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By

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ABSTRACT

CONNECTING TRAUMA SURVIVAL AND FAMILY EMPOWERMENT: A QUALITATIVE INQUIRY OF THE IMPLICATIONS FOR FAMILY-BASED SERVICES

By

Kathleen Burns Jager

The purpose of this study was to examine the effects of traumatic abuse survival on the family empowerment process for women engaged in family-based services with their emotionally disabled children. The goals of this study were to provide a forum for the voices of mothers' knowledge and experience to determine the relationship between trauma survival and participation in family-based services as they relate to the family empowerment process. Sixteen women who are survivors of traumatic abuse and are participating in family-based services with their children were interviewed. All completed a demographic questionnaire, an abuse history questionnaire, and the Family Empowerment Scale (FES) (Koren, DeChillo, & Friesen, 1992).

Three theoretical foundations informed this study: human ecology theory with a focus on family empowerment, feminist theory, and trauma theory. This study was conducted by applying qualitative feminist interview methods triangulated with information gathered through assessment instruments. Data were collected through semi-structured, qualitative interviews with each mother. Interview questions were designed to capture concepts related to maternal participation in family-based services and to explore concepts related to women's

trauma survival. The three assessment instruments were administered by the researcher to support and clarify qualitative data.

Data analysis revealed three key findings in which the effects of traumatic abuse experiences and survival were noted: relational perceptions, family empowerment process, and the level and expression of empowerment supported by family and service system subscale scores of the FES.

This study has implications for family-based services providers who facilitate family empowerment processes with women who are also survivors of traumatic abuse. The findings of this study suggest that it is imperative for family-based service providers to acknowledge the effects of women's survival, basic safety needs, personal worth, breeches of trust and (dis)connection as they facilitate connections between families with natural and community supports.

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CHAPTER ONE

Introduction

Background of the Problem

Family-based services seek to expand the internal and external resources available for families to nurture and care for children with serious emotional disturbances (Lindblad-Goldberg, Dore, Stern, 1998) through the facilitation of family empowerment (Koren, DeChillo, & Friesen, 1992). Though multi-generational abuse is a topic often discussed in family-based services case studies (Berg, 1994; Boyd-Franklin & Hafer Bry, 2000; Lindblad-Goldberg, Dore, Stern, 1998; Pecora et al., 1995), the conceptual focus remains on the process of facilitating family empowerment for families in which children experience emotional difficulties. Literature on traumatic abuse states that traumatic experiences destroy sustaining bonds between individuals and their communities (Herman, 1997). Disempowerment and disconnection experienced by trauma survivors (Herman, 1997) is not considered in the conceptual frameworks of family-based services or family empowerment. This research seeks to inquire about the effects of surviving traumatic abuse on the process of family empowerment for mothers of multi-stressed families engaged in family-based services.

This study focused on mothers who are abuse survivors; who are raising children who have emotional difficulties, in families that have been identified by a community agency as being "at-risk" for having their children removed from the

home. The mothers who participated in this research are involved in a voluntary and intensive family-based services program in their community, to make progressive, empowering changes that will keep their families intact.

Contextual Implications for Trauma Survival

People who endure atrocities likely suffer predictable psychological harm (Herman, 1997). The critical element that makes a violent event a traumatic experience is the subjective assessment by victims of how threatened and helpless they feel (van der Kolk, McFarlane, & Weisaeth, 1996). The spectrum of traumatic disorders covers effects that range from a single, overwhelming event, to prolonged and repeated abuse (Herman, 1997). Although there may be particular consequences from particular types of abuse, abuse of all kinds can produce serious and debilitating outcomes that can color the lives of individuals, their children, and how they relate to themselves and others. Trauma destroys sustaining bonds between individuals and their communities (Herman, 1997) by attacking the basic trust of survivors; while in its' path creating difficulties with intimacy, and consequently with relating to self and others. Such difficulties are inevitably reflected in survivors' family systems, how they parent their children (Walker, 1999), and in their social and community relationships as well (Herman, 1997).

"Given both the power of trauma to disrupt psychologically and the emotionally pivotal place of the child in the family, it is not surprising that abuse and trauma have the potential to be re-visited by the next generation in a myriad of ways (Walker, 1999)." Trauma survivors enter parenthood at different points

in the resolution of their own suffering and symptoms (Walker, 1999). Walker (1999) noticed that survivors of trauma place great importance on becoming parents, and have a deep desire and commitment to offer their children an experience essentially different and better than their own. She notes that in order to assist both survivors and their children to prevent further loss, isolation and unhappiness, their concerns need to be recognized and addressed with sensitivity (Walker, 1999).

Family Empowerment and Family-Based Services

Virginia Held (1993) stated, "The power to give voice to one's aspiration to be heard is not so much the removal of an external impediment as the beginning of an internal empowerment" (p.12).

Family empowerment is conceptualized as a central goal and value within the mental health services delivery system for families whose children have serious emotional disabilities. Empowerment has emerged as a reflection of the growth of the consumer movement and its emphases on self-help and self-reliance. The concept of family empowerment is inherent to "family-centered" models of practice and care that focus on family strengths, possibilities and natural supports, rather than on deficits (Koren, DeChillo, Friesen, 1992). The Child and Adolescent Service System Program (CASSP) of the United States Department of Health and Human Services promotes empowerment by its' view that families are full participants in all aspects of the planning and delivery of services to children with serious emotional disabilities (Stroul & Friedman, 1986; Vosler-Hunter, 1989 as cited in Heflinger & Bickman, 1996).

In the broadest sense, empowerment implies a process that enables individuals to gain control over their lives by influencing their interpersonal and social environments (Hasenfeld, 1987; Parsons, 1991; Rappaport, 1981; Zimmerman & Rappaport, 1988). Empowerment has also been conceptualized as a state (e.g. anger, joy), and no single definition can accommodate both "process" and "state" conceptualizations (Singh, et.al, 1995).

In general, when conceptualized within the framework of the mental health services delivery systems, family empowerment is "a process by which the families access knowledge, skills and resources that enable them to gain positive control of their own lives as well as improve the quality of their lifestyles (Singh, 1995, p13)." Though it is acknowledged that mental health service providers and professionals cannot directly empower families, there is a growing support for the notion that professionals do serve a vital role in facilitating or assisting families to empower themselves within this system. Professionals can help facilitate increases in levels of family empowerment by making structural changes in the process of service delivery to families and their children (Singh, et al., 1995; Singh, et al., 1997).

Among the mental health services embracing the value of family empowerment as central to quality practice and care is *the family-based services* movement (also known as: family preservation services, community-based services, home-based services). These services are based in the principle assumption that, in most cases, children's development and emotional well-being are best ensured through efforts to maintain children in the home of their

biological parents or extended family -- providing that at least minimal standards of parenting are maintained (Pecora, Fraser, Nelson, McCroskey & Meezan, 1995). This investment in family preservation grew from the 1980 passage of Public Law 96-272, also known as the Adoption Assistance and Child Welfare Act of 1980, which mandated that the most preferable outcome for children is to remain in the home with their biological families. Reasonable efforts must be made by child welfare agencies to keep children safely with their families before determining that children be removed into foster care (Berry, 1997; Wells & Beigel, 1990). Family-based programs provide a viable alternative to out-of-home placement for some children and help to improve family functioning in specific areas (Pecora et al., 1995). The underlying philosophy of the family preservation model is that in order to make significant changes with a child or children experiencing emotional disturbance, the family must be considered. Therefore the emphasis of family-based family intervention is with the "family-at-risk" rather than on the "child-at-risk" (Zarski, Pastore, Way, & Shepler, 1988).

Family-based services are distinguished from other programs by an ecological view that emphasizes the family, family members, and their social environments as targets for change. Family empowerment is a central theme in the provision of services which are geared specifically to meet each family's needs rather than categorically, and are delivered primarily in the family's home (Frankel, 1988), as well as in children's schools, juvenile court, and any other place that is a community or natural support associated with the family's needs. Although practitioners engaged in family-based services recognize and address

any dysfunction in the family system that is likely to interfere with a family's ability to maintain and nurture a seriously emotionally disabled child, attention is directed toward establishing relationships between the family and community services, organizations, and institutions that can support and enhance their efforts. Family-based services focus on expanding the family's available internal and external resources to nurture and care for a child with serious emotional disturbance (Lindblad-Goldberg, Dore, Stern, 1998).

A crucial element of family empowerment is *choice*: It is up to each family member to interpret the family context, needs and resources available to choose the best course of action for that particular person, in that particular family, at that time (MacMillan & Turnbull, 1983; Nash, Rounds & Bowen, 1992; as cited in Heflinger & Bickman, 1996). A family's empowerment status is often the critical factor in the success or failure of its attempts to access services as well as the outcome of the services received. Some families enter the mental health service delivery system more able to form partnerships with professionals and advocate for the needs of their child; whereas others tend to feel overwhelmed and powerless when interacting with professionals in the service delivery system (Singh, et al., 1997).

Family empowerment also implies the belief that people know what is best for them and their families. This knowledge however, is often obscured by socialization processes that may have taught them to be mistrusting of their own experiences, impeding family empowerment (Vanderslice, 1984).

The literature states that parents of emotionally impaired children participating in family-based services may need to change or modify their self-perceptions to participate more effectively as partners with professionals in the children's treatment planning. Modified self-perceptions may include believing that as a parent: a) I can be an important and valuable member of my child's mental health treatment team, b) I have a lot to contribute to treatment planning and decision-making for my child, c) I can influence professionals and the treatment for my child, d) I accept responsibility for solving problems and making decisions in the best interest of my child, e) I can take an active and assertive role in planning and implementing the treatment plan for my child, and f) I believe I am an equal partner with professionals who are treating my child. These self-perceptions reflect an empowered stance – one that promotes parental involvement and seeks appropriate solutions for the problems that brought the family into the mental health service system for treatment (Heflinger & Bickman, 1996). Family-based service professionals are expected to partner with families to provide context, or set events that will enable families to take more control of their lives (Singh, et al., 1997).

