support and understanding of each other. In seeking change, the young couple had to grapple with breaking a linguistic taboo, criticism and anger from the family for betraying them, danger of revenge and confrontation, and in the case of the young woman, the loss of close female company that in the past had been so supportive and important to her.

Since the therapeutic dialogue does not necessarily follow stereotypical patterns of linguistic interaction, it is also important to recognize that the way a question is constructed and the beliefs and meanings it contains determines in part the answer that can be given (Anderson and Goolishian, 1988; Coates, 1986). Therefore when talking about violent behaviour, we make it clear that we regard the speaker and listener as equally important. For many couples this is a revolutionary idea. Even if one of the couple is shy and fearful, we introduce the idea of equity in our work and do our best to maintain that focus. However, we also keep in mind the finding that violent behaviour alters the meaning of non-violent communications, and remember that 'intonation always lies at the border of the verbal and non-verbal, the said and the unsaid' (Volosinov, 1972). We regard tone and intentionality as part of the intimidatory process. These issues are often delicate and difficult to untangle, but are important because if the perpetrator stops physically violent behaviour but continues to intimidate – through attitude, facial expression, physical posture and use of language – then only partial change has been achieved.

### *Therapist well-being*

Working in such an intense way with difficult and dangerous issues, we are aware of risks of secondary traumatization for us as therapists. Sources of trauma in our work stem from (1) hearing gruelling accounts of physical cruelty, (2) our disappointment when the violence continues, (3) our risk of an inflated sense of responsibility around cases, particularly in the absence of a wider agency context of our own, and (4) the tensions around introducing systemic ideas into a conservative legal system, which has no tradition of acknowledging

the role of emotion in people's thinking and behaviour. We look out for our well-being in our consultation with each other, our consultation with similar projects, our consultation with colleagues with specific expertise, in keeping abreast with the literature on the signs of secondary traumatization in therapists, and in balancing our various activities, both personal and professional. Although Bograd and Mederos (1999) have written recently about the effects on therapists of doing this work in terms of transference and countertransference reactions, alongside a consideration of how therapists can seek to ensure their physical safety, we find little in the systemic literature on this topic.

### **Contraindications**

In conclusion, we have distilled the foregoing discussion and the work of those authors (e.g. Reder and Lucey; Goldner) who have influenced us into a set of contraindications for therapeutic rehabilitation in the aftermath of physical violence from one family member to another. These are not intended as a heuristic; rather as an aid to clinical formulation and decision-making when considered together. Our methodology relies on the triangulation of different sources of information and perspectives.

- 1 Unable to acknowledge that violence is a problem.
- 2 Unable to accept responsibility for violent behaviour. We ask ourselves whether clients have the ability to listen to others, to what extent they deny their violent behaviour, whether they blame others, including professional workers, and whether there is consistency between the written reports and verbal descriptions in our meetings. When working with a woman's violence towards a male partner, we are mindful of whether she is violent in self-defence while living with an abusive man, or whether her violence occurs apparently in the absence of physical and psychological intimidation from her male partner (James, 1996).
- 3 Unable to work constructively to solve problems around violence. Commitment can be explored by asking about what has worked in the past and what successes have been achieved. We want to know what resolutions have been offered and tried, if any, and in what contexts they were offered.
- 4 Lack of appropriate boundaries around anger expression and

- control. We are concerned by persistent externalizing of the problems, both in terms of the context for behaviour and of personal responsibility.
- 5 Problem drinking and drug-taking and an unwillingness to seek treatment.
  - 6 No internal motivation for change. We would need to judge that our clients have internal motivation for change, alongside any externally induced motivation, especially as talking about anger and making a commitment to change is anxiety provoking and risky for all concerned.
  - 7 No acknowledgement that relational factors may contribute to the problem. We search for our clients' understanding of the relationship aspects of their partnership and their responsibility towards that partnership, including their understanding of their own and others' roles.
  - 8 Inability to empathize with the victim or to listen to another point of view. We look for evidence of empathy for the victim's experience and the developing capacity to reflect on intentions, choices and actions which includes the capacity to tolerate different views of oneself in relation to others. The importance of reflective self-function (Fonagy *et al.*, 1994) is captured in our questioning around perceived self-worth, shame, anxiety and their effects on everyday life in the aftermath of physical violence.
  - 9 Consistent blaming of others, either family or professional workers.
  - 10 Lack of consistency between verbal descriptions and reports.
  - 11 Unable to agree on the purpose or usefulness of therapeutic intervention.
  - 12 Unable to work with professionals co-operatively, or to see them as potentially helpful. These last two contraindications are about the possibility of making a therapeutic relationship, which rests on trust, openness, listening to the views of others and the ability to accept criticism. We consider whether family members believe that a professional in a therapeutic context can be helpful. Sometimes therapeutic help is indicated, and sometimes not.

## **Conclusion**

We hope we have shown how we have developed some practical

solutions to the complex and difficult task of working therapeutically with couples and parents in the aftermath of physical violence in the UK context. Much of the therapeutic writing in this field has originated in the USA (Bograd and Mederos, 1999; Goldner, 1998) and in Australia (James, 1996; Jenkins, 1990). We try to work therapeutically in line with the recommendations of the outcome research on interventions with men who physically abuse their female partners (Dobash *et al.*, 1999; Dunford, 2000). Working in a small independent agency where our decisions and actions are exposed and without the support of a larger agency, we have responded to the challenge of needing our own policy on domestic violence, of taking responsibility within our work for reviewing and maintaining safe outcomes, and of critically reviewing our own practice with our referrers and the family members with whom we work to achieve safety in relationships.

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