Multi-Stressed Families as Family-Based Services Consumers

Families with a child or children having severe emotional disturbance or families "in serious trouble" experience degrees of oppression and social isolation (Lindblad-Goldberg, Dore, Stern, 1998; Pecora et al., 1995). It is a reality that families who are consumers of family-based services experience multiple, complex, problems and stresses. "Because families present with so

many problems (e.g., homelessness; medical crises; sexual abuse, physical abuse, and/or neglect; suicide attempts; and arrest or incarceration), such families often prove daunting for even the most experienced workers (Boyd-Franklin & Hafer Bry, 2000)." Many of the crises experienced by these families are repetitive and multigenerational. Despite services offered to these families through schools, government agencies, social welfare, and the like, the families seem to change very little over time. When families operate in continual crisis mode, they have become inured to loss and block the further pain. Crises become a way in which some families learn to deal with painful experiences, memories and past traumas. Traumatic memories can lead to repetitive acting out in an attempt to master the pain of the earlier experience or to avoid it. Common multi-generational crises include physical and sexual abuse (Boyd-Franklin & Hafer Bry, 2000).

Many adult survivors who are parents have never come to the attention of child protection or other child & family service agencies and are not recognizable as a distinct group for research purposes. Research that involves parents who are survivors clearly focuses on the repetitive cycle of abuse, which can result in the active or passive mistreatment of the next generation. Caught up in the cycle, parents may abuse their child, collude with another who abuses their child, fail to protect their child from abuse, or simply be too depleted to care for their child (Walker, 1999). Lee & Casady (in review) suggest a strong association between high cumulative family stressors and maladaptive parental personality traits, presenting as threats to the well being for children in the home (Lee &

Casady, in review). Social isolation, relatively weak informal social supports, greater life stresses, and feelings of depression and loneliness have also been identified as characteristics of neglectful families (Gaudin, Polansky, Kilpatrick & Shilton, 1993). Working through hurts and losses that parent-survivors have felt and continue to feel may indeed help parents be more empathic towards their children (Lee & Stacks, in review).

Many families targeted by family-based services are also poor. Families living in poverty include a wide spectrum of cultural and racial groups, living in rural as well as urban settings. Poor families from all races and cultures often perceive themselves as being at the mercy of powerful systems with which they interact. Particularly for these families, empowerment is an essential treatment goal (Boyd-Franklin & Hafer Bry, 2000).

Though empowerment is a central goal for the functioning and healing of these families through family-based services, the actual process of how a family becomes empowered is a multifaceted one and little is known about it (Koren, DeChillo, Friesen, 1992). In many cases, empowerment requires working against beliefs and behaviors that are supported by or embedded in current social structures. There are forces at work to maintain the current social system with its concomitant, unequal distribution of power and resources that are both strong and complex (Vanderslice, 1984). Furthermore, there is a gap in the family empowerment literature regarding the imbalances of power in our society specifically experienced by mothers/women. It is the philosophy of the family-based mental health services delivery system that families should have equal

access to "partner" with a mental health professional, and to have a "choice" in how their systems of care wraparound their family and vice versa (Heflinger & Bickman, 1996). The literature appears to describe family empowerment as a tautology. A parent needs a certain amount of knowledge, skill and self-efficacy to increase family empowerment, yet family empowerment is defined by the process and presence of gaining and having these qualities.

Despite acknowledgement of oppression and isolation as related to matters of emotional disability and family context, the literature falls short of incorporating both relational and societal barriers to women's power and freedom in its discussion of the process involved in helping families take control of their lives and partner with community professionals. This omission is critical to the plight of mothers and how they support, advocate for, and parent their children who experience emotionally disability.

The culture of violence against women that is engrained in our society (The Boston Women's Health Book Collective, 1998) is assumed and prevalent in descriptive case examples throughout the family-based services literature, (Berg, 1994; Boyd-Franklin & Hafer Bry, 2000; Lindblad-Goldberg, Dore, Stern, 1998; Pecora et al., 1995), suggesting that sexual abuse and violence against women are common, reoccurring problems for families utilizing family-based services. However, existing family-based services philosophy and research does not connect the larger societal oppression of women to family empowerment outcomes.

This study will examine the process of mothers' experience and personal development of family empowerment as it relates to their participation in family-based services and their trauma experiences and survival. The following are concepts of inquiry related to maternal participation in family-based services: the role of community supports, the role of natural supports, relationships with family-based service professionals, and the level and expression of family empowerment. The following aspects of maternal trauma experiences and survival will also be explored: community response to trauma, social networks as supports for trauma recovery, survival skills, and perceived levels of individual empowerment in relationship to trauma survival.

Purpose of the Study

The purpose of this study is to identify and explore mothers' processes of developing and experiencing family empowerment. This study focused on women who have experienced abuse and oppression, and who also are mothers of children having emotional difficulties. These women are engaged in intensive family-based services in their communities. They are involved in a process that embraces a family-centered philosophy, implying that mothers may "choose" to "partner" with community professionals. Family empowerment, which is the goal for these services, seeks to enhance knowledge, skill, and self-efficacy while promoting parental involvement in seeking appropriate solutions for problems. This stance moves beyond blame and toward resolution in an environmental context in which problems and barriers to meeting needs are overcome (Heflinger & Bickman, 1996). Family empowerment, though acknowledging

oppression experienced by families of children with emotional disability, emphasizes inherent strengths and family supports but does not specifically address the experience of women, particularly mothers. It also falls short of addressing crucial issues such as power imbalances, losses of freedom and societal obstacles that mothers may experience due to the severity of their family situations, and surviving their own histories of trauma due to physical and/or sexual abuse.

This research project will provide a forum for the voices of mothers who are involved in family-based services. Primary areas of study will include the relationship between mothers' trauma survival experiences and mothers' perceptions of family-based services as they relate to the family empowerment process. The effects of the following concepts will be considered in the relationship between trauma survival and family empowerment: 1) trauma experiences, 2) community response to trauma, 3) social network support for the trauma survivor, 4) survival skills, 5) levels of individual empowerment for mothers, 6) experience in family based services, 7) community supports, 8) natural supports, 9) family-based service professional relationship, 10) maternal levels of family empowerment, and 11) perceived successes and competencies reflected as outcomes in the family empowerment process.

This is a triangulated qualitative study that will consist of in-depth, semi-structured interviews and the use of the Family Empowerment Scale (Koren, DeChillo & Friesen, 1992) to support qualitative data. This study is based on feminist family principles, recognizing the development of mothers who have and

are surviving abuse and oppression. Feminist writings on empowerment suggest the need to place the subject's interpretation and mediation of her experiences at the center of our inquiries to the "how" and "why" of power (Deveaux, 1994). This study aims to include attention to the sources of disempowerment and oppression experienced by women, as well as examine the issues of women's empowerment, women's capacities for self-determination and freedom, and the conditions in which these flourish (Deveaux, 1994) in the context of family and community systems of care.

Significance of the Study

Concepts related to empowerment play a central role in the shaping of services for families whose children have emotional disabilities. Although family empowerment is often stated as a program goal, the concept lacks specificity. Research is needed that includes exploration of the means by which parents gain empowerment and the various paths through which their empowerment may be pursued and developed (Koren, DeChillo & Friesen, 1992). This study will investigate the process of family empowerment for mothers who have experienced and survived trauma; underlining the relationship between trauma survival experiences with how mothers participate in family-based services and partner with community professionals involved in their children's care.

Patterson (1996) discussed the need for more research to advance understanding of the relationship between individual health and family health. Included among their research recommendations are: theoretically based research, the use of multiple methods, and qualitative studies involving family

processes that assess individual subjectivity and shared family constructions of meaning to bring forth family members' voices and realities. Also recommended are studies that focus on health and are designed to identify protective factors that contribute to good outcomes in children and families (Patterson, 1996).

This qualitative study is grounded in human ecology theory, trauma theory, and feminist theory. Feminist methods of qualitative analysis will be used and supported by quantitative instrumentation. This study aims to bring forth the unique experiences and voices of mothers involved in family-based services with their children, underlining their competency, strength, and experience that affects and informs the mental health services delivery systems that serve their families.

Major Research Questions Posed

> Feminist research most often analyzes some aspect of gender or power dynamics as they presently exist in an effort to make the invisible visible and to illuminate alternatives. Such power dynamics may operate in the control of information, knowledge, or theory, as well as in clinical practice and training. (Myers Avis & Turner, 1996, p.151)

Family empowerment is a goal central to the children's mental health service system and the family-based services that it offers. Families become involved in intensive services as such when they experience multiple stressors, emotional disturbance in one or more of the children, and the lack of resources and social support that is needed for them to successfully cope with their environments. The concept of family empowerment gives voice to family efficacy, skill, creativity and strength in its advocacy for equality and choice for families and family members. Family empowerment also acknowledges the oppression and social isolation that can come about when dealing with stress,

stigma, and emotional disability. However, in feminist research we acknowledge gender as a fundamental aspect of social relations, one that generally involves domination and asymmetric power (Myers Avis & Turner, 1996). Family empowerment as a concept and central goal of family-based services, has little to say about the aspect of gender present in power dynamics as they exist in families, communities and society at large. This study is an effort to illuminate the family empowerment experiences of mothers who have and are surviving their own abuse, as they advocate for their children and family in partnerships with professionals in the mental health system.

The major research questions being explored in this study include:

1) How do mothers' trauma experiences and survival affect their participation in intensive family-based services?
2) How do mothers' perceptions of community support for their families with emotionally disabled children relate to maternal experiences with community response to trauma?
3) What is the relationship between mothers' social support networks that help them cope with trauma experiences and natural supports that mothers' turn to for help in coping with family problems involving their children?
4) How do survival skills of mothers who are trauma survivors affect the process of "partnering" with mental health professionals to achieve increased family empowerment?
5) How do mothers' personal perceptions of autonomy, empowerment and connection affect the process of family empowerment?

6) What is the level and expression of family empowerment for mothers who are trauma survivors?
7) What do survivors perceive that they need to address in their trauma recovery that could help them gain further family empowerment?
8) What do survivors perceive that they need from family-based services in order to achieve greater family empowerment, thus becoming a more effective parent to their emotionally impaired child?
9) What do mothers who are trauma survivors perceive to be their successes and competencies reflected as outcomes of the family empowerment process?

Conceptual Map

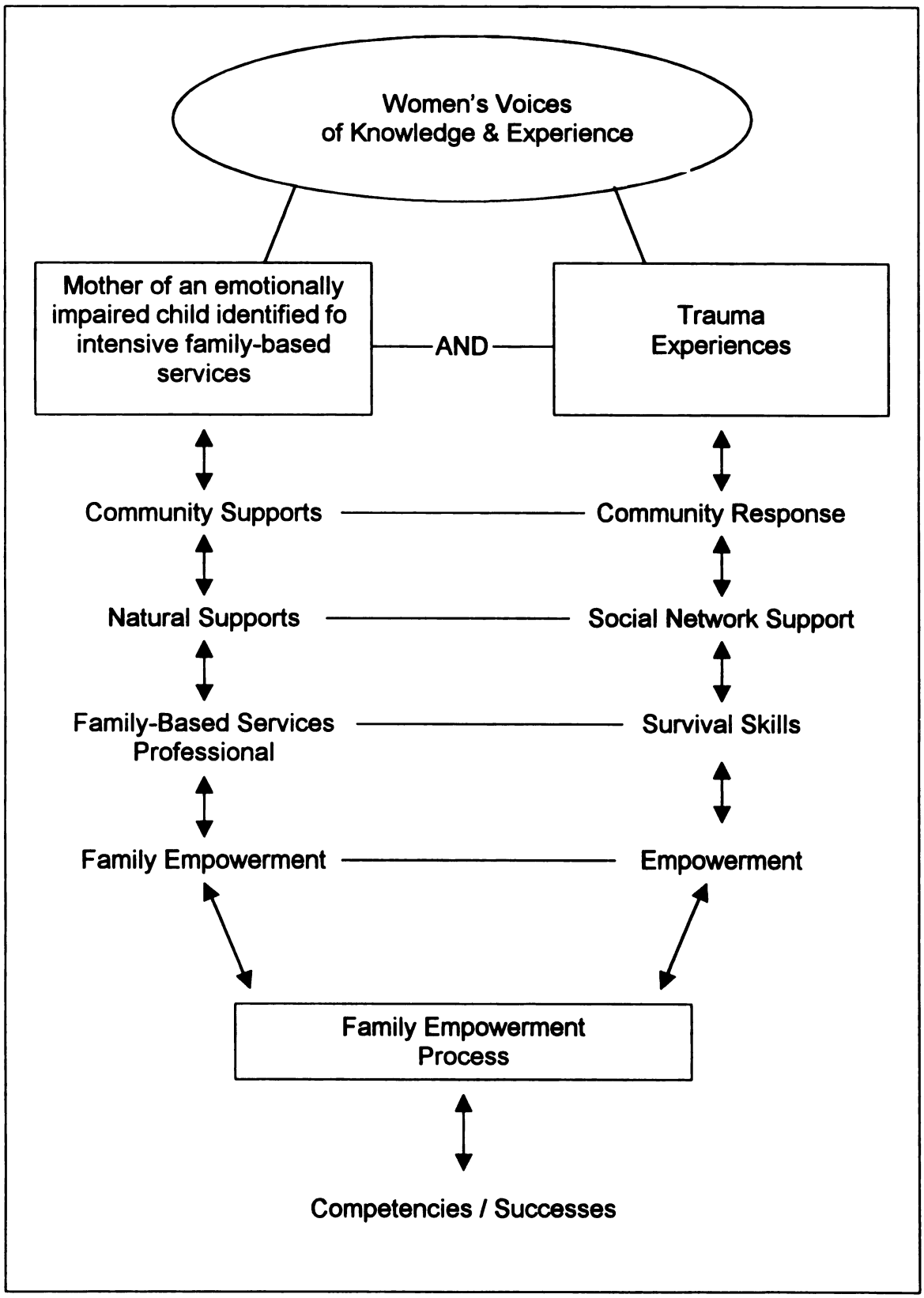
The conceptual map (see figure 1.1) illustrates the plan for this study. The sample will consist of mothers participating in intensive home-based services offered by Ionia County Community Mental Health. Mothers who have endorsed a personal history of having been traumatically physically and/or sexually abused are eligible to participate as informants.

The purpose of this study is to explore the process of the maternal experience and development of family empowerment within a framework that privileges women's voices of knowledge and experience. Based on the literature and my clinical experience, I hypothesize that the following will emerge as relevant factors influencing the family empowerment process for mothers as trauma survivors during their participation in intensive family-based treatment: 1) community support and response, 2) social networks and natural supports, 3)

survival skills affecting relationships with family-based professionals, 4) levels and expressions of family empowerment related to individual levels of empowerment, autonomy and connection, and 5) perceived successes/competencies reflected as outcomes of the family empowerment process.

The overarching framework is illustrated by the oval at the top of the map. The experiences of women hypothesized to come together in the process of family empowerment are displayed in boxes directly under the overarching framework. These experiences are: 1) being the mother of an emotionally disabled child in a family that is identified for family-based services, and 2) being a trauma survivor. Under each experience are factors related to that experience. The two-way arrows above and below each factor illustrate that these factors areas are interrelated within each experience. The solid lines which connect the factors between family-based services experiences and trauma experiences reflect the hypotheses that both experiences and their interrelated factors are mutual influences in feeding the process of family empowerment and its' reflected outcomes of perceived successes and competencies.

Figure 1.1: Conceptual Map



Theoretical Framework

Three theoretical frameworks guided this study: Human Ecology theory, with an emphasis on family empowerment, feminist theory and trauma theory.

Human Ecology Theory

Human Ecology theory is focused on humans as both biological organisms and social beings in interaction with their environment (Bubolz & Sontag, 1993). To be effective, the interaction must occur on a fairly regular basis, over extended periods of time. Enduring forms of interaction in the immediate environment are called proximal processes (Bronfenbrenner, 1999). Human Ecology theory considers that the family is a life-support system, dependent on the natural environment for physical sustenance and the social environment for humanness and for giving quality and meaning to life (Hook & Paolucci, 1970). An ecological paradigm is often used in family-based practice to examine the interplay between person and his environment, stressing that the focus of intervention is the family unit in the context of its environment. Professional intervention is addressed to the total family constellation as an open dynamic system and to the ongoing transactions with the impinging environment (Maluccio, 1991).

In a bioecological model, a critical distinction is made between the concepts of environment and process, with proximal process in a central position that is defined in terms of its functional relationship to both the environment and to the characteristics of the developing person. Environmental contexts influence proximal processes and developmental outcomes not only in terms of the

resources that they uncover, but also in the degree to which they provide stability and consistency over time that proximal processes require for their effective functioning (Bronfenbrenner, 1999).

The family preservation movement of child welfare services works to support and maintain families while optimizing children's development. The philosophy of family preservation calls on families to use their communities and extended families for support, and mental health professionals to operate from a strength-based perspective. Family-based services have emerged that are grounded in human ecology theory and aim to preserve the family, promote the well-being of children and families, enhance families natural support networks and embrace a value-system of family empowerment (Berry, 1997).

Family-based services and family preservation policy appear to operate from a bioecological perspective (Bronfenbrenner, 1999) in that they consider the developing child and the child's environment, in which processes of interaction are taking place; the nature of the developmental outcomes under consideration, and the social continuities and changes occurring over time throughout the child's life. Family preservation policy and parental mandates point toward a partnership between parents and mental health professionals. The term partnership implies collaboration, shared rights and responsibilities and sharing to reach a common goal. The common goal of parent-professional partnership aims to develop competence in the individual child with emotional disabilities, but also supports and encourages that child's family and community to become more caring and competent (Heflinger & Bickman, 1996; Hobbs et al., 1984; Moroney

& Dokecki, 1984). Supporting families in their abilities to master developmental tasks, manage tension, negotiate social systems, and recognize the primacy of social supports in the community follows a socio-ecological approach (Heflinger & Bickman, 1996).

An ecological approach to children's mental health service delivery supports transactionalism in parent-professional interaction. A transactional approach implies that (1) any definition of a child's problem must include recognition of the context within which the child operates and include the frames of reference of the child and other family members and (2) any treatment plan must recognize the dynamic and changing interrelationship between the child, the family, the mental health professional, and the broader social system within which they operate (Heflinger & Dokecki, 1989). The formulation of transactionalism requires active participation by all family members in treatment planning and decision-making (Heflinger & Bickman, 1996).

Family empowerment is a specific goal toward which parent-professional partnerships should aspire. The concept of empowerment is still being developed however and there is varied consensus on its nature and definition. Numerous attempts have been made to define empowerment broadly but these have been unsuccessful because empowerment has been conceptualized as a state as well as a process that involves change in individuals and in mediating structures. No single definition has yet been able to accommodate the two conceptualizations. In general, the concept of empowerment has come to imply a process by which individuals gain control over their own lives by influencing

their interpersonal and social environments (Hasenfeld, 1987; Parsons, 1991; Rappaport, 1981; Singh, et al., 1995; Zimmerman & Rappaport, 1988).

Singh et al. (1995) believes that in the context of human service delivery systems, family empowerment is a process by which families access knowledge, skills, and resources that enable them to gain positive control of their lives as well as improve the quality of their life-styles (Singh, et al., 1995).

Heflinger and Bickman (1996) state that illusive concept of family empowerment may be operationalized as helping parents to become collaborators in their children's mental health treatment. Concurrent with the philosophy of intensive, family-based treatment programs, Heflinger and Bickman (1996) believe that parents could benefit from programs that teach skills to promote access to needed information and resources. Furthermore, self-efficacy should be a direct focus of efforts to promote family empowerment. Self-efficacy in this context is parents' beliefs that their involvement in their children's mental health treatment will make a difference (Heflinger & Bickman, 1996).

Parent involvement however, cannot be measured as a uni-dimensional construct – the more time the parent spends with professionals engaged in treatment focused activity is not the single focus of programs with family empowerment as a central goal. Smaller levels of parental involvement can be interpreted in many ways from parental neglect of the child, to lack of opportunity, systemic or professional barriers, or competing family needs. Though it is a temptation to promote high levels of parent participation as the goal of family empowerment, it is critical to remember that a key element of family

empowerment is *choice* (Heflinger & Bickman, 1996). It is up to each family member to interpret the family context, needs, and resources available and to choose the best course of action for that particular family member in that particular family at that particular time (MacMillan & Turnbull, 1983; Nash, Rounds & Bowen, 1992). In that regard, an empowered parent may choose not to participate at any point in treatment planning or meetings based on their beliefs for the total needs of the family. There are many scenarios to parent participation in family-based services, but the primary issue remains as family choice. A parent-professional partnership model of interaction should recognize and address the issue of choice for levels and expressions of parental involvement in family based services for children (Heflinger & Bickman, 1996).

A Feminist Framework

Feminist theory is a perspective that explores the meanings of gender concepts. It begins with the assumption that gender is a pervasive category for understanding human experience (Littlejohn, 1989). Its' fundamental goal is to analyze gender – how it is constituted and experienced; how people know, think, and make decisions by it, and how people ignore it. The study of gender issues includes but is not limited to what are considered particularly feminist issues such as situations of women and the analyses of male domination. Feminist theory recovers and explores aspects of societies that have been suppressed, denied, or unspoken within male-dominant view-points (Flax, 1990).

Feminism in the social sciences challenges claims that knowledge can be neutral, objective, or value-free. Knowledge is power, and those who control the

making and definition of knowledge also control cultural construction of reality and meaning. Foucault (1980) has discussed that women's experiences may be seen as "subjugated," (as cited in Deveaux, 1994) invisible, or suppressed in a predominantly male construction of reality that reflects and legitimizes dominant ideologies, power structures and social interests (Myers Avis & Turner, 1996).

Feminist standpoint epistemologies maintain that women's experiences, knowledge and voices have been subjugated and are not visible in an existing, predominantly male construction of reality (Myers Avis & Turner, 1996). In the family-centered philosophy embraced by children's mental health delivery systems of care, "family empowerment" is an outcome for family-based services. Family empowerment implies parental partnership and choice when working with mental health professionals for the survival and health of families. Concepts such as "partnership" and "choice" imply equal access to power even though it is known that women who have been abused have been violated and made to feel powerless and unequal in relationships in their lives. Female survivors have experienced power imbalances and oppression. A feminist position about the abuse of women, declares the way that people are conditioned to function and do function when they are raised in a patriarchal culture. This often results in women being the victims of male abusers (Dinsmore, 1991). Feminist standpoint epistemologies advocate for using research methods that begin with the experience of women as a subordinated group, grant women voice and the right to be heard, and develop conceptual categories appropriate to women based on women's own experiences (Smith, 1987).

A feminist perspective recognizes the importance of asking whether the treatment of "family empowerment" enables us to recognize women's experiences of freedom and losses of freedom. To understand the workings of power and the responses that power elicits, it is necessary to ask how women experience freedom and barriers to freedom. Feminists need to look at the inner processes that condition women's sense of freedom or choice in addition to external manifestations of power and dominance (Deveaux, 1994). This study will ask women who have survived abuse, who are parents to emotionally impaired children about the choices and barriers to choice that they experience when participating in family-based services which embrace family empowerment as an outcome.

Addressing women's freedom, or choice, must emphasize that "the self-development of women involves changing the affective tastes, the emotional coloration, with which we experience the world, not only the outer obstacles in that experience (Held, 1993)." A feminist perspective insists that we must reflect upon internal impediments to exercising choice as well as tangible obstacles to its realization in our consideration of practices and conventions that may have disempowering effects for women. Lastly, feminism involves recognizing certain experiences as ongoing expressions of resistance to power (Deveaux, 1994). This study will celebrate women's development and experience of family empowerment and the ways that women choose to support and advocate for their children as they participate in family-based services in their community. This study will view women as far more than the obstacles that they have faced.

It will serve as a forum for women's creativity in surviving trauma and abuse, and how these competencies affect the ways that women manifest family empowerment in their families of creation.

Trauma Theory

"Psychological trauma is an affliction of the powerless (Herman, 1997)." At the moment of trauma perpetrated by another human being, victims are rendered helpless by the overwhelming force of an atrocity. Traumatic events overwhelm ordinary systems of care that give people a sense of control, connection and meaning in their lives. Though it was once believed that such atrocities were uncommon, this is sadly inaccurate. Rape, battery and other forms of sexual and domestic violence are so common a part of women's lives that they can hardly be described outside the range of ordinary experience. Even so, traumatic events are indeed extraordinary, not because of the misperception that they rarely occur, but because they overwhelm the ordinary human adaptation to life. Traumatic events generally involve threats to life or bodily integrity, or can take the form of a close personal encounter with violence or death (Herman, 1997).

Traumatic reactions occur when neither resistance nor escape is possible, and action is to no avail. The human system of self-defense becomes overwhelmed and disorganized. Traumatic events produce profound, and lasting changes in physiological arousal, emotion, cognition, and memory. Traumatic events may sever these normally integrated functions as well. For example, traumatized people may experience intense emotion but without clear memory of

the event, or they may remember everything in detail but are disconnected from any emotion. Trauma survivors may find themselves in a constant state of vigilance and irritability without knowing why. Traumatic symptoms have a tendency to be disconnected from their source and take on a life of their own (Herman, 1997).

Throughout history, some people have adapted to terrible life events with flexibility and creativity, while others become fixated on the trauma and go on to lead traumatized and traumatizing existences. Despite the human capacity to survive and adapt, traumatic experiences can alter people's equilibrium to such a degree that the memory of one particular event comes to taint all other experiences. Some people are not able to integrate the awful experience and begin to develop specific patterns of avoidance and hyperarousal associated with post-traumatic stress disorder (Van Der Kolk & McFarlane, 1996).

The many symptoms of post-traumatic stress fall into categories of hyperarousal, intrusion, and constriction. Hyperarousal reflects the persistent expectation of danger, intrusion reflects the indelible imprint of the traumatic moment, and constriction reflects the numbing response of surrender. Following a trauma experience, the two contradictory responses of intrusion and constriction establish an oscillating rhythm. This dialectic of opposing psychological states is the main characteristic of the post-traumatic stress syndromes. Trauma survivors lack balance as they find themselves caught between extremes of amnesia or of reliving the trauma between floods of intense, overwhelming feelings and arid states of no feelings at all, between

irritable, impulsive actions and complete inhibition of actions. "The instability produced by these periodic alternations further exacerbates the traumatized person's sense of unpredictability and helplessness. The dialectic of trauma is therefore potentially self-perpetuating (Herman, 1997)."

Herman (1997) discusses that over the course of time, the dialectic of trauma undergoes a gradual evolution. Initially, the intrusive reliving of the trauma event is dominant and victims remain in a highly agitated state, vigilant for new threats. These symptoms emerge most prominently in the first few days following the trauma and lessen to some degree within three to six months, and then continue slowly over time. While specific, trauma-related symptoms seem to fade over time, they can be revived even years after the event, by reminders of the original trauma (Herman, 1997).

As intrusive symptoms diminish, constrictive symptoms come to predominate. Traumatized persons may no longer seem frightened and may resume the outward appearance of their previous lives. However the severing of events from their ordinary meanings and distortions in the sense of reality persist. Survivors may complain that they are just going through the motions of living, or feel as though they are just observing the events of daily living from a distance. With the passing of time, these negative symptoms may become the most prominent feature of the post-traumatic disorder, and with post-traumatic symptoms being so varied and persistent, they may be mistaken for enduring characteristics of survivors' personalities. Long after the event, many traumatized people feel that a part of them has died (Herman, 1997).

Dinsmore (1991) views these "negative symptoms" as survival skills for women who were repeatedly abused as children. Symptoms that include dissociation, hypervigilance, isolation, and/or using sex as a negotiating tool are survival techniques necessary to help child-victims survive pathological adult-child relationships. These survival techniques are normal responses to abnormal childhoods, and they usually continue into adulthood. Not all survival skills are debilitating. Survivors need to celebrate their survival skills, examine each one individually and decide which are no longer needed and which skills may continue to be useful. In honoring survival skills, it is important to look at their origins and see the strength and creativity of the survivors (Dinsmore, 1991).

This study will inquire about survival skills of the informants; their strength and creativity in relationship to family empowerment and improving the health of their families.

Trauma events have primary damaging effects on the victim's systems of attachment and meaning that link that individual to the community (Herman, 1997). Traumatic events destroy the victim's fundamental assumptions about the safety of the world, the positive value of the self and meaningful order of creation (Janoff-Bulman, 1985).

Herman (1997) discusses that in situations of terror, people spontaneously seek their first source of comfort and protection. In situations of trauma, when their cry goes unanswered, their sense of basic trust is shattered. Traumatized people feel utterly abandoned and alone, with a sense of alienation and

disconnection pervading their relationships. When this sense of connection with caring people is shattered, traumatized persons may lose their basic sense of self, and developmental conflicts, long since resolved are re-opened. Trauma forces survivors to relive all their earliest struggles over autonomy, initiative, competence, identity and intimacy (Herman, 1997).

A developing child's positive sense of self depends upon a caretaker's benign senses of power. When a caretaker shows regard for a child's individuality and dignity, the child feels valued and respected, developing autonomy – a sense of the child's own separateness within a relationship. Trauma violates the autonomy of the person at the level of basic bodily integrity. The body is invaded, injured and defiled. At the moment of trauma, the individual's point of view counts for nothing. The trauma of physical and/or sexual abuse is precisely to demonstrate contempt for the victim's autonomy and dignity. The traumatic event therefore destroys the belief that one can be oneself in relation to others. Reactions of both shame and doubt are normal following the experience of trauma. Things are no longer what they seem. Herman (1997) also discusses that the effects of trauma elicit feelings of guilt and inferiority, a sense of dis-connection between individual and community, and struggle between isolation and clinging to others (Herman, 1997).

This qualitative study will address how women who have survived the trauma of physical and/or sexual abuse experience partnering with a mental health professional to set goals and make decisions using the family's existing resources. Having experienced breaches of safety and trust due to trauma,

what is it like for them to work with a professional whose goal is to partner with them to help them improve their families? What do survivors need to feel safe, connected and respected in their relationship with family-based services professionals?

The core experiences of psychological trauma are disempowerment and disconnection from others. Recovery, according to Herman (1997), is based upon the empowerment of the survivor and the creation of new connections within the context of relationships (Herman, 1997). All people mature and thrive in a social context that has profound effects on how they cope with stresses (Van Der Kolk, 1996).

Because traumatic life events damage relationships, people in the survivor's social world have the power to influence the eventual outcome of the trauma. The survivor's sense of self has been shattered, and can only be rebuilt in connection with others. In the immediate aftermath of the trauma, rebuilding of trust is the primary task in which assurances of safety and protection are of greatest importance. Once a sense of basic safety has been reestablished, the survivor requires supportive respect for her autonomy and personal worth (Herman, 1997).

This study will inquire about the survivor's use of natural supports in helping her through her trauma survival as well as the role of natural supports in assisting her with her emotionally disabled child or children.

Sharing the traumatic experience with others is a precondition for the restitution of a sense of a meaningful world and this involves assistance not only those closest to the survivor, but also from the wider community. The response of the community has a powerful influence on the ultimate resolution of the trauma. Restoration of the breach between the survivor and the community depends upon public acknowledgement of the traumatic event and upon some form of community action. Once it is publicly recognized that a person has been harmed, the community should take action to assign responsibility for the harm and to repair the injury. These responses of recognition and restitution are necessary to rebuild the survivor's sense of order and justice (Herman, 1997).

This study will address how mothers' trauma experiences and responses affect their connection to the community and to the community mental health system by examining how the larger community response to the trauma itself may influence mothers' relationship with family based services and consequently effect the process of family empowerment. Is the survivor's participation in family-based services perceived by the survivor as a part of community recognition and restitution?

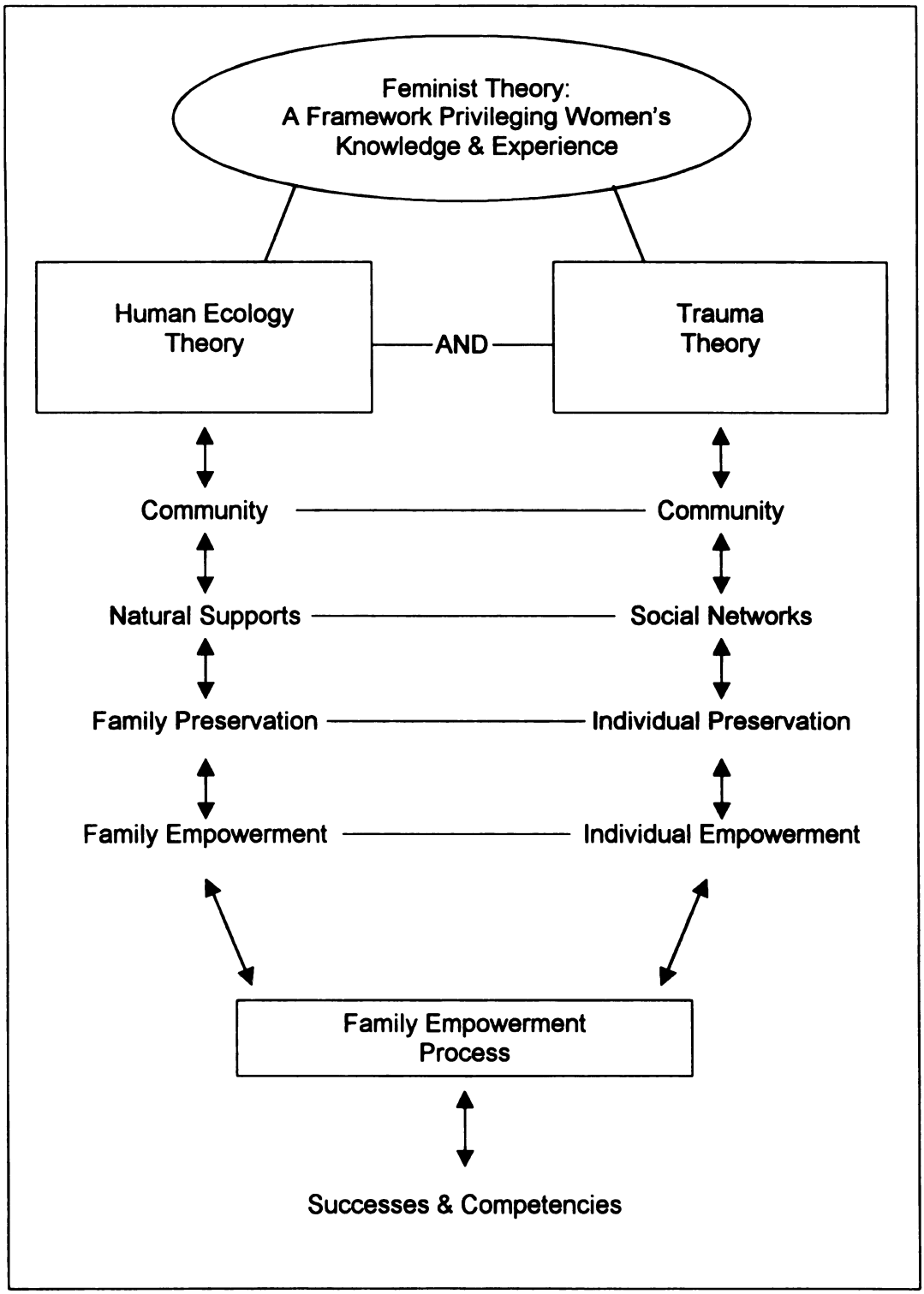
Theoretical Map

Figure 1.2 is the integration of human ecology theory and trauma theory informed by a feminist framework. The map displays the relationship between human ecology theory with its' interrelated concepts, and trauma theory with its' interrelated concepts. In this map, trauma theory considers that when a person experiences trauma, various aspects of their environment impact the trauma experiences, which include the aftermath, response and recovery. The aspects of the environment specifically noted in trauma theory include: community, social networks, individual preservation, and state of individual empowerment feeding into the family empowerment process. In a parallel fashion, through the lens of human ecology theory, the maternal experience of having a family with an emotionally impaired child, is affected by various aspects of the environment as well. The aspects of environment considered by human ecology include: community, natural supports (including family and friends), family preservation, and level and expression of family empowerment – all of which feed into the family empowerment process. The family empowerment process, in turn, feeds back into them.

This research will privilege women's knowledge and voices to explain that when mothers have both experiences of surviving trauma, and of mothering emotionally impaired children, there is fluidity between these experiences. Human ecology theory and trauma theory bridge to each other in their attention to the impact of environmental aspects that affect the functioning of mothers nested within their bodies, families, social networks, and communities. This

study will address that trauma experiences bridge to experiences of mothering an emotionally impaired child, and how the fluidity between these experiences and the aspects of the environment which affect them are related to the family empowerment process and its' outcomes of success and competency for families engaged in family-based services.

Figure 1.2: Feminist Theory Bridging Human Ecology and Trauma Theory.



Definition of the Terms

1. Mother

Theoretical: The woman who is the primary caretaker for the children of the family. She is acknowledged by the family as the "mother" in the family system. She may or may not be biologically related to the children.

Operational: The woman who is the primary caretaker for the children of the family. She is acknowledged by the family as the "mother" in the family system that is participating in intensive family-based services. She may or may not be biologically related to the children.

2. Trauma survivor (or "survivor")

Theoretical: Someone who has lived through events that generally involve threats to life or bodily integrity, or a close personal encounter with violence and death. Traumatic events confront human beings with the extremities of helplessness and terror and evoke the responses of catastrophe (Herman, 1997).

Operational: A woman and mother who has lived through sexual and/or physical abuse during her life. She also reports that the abuse she experienced was traumatic for her.

3. Family Empowerment

Theoretical: "A process by which the families access knowledge, skills and resources that enable them to gain positive control of their own lives as well as improve the quality of their lifestyles (Singh, 1995).

Operational: (process) The mother's self-perceptions about her participation, role, influence, value, decision-making and equal partnership in her child's mental health treatment reflect an empowerment stance concurrent with her involvement in seeking appropriate solutions for the problems that brought the family into the mental health service system.

Operational: (state of level and expression): Three levels of family empowerment (family, service system, community/political) reflected by the expressions about personal attitudes, knowledge and behaviors. The level and expression of family empowerment is measured by the Family Empowerment Scale (Koren, DeChillo & Friesen, 1992).

4. Survival skills

Theoretical: Survival skills are learned behaviors that were necessary for survival in an abusive relationship. These skills are generally acquired through childhood trauma experiences, and they usually continue into adulthood (e.g. hypervigilance, dissociation) (Dinsmore, 1991).

Operational: The informant's perception of her skills that helped her to survive her trauma experiences.

5. Success and competency

Theoretical: Accomplishment and capability. Outcomes in which the family remains intact, develops/utilizes a social support network in the community, and has positive experiences with family coping style and family functioning. These outcomes reflect the process of family empowerment.

Operational: Mother's report of good outcomes for herself or other family members who are actively participating in treatment. These outcomes may take place in the context of currently family-based treatment, or they may be in the past but perceived by the family as something to build on for future outcomes.

6. Community response

Theoretical: Public acknowledgement of the trauma experienced by the informant and community action taken (recognition and restitution) (Herman, 1997).

Operational: Informant's report and perception of public acknowledgement of the trauma and community action taken.

7. Intensive family-based services

Theoretical: Intensive family-based services requires a "whatever it takes" philosophy that reflects the need for flexibility and creativity in designing services that meet the needs of families. Families are viewed as partners in both the design and delivery of services. These intensive services include four program

components: family support services, therapeutic intervention, case management/service coordination, and emergency crisis intervention. These services have three goals: 1) preserve family integrity and prevent out-of-home placement, 2) link the child and family with appropriate community agencies to create an on-going community support system, and 3) strengthen family coping skills and capacity for effective functioning in the community (Linblad-Goldberg, Dore & Stern, 1998).

Operational: The family intervention team (FIT) program at Ionia County Community Mental Health that abides by the theoretical program description.

8. Child with Emotional Impairment (disturbance, disorder, or disability)

Theoretical: A child is designated as having emotional impairment and is considered as a candidate for intensive, family-based services by meeting one or more of the following criteria: A DSM IV – Axis 1 diagnosis; active suicidal, homicidal or psychiatric symptoms; high risk for abuse, molestation, and/or severe neglect; involvement in the juvenile court system; or a CAFAS – Child and Adolescent Functioning Assessment Scale (Hodges, 1994) score of 40 or higher.

Operational: The identified child receiving services through the family intervention team. This child meets the above theoretical criteria.

9. Mental Health Services delivery systems (or systems of care)

Theoretical: The Mental Health and Substance Abuse Working Group of President Clinton's Task Force on Healthcare Reform advanced a principle that ensures children and adolescents with serious emotional disorders are served within organized systems of care. Organized systems of care emphasize comprehensive and individualized services that are provided in the least restrictive environment, full participation of families, cultural competence, and organized network of community-based providers, management mechanisms, and coordination across multiple providers and child-serving systems (Hunter & Friesen, 1996; Pires & Stroul, 1996).

Operational : The services and programs of Ionia County Community Mental Health and its relationships with other child-serving systems in Ionia County, such as the intermediate school district, juvenile court and child protective services.

10. Community Supports

Theoretical: Community agencies participating in the treatment of the family and/or one or more of its' members. "Community supports," as discussed by Community Mental Health, are paid, formal supports that are described as the "service system" by Koren, DeChillo, & Friesen (1992). The service system involves the professionals and agencies that provide services to families (Koren, DeChillo, & Friesen, 1992).

Operational: As discussed in the interviews with research participants, community often involved the mental health service system, courts, schools,

police, and at times, neighbors. Women in the study described "community supports" as people who were involved in their larger contexts. Community supports were more formal than close friends or family members. They were people organized by geography (neighbors), organizations, or agencies. Community supports were viewed as people grouped within the community who were influential and could make a difference in the daily experiences of the mothers and their children.

11. Natural Supports

Theoretical: These include the "natural" resources and supports that are available to families including extended family, friends, and neighbors; as well as church, educational and recreational activities, civic activities and organizations (Lindblad-Goldberg, Dore & Stern, 1998).

Operational: Research participants discussed their natural supports as close friends, intimate partners, and family members only. The schools, churches, or other organized groups of people were viewed and discussed as "community supports."

12. Family-based service professional

Theoretical: A professional who provides intensive, family-based services. This person should have a graduate degree in a human service field and at least two years of clinical experience. The professional must be receptive to a systemic, strength-based orientation and provide services that implement the following

assumptions: all families have strengths, parents are essential partners in the therapeutic process, and that the professional never has all the answers. Family-based service professionals working as a team that is lead by an experienced supervisor is the preferred standard (Lindblad-Goldberg, Dore & Stern, 1988)

Operational: A Family Intervention Team Therapist at Ionia County Community Mental Health.

13. Social network support

Theoretical: Family, intimate partners, and close friends who provide emotional support to trauma survivors (Herman, 1997).

Operational: Trauma survivors reported experiences of emotional support from their family, friends, and intimate partners.

14. Individual empowerment

Theoretical: A process that enables individuals to gain control over their lives by influencing their interpersonal and social environments (Hasenfeld, 1987; Parsons, 1991; Rappaport, 1981; Zimmerman & Rappaport, 1988).

Operational: Informants' reported self-perceptions of: efficacy (Bandura, 1977, 1982), autonomy, personal worth, and connection (Herman, 1997).

CHAPTER TWO

Review of Literature

Introduction

This literature review will discuss the family empowerment research as it has evolved as an outcome for family-based services. The literature will demonstrate what is known about family empowerment, how it is measured, and what it means for families who are consumers of family-based services. Discussions of feminist principles and women's trauma experiences will be presented in relationship to consumers of family-based services.

The Family Empowerment Construct

Changes in treatment philosophy for Children's Mental Health have resulted in more children with serious emotional disabilities living with their families in the community (Heflinger & Bickman, 1996). The function of the family system is to facilitate interaction between the child and his or her community (Bronfenbrenner, 1979). For a family raising a child with serious emotional needs, often times the mental health service delivery system becomes an active participant with the family system. The relationship between parents and professionals is a central dimension of children's mental health services. It is a dimension to be examined and strengthened (Heflinger & Bickman, 1996).

The Child and Adolescent Service System Program (CASSP), housed in the Center for Mental Health Services within the Substance Abuse and Mental Health Services Administration of the Public Health Service, U.S. Department of Health and Human Services, has promoted the view of families as full

participants in all aspects of planning and delivery of services to children with serious emotional disorders. CASSP principles stress that the needs of families must be addressed in addition to the needs of the identified child mental health consumer (Stroul & Friedman, 1986; Vosler-Hunter, 1989; as cited in Hunter & Friesen, 1996).

Family empowerment is a goal that is central to efforts for improving services for families whose children have emotional disabilities. The emergence of the concept of family empowerment reflects developments in the growth of the consumer movement with its emphasis on self-help and self-reliance (Moxley, Raider, & Cohen, 1989), the application of practice models that focus on family strengths (Cochran, 1987; Dunst, Trivette & Deal, 1988; Poertner & Ronnau, 1992), the explicit addition of empowerment values within public policies and programs (Gallagher, Trohanis & Clifford, 1989; Stroul & Friedman, 1988), and the recognition that mental health services can be delivered in ways that promote self-efficacy (Koren, DeChillo & Friesen, 1992; Bandura, 1977; 1982; Dunst & Paget, 1991; Dunst & Trivette, 1987).

For children's mental health services professionals, the family empowerment process is defined by the delivery of services in ways that promote and maximize parental self-efficacy (Bandura, 1977). Family-based services specialize in child welfare and focus on the family as the target for intervention, rather than on the child or parents separately. The philosophy of family-based services is that the best way to provide services to a child is by strengthening and empowering his or her family as a unit (Berg, 1996). It is believed that

empowering parents by facilitating increases in parents' knowledge, skills, competencies and resources will increase parents' abilities to advocate for their children across various entities in the child service system. (Cunningham, Henggler, Brondino & Pickerel, 1999; Singh et al., 1997; Zimmerman & Rappaport, 1988). Family empowerment also involves the family as a partner in the decision-making and goal-setting process and uses the family's existing resources. Family-based services strive to enhance family members' sense of control and mastery that families have over their own lives (Berg, 1996; Koren, DeChillo & Friesen, 1992; Singh, et al., 1995; Singh et al., 1997). The result is that family members feel an increased sense of competency in conducting their lives, and can create a safe and nurturing environment for the children. They can make these gains and maintain the unique cultural and ethnic characteristics of their family unit. With such help, families are able to live independently with a minimum of outside interference (Berg, 1996). Generally, the state of family empowerment is evidenced by a family that perceives itself as being able to successfully negotiate the mental health services delivery system, utilize it to meet their needs, and finally transcend the need for assistance from it. However, the dynamic nature of empowerment is such that there can be no final state of empowerment. Family empowerment is simultaneously a product and a process (Curtis & Singh, 1996; Staples, 1990).

The Family Empowerment Scale (FES)

Empowerment has been described as both a process and a state, as both an individual and collective characteristic, as an attitude, perception, ability,

knowledge and action, and as a phenomenon that can be expressed in a range of circumstances and environments (Koren, DeChillo & Friesen, 1992). Much of the family empowerment literature is conceptual in nature and characterized by support for the underlying assumptions of the family empowerment model (Cunningham, Henggler, Brondino & Pickerel, 1999; Singh et al, 1995). To empirically examine the underlying assumptions of the construct of family empowerment, Koren, DeChillo & Friesen (1992) designed the Family Empowerment Scale (FES). The FES was designed to assess empowerment in parents and other family caretakers whose children have emotional disabilities, by providing a snapshot view of empowerment at one point in time. The FES framework consists of two dimensions: 1) the level of empowerment, and 2) the ways empowerment is expressed. The FES is designed to measure empowerment at the levels of: family, service system, and community. The FES is designed to measure the expression of empowerment in three ways: knowledge, behaviors, and attitudes (Koren, DeChillo & Friesen, 1992).

The FES is referenced in much of the family empowerment literature discussed in this review. The FES will be used in this study to support qualitative interview data, and will be discussed in greater detail in Chapter three.

Development of Empowerment

The authors of the Family Empowerment Scale, Koren, DeChillo & Friesen (1992), recommended that future research with the FES might include further exploration of the means by which parents gain empowerment and the various paths through which their empowerment may be pursued and developed. The

authors gave examples that some parents had reported to them that a particularly good relationship with a service provider was instrumental in their becoming more empowered. Other parents reported that poor services had a similar effect by serving as an impetus to actively search for better resources for their children and families. In either process, parents discovered inner strengths and abilities, becoming more empowered. "Clearly, the process of becoming empowered is a multifaceted one and little is known about it (Koren, DeChillo & Friesen, 1992)."

Singh and associates (1995) studied the empowerment status of two groups of families; those with children who had serious emotional disturbance, and those who had serious emotional disturbance combined with attention deficit/hyperactivity disorder (ADHD). In this study, 228 families completed the Family Empowerment Scale and provided demographic data concerning family composition, race, education, income, membership in a parent support group, and the mental health status of their children. Demographic variables were entered into a MANOVA model to predict empowerment status of families across the four factor subscales of the FES (determined by Singh and associates (1995) to be: systems advocacy, knowledge, competence and self-efficacy). The results indicated that membership in a parent support group was a strong predictor of family empowerment, particularly of the systems advocacy and knowledge dimensions of empowerment. The mental health status of the child affected levels of empowerment only on the self-efficacy scale, with parents of children having severe emotional disability combined with ADHD reporting more

empowerment on this dimension. This finding suggests that parents of children with combined mental health disabilities feel more empowered to utilize the mental health system to obtain the services that they need, and that the additional needs of these children may serve to motivate the parents to be more active in seeking services for their children. Findings also demonstrated that mothers report higher levels of family empowerment than fathers on all four subscales of FES. The largest difference between mothers and fathers occurred on the competence subscale, where fathers perceived themselves as less capable and confident in dealing with their children's disabilities. However, only 12% of respondents were fathers and only one parent from each family completed the FES. Data also indicated that respondents with less formal education reported feeling more empowered on the knowledge about the mental health services delivery system. These data representing level of completed education are difficult to interpret in and of themselves (Singh et.al, 1995).

In a follow-up study, Curtis and Singh (1996) investigated the socio-demographic correlates of family involvement in mental health services for children who have emotional and behavioral disorders. They also investigated the relationship between family empowerment and family involvement. The Family Involvement Scale – Family Version (FIS-F) was used to measure involvement of a sample of families receiving mental health services for their children. The Family Empowerment Scale (FES) was used to measure empowerment with the same sample. In addition, demographic data specifying family composition, race, level of education, income, membership in a parent

support group, and the mental health status of the children was also collected (Curtis & Singh, 1996).

The results showed that mothers, as well as respondents with less formal education, reported greater involvement in services for their children than fathers who were more educated. There had been no previous work examining gender differences in perceptions of family involvement, so this finding that highlights gender and level of education was difficult to interpret without additional data. In this sample, the number of fathers was small in comparison to the mothers. Only one parent from two-parent households completed the FIS-F, precluding direct comparisons between mothers and fathers in the same household (Curtis & Singh, 1996). Compared with research earlier discussed in this paper, authored by Singh, et al. (1995), which demonstrated that mothers report higher levels of family empowerment on two factors of the four factor structure solutions of the FES, it can be hypothesized that there is some process inherent in mental health services delivery systems that results in mothers' self-perceptions of greater empowerment and involvement in family-based services than fathers. Or, this finding may merely reflect society's expectation that mothers assume the primary responsibility for accessing services for their children (Curtis & Singh, 1996).

Curtis and Singh (1996) found that the knowledge subscale of family empowerment was moderately correlated with all subscales of family involvement, suggesting that parents' knowledge of mental health service delivery systems is critical to parent participation. However, the direction of this causality is not known. Personal empowerment was weakly correlated to the

Treatment subscale of family involvement. This indicated a relationship, though not a strong one, between parent perceptions of family empowerment at the personal level and their perception of involvement in treatment. This research established a link between family empowerment and family involvement. Curtis and Singh (1996) do not believe that there is a simple, linear relationship between family involvement and family empowerment to be demonstrated. The authors state their position is that there is an inseparable, reciprocal relationship between family involvement and empowerment. They hold the constructivist view that the active role of parents creates their cognitive, social and political worlds in a effort to access the best services for their children (Curtis & Singh, 1996).

Elliott, Koroloff, Koren & Friesen (1998), designed an outreach intervention intended for low-income families whose children had been identified as needing mental health services. The intervention was intended to engage families into mental health services and encourage recommended service continuance. It involved the use of paraprofessionals called "family associates." Family Associates served as guides for navigating the mental health service system, providing families with information, emotional support, and help overcoming specific barriers to services such as lack of transportation or appropriate child care (Elliott, Koroloff, Koren & Friesen, 1998).

The Family Associate Approach implemented a quasi-experimental research design, in which three Oregon counties implemented the Family Associate Approach and four Oregon counties continued with their mental health

services as usual. Counties were randomly assigned to the intervention or treatment group from three pairs of matched counties. The aim of the intervention was to test the effectiveness of using family associates who provided outreach, information and support to families initiating children's mental health services following a referral. Family associates were not mental health professionals, but were parents who had experience negotiating complex service systems on behalf of their own children (Elliott, Koroloff, Koren & Friesen, 1998).

The results of the study demonstrated that the Family Associate Intervention was effective in helping families initiate mental health services. In addition, the intervention was effective in helping families to improve their sense of empowerment as measured by the Family Empowerment Scale. Families in the intervention group scored significantly higher than families in the comparison group on both family and service-system subscales of the FES. For the family empowerment subscale, adjusted posttest means based on standard ANCOVA were 47.6 and 46., $F(1,200) = 7.99$, $p < .01$, $eta^2 = .03$ for intervention and comparison groups, respectively. For the service-system subscale, adjusted posttest means based on the standard ANCOVA were 50.9 and 49.3, $F(1, 200) = 4.43$. $p < .05$, $eta^2 = .02$ for intervention and comparison groups, respectively. No significant differences were apparent for the community/political empowerment subscale. These findings suggest that outreach at the point of entry into the mental health system may have a positive impact on a family's sense of mastery and ability to cope with difficult situations (Elliott, Koroloff, Koren & Friesen, 1998).

In addition, the findings from the study illustrated the complexities of barriers that families face to initiating and continuing with mental health services. Circumstances that affect low-income families, such as not enough food, clothing or money to pay for utilities, lack of transportation and child-care were discussed as contributing barriers to treatment (Elliott, Koroloff, Koren & Friesen, 1998).

Another study by Scheel and Rieckmann (1998) pursued an empirically derived description of parent self-efficacy and parent empowerment specific to the context of clinic-referred, emotionally or behaviorally disordered, preschool children. Parent self-efficacy and parent empowerment was assessed through the Family Empowerment Scale. Parent internal perceptions of stress, family functioning, stress due to child condition, and extrafamilial influences were considered in separate predictive models of parent self-efficacy and parent empowerment. The study sample of volunteer parents demonstrated through responses to the FES, that parents did tend to possess negative judgements of their abilities to effect changes in their interactions with family, the larger counseling agency, and with community/political systems. Results indicated that the parent possessing low self-efficacy tends to experience high levels of internal stress and is a member of a family which functions less adaptively and cohesively. Second, the parent who feels disempowered also tends to experience internal stress and is a member of a family that functions less adaptively and cohesively. Additionally, the disempowered parent tends to be less educated and may be unemployed (Scheel & Rieckmann, 1998).

Family Empowerment Linked to Family Functioning

Much of the literature has been directed to discussion of the definition of family empowerment, as well how to measure it, and individual, family, and family services program characteristics that are linked to empowerment. Linking empowerment to improved child and family functioning however, is at the heart of the prevailing emphasis on empowerment. It is imperative to demonstrate a relationship between services that embrace the treatment philosophy of family empowerment to improvement in clinical outcomes for children and families (Cunningham, Henggeler, Brondino & Pickrel, 1999).

Cunningham, Henggeler, Brondino & Pickrel (1999) examined two underlying assumptions of the family empowerment perspective: (1) that a well-validated family-based treatment that explicitly aims to empower caregivers can do so, and (2) that increased caregiver empowerment should be associated with improved youth and family functioning. The data used to examine these assumptions were based on a randomized trial of family-based, multisystemic therapy (MST) versus the usual community services for substance abusing or dependent juvenile offenders. The results provided partial support for the underlying assumptions of the family empowerment perspective. MST in comparison with the usual services increased caregiver perceptions of empowerment at the service system level, but not at the family level. Increased empowerment at the family and service system levels was associated with improved family relations, but not with decreased youth behavior problems (Cunningham, Henggeler, Brondino & Pickrel, 1999).

Family Empowerment Linked to Improvements in Child Adjustment

In a more recent study that targeted children and their parents receiving mental health services, Taub, Tighe & Burchard (2001) examined the relationships between family empowerment, children's mental health and longitudinal changes in family empowerment. Data from 131 children and their parents demonstrated that family empowerment increased significantly over time while a child was receiving mental health services. There was also a trend in which parent-reported community empowerment increased as well. Parents' reports of children's behavioral adjustments were found to correlate significantly with both family and service system empowerment as measured by the FES at follow-up, which took place approximately a month and a half after intake. With-in subjects analyses of the FES indicated that overall empowerment increased significantly over time, $F(1, 130) = 9.91$, $p<.005$, as did family empowerment, $F(1, 130) = 16,85$, $p < .005$). Service system and community empowerment subscales did not demonstrate improvement. The change in family empowerment over time was found to be a significant predictor of change in children's externalizing behavioral problems while in services. Discussion of this finding noted that it is equally plausible that children's decreased problem behaviors impacted by therapy, leads to increases in a sense of control and efficacy with parents (increased family empowerment) or that increased family empowerment within services leads to a decrease in children's problematic behaviors, or a combination of both (Taub, Tighe & Burchard, 2001).

In the same study, a different picture emerged that demonstrated no significant relationship between family empowerment and the internalizing problems of the children. It is supposed that internalizing problems pose much less of a burden on parents. The number of hours spent participating in mental health services was the only significant predictor of change in children's internalizing problems. Though the design does not allow inference of causality, it is more likely that hours of mental health service led to a reduction in internalizing problems. Emotional problems such as depression, anxiety or withdrawal may very well be unlikely to be influenced by parental efficacy and control, or conversely, improvements with internalizing problems may also appear not to affect parents' sense of empowerment (Taub, Tighe & Burchard, 2001).

The literature demonstrates support for the impact of family-based services that embrace a family empowerment outcome philosophy. Simultaneously, the many complexities that occur with conceptualizing and operationalizing family empowerment as an outcome for family-based services are clearly evident. Gender has been discussed in relationship to increased levels of family empowerment (Curtis & Singh, 1996; Singh et al., 1995). Varying explanations have been hypothesized for this phenomenon, but no causal inferences have been made. Parent history of trauma has not been explored in relation to levels of family empowerment.

Feminism and Empowerment

Feminist analyses of empowerment begin with critiques about the gendered characteristics of knowledge construction. Knowledge is constructed from the standpoint of the privileged. It is objectified, abstract, and decontextualized from the context in which it occurs. Knowledge tends to be organized in logical dichotomies that make contrasts on some sort of continuum. Mainstream knowledge views the individual as the unit of analysis (Sprague & Hayes, 2000).

A criticism of empowerment is that it has been about the abstract individual, while real people with disabilities live lives marked by gender, race and class relations. Where people fall on these characteristics and other dimensions of inequality shape the resources they can draw and the constraints they face. For people who are marginalized by inequality, to be empowered requires that members of all marginalized groups are empowered (Sprague & Hayes, 2000).

Feminist writings argue that the way to begin to talk about empowerment is from the standpoint of women and the disadvantaged. This allows us to think of power as a capacity and to see people struggling to create and enact their selves in the context of the social relationships in which they live their daily lives (Sprague & Hayes, 2000). A feminist view of empowerment suggests a need to place the subject's interpretation and mediation of her experiences at the center of our inquiries into the how and why of power (Deveaux, 1994). Empowerment can be understood as a person's perceived and actual ability to determine one's

life and community. It concurrently involves one's individual sense of potency as well as one's demonstrated power to influence, in relationship with others, the conditions and contexts of daily existence. Feminists also believe in the importance of drawing the distinction that empowerment is the "power-to." This is in contrast to having "power-over," which instead focuses on controlling others (Yoder & Kahn, 1992). Empowerment is a series of attacks on subordination of every description (Simon, 1990). The definition of empowerment is two fold in that it involves both the individual and the community revisioning and reformulating the conditions of daily life (Tretheway, 1997).

Feminist social work practice assumes that full empowerment of women will not occur unless women are empowered on both an individual and a community level (Bricker-Jenkins, 1992; Gottlieb, 1992). Empowerment is best fostered in contexts where problems are not viewed solely as personal deficits, but also as consequences of the failure of contemporary society to adequately meet the needs of all persons (Bricker-Jenkins, 1992). Political analyses of personal problems and empowerment of women clients can enhance whatever else occurs in the course of service delivery (Gottlieb, 1992).

Trauma and Empowerment

Violence against women is a worldwide problem. Most women have a hard time imagining freedom from the threat of harassment, battering, and sexual assault. Violence is deeply embedded in our culture and it is a part of women's lives (The Boston Women's Health Book Collective, 1998). In the United States, FBI statistics indicate that every fifteen seconds a woman is beaten by her

husband or boyfriend. Every six minutes a woman is forcibly raped. One in three American women are sexually assaulted during her lifetime. One fifth to one half of American women were sexually abused as children, most of them by an older, male relative (The Boston Women's Health Book Collective, 1992). Allard, Albelda, Colten & Cosenza (1997) found that nearly two-thirds of women who receive public assistance have been abused by an intimate partner at some time in their adult lives (as cited in The Boston Women's Health Book Collective, 1998).

Any given family-based services program is but one component of the system each community has developed to respond to the needs of its families and children (Pecora, Fraser, Nelson, McCrosky & Meezan, 1995). The Family Intervention Team program at Ionia County Community Mental Health estimates that approximately 90 percent of mothers participating in intensive, family-based services over the past year have reported experience of traumatic of physical and/or sexual abuse in their histories.

Central to the role of victims of trauma in any given society are the demands that they place on the community's moral and economic resources. Contrary to general perceptions, few trauma victims make demands for compensation and special privilege. Many victims are quiet in their suffering and are constrained by their sense of shame and helplessness, as well as by a need to maintain self-respect and independence. Others noisily reenact their traumas either by retraumatizing themselves or traumatizing others, both inside and outside their own families (McFarlane & Van Der Kolk, 1996).

Most trauma victims who are conscious of the effects of trauma on their lives preserve their self-protective instincts and are highly ambivalent about having people find out what happened to them. For example, rape victims are typically aware that they run the risk of not being believed, of being blamed for the rape, and of having their sexuality exposed and scrutinized. Public admission of domestic violence can be made difficult due to feelings of shame about not being loved by one's spouse, about being unable to protect oneself and one's children, about admitting one's physical and financial powerlessness, and about failing to bring happiness and security to one's family. In domestic and dating relationships, it can be difficult to discern between appropriate trust and carelessness or failure to protect oneself. The question of where to place the locus of responsibility for self-protection is at the heart of the social issues that are stirred up by post-traumatic stress. Intimate violence may necessitate conspiracies of silence; true and false accusations; and failures to take responsibility for violent, provocative, and humiliating behavior (McFarlane & Van Der Kolk, 1996).

If memories of child abuse, domestic violence, and torture are not worked through, they tend to be expressed as irrational symptoms, or behaviors that represent derivations of unresolved aspects of the trauma. People who have lived in abusive environments for long periods of time, may have never learned, or may have forgotten the rules of civil conduct. The confusion and helplessness of many trauma victims are expressed in passivity and failure to take responsibility. Patterns of fear and dissociation may interfere with the capacity to

communicate feelings and wishes. When traumatized persons feel threatened, their attitudes may express fear of abandonment or compliance with their abusers. Passivity and helplessness may alternate with outbursts of rage and resentment. Neither passivity nor intimidation leaves room for mutuality and responsiveness to other people's needs (McFarlane & Van Der Kolk, 1996).

Since both trauma victims and witnesses experience intense emotions when confronted with passive or intimidating behaviors, they are likely to lose sight of the fact that the behavioral roots are in past trauma. Both will construct complex rationales to justify their reactions. Often these take the forms of elaborate grievances for the victims and diagnostic constructs for the witnesses. Both return a sense of control to the parties involved. Ironically both are likely to perpetuate the trauma in their interpersonal relationship, which is dichotomized in terms of dominance and submission. After the breakdown of collaboration and self-protective reserve, the results are that one person will be seen as powerful, and the other as powerless. The trauma will continue to be played out between victims and oppressors. Calling victims "survivors" is a euphemism that denies the reality of these dichotomies of powerlessness (McFarlane & Van Der Kolk, 1996).

Reason and objectivity are not the primary societal reactions to traumatized people. Unfortunately, society's reactions seem to be primarily conservative impulses in the service of maintaining that the world is fundamentally just, that people can be in charge of their lives, and that bad things only happed to people who deserve them. Societies tend to be suspicious that

victims will contaminate the social fabric, undermine self-reliance, consume social resources, and live off of the strong. The weak are viewed as a liability and after an initial amount of compassion, are vulnerable to being singled out as parasites and carriers of social malaise. Society can only make a commitment to victims if it accepts the following two ideas: "(1) that victims are not responsible for the fact that they were traumatized; and (2) that if victims are not helped to deal with the memories of their trauma, they will become violent and anxious people, unreliable and easily distracted workers, inattentive parents, and/or people who use drugs and alcohol to help them cope with unbearable feelings (McFarlane & Van Der Kolk, 1996)."

The abuse histories of women, and in this case mothers, reflect not only personal histories, but the larger picture of violence against women in our culture (Dinsmore, 1991). Therefore it is an irony that the response of the community has a powerful influence on the ultimate resolution of the trauma. Restoration of the breach between the trauma survivor and the community depends upon public acknowledgement of the trauma and upon some form of community action to assign responsibility for harm or to repair the injury (Herman, 1997).

The impact of the suffering of trauma victims and on observers makes it difficult to maintain an objective stance about the effects of trauma. Yet in order to fully comprehend the effects of trauma, and in order to find out what constitutes truly effective treatment, scientific methods need to be applied to transform subjective experience into empirical data. Research does not want to lose perspective of the suffering, or obscure the personal experience of trauma,

but the components of people's responses to trauma need to be observed in efforts to analyze the complexities of trauma experiences and responses, and thus be able to plan effective interventions and treatment. Studies of trauma should allow data to emerge that will help clinicians to face the realities of trauma and its effects on the human community (McFarlane & Van Der Kolk, 1996).

Conclusions

The literature has established the prevalence of violence against women in our culture and acknowledged various levels of oppression experienced by women. Viewed largely as functions of our culture, marginalization of women and obstacles to women's power are prevalent in all levels of our contexts (The Boston Women's Health Book Collective, 1992; Dinsmore, 1991; Sprague & Hayes, 2000). The philosophy of family empowerment embraces the idea of facilitating a "power to" with families who are struggling and seeking help from children's community mental health services. It is important to begin to address the gaps in the research that do not acknowledge the particular obstacles to empowerment that women may face in their daily lives with their families, social networks, and communities.

The history of abuse and the experience of having an emotionally impaired child both lead to discussion of the construct of empowerment as a desired outcome for improved individual and family functioning. Both experiences underline the role of the community as essential in a person's gaining the "power to" influence one's environment by the use of knowledge, skill and self-efficacy. It is essential for those who embrace a family empowerment

treatment philosophy to begin to explore how women's experiences of trauma affect their experiences of getting help for their families and children through family-based services.

CHAPTER THREE

Research Design and Method

Introduction

Chapter three contains a description of the research procedures that were used in this study. The topics addressed in this chapter include the rationale for qualitative method, research design, validity concerns and data analysis.

Methodology and Research Design

This is a triangulated qualitative study that includes interviews and assessments. Triangulation refers to combining methods or sources of data as a way to enhance understanding of the setting and the people being studied (Taylor & Bogden, 1998). Layers of information are added to the study by using one type of data to validate another. Feminist researchers combine many methods so as to cast their net as widely as possible in the search for understanding critical issues in women's lives. Triangulation of data also serves to support the scientific status of research and increase its utility to readers (Reinharz, 1992).

Sixteen mothers participating in the Family Intervention Team services at Ionia County Community Mental health were interviewed. These mothers, who have at least one child considered to have emotional impairment, reported a history of having been traumatically physically and/or sexually abused. The research process involved one in-depth, semi-structured interview with each mother. The interviews addressed mothers' knowledge and experiences with the

intersection of trauma history and levels of family empowerment in relation to their participation in intensive family-based services. The interview questions were designed to capture the following concepts related to maternal participation in family-based services: the role of community supports, the role of natural supports, relationships with family-based service professionals, and the level and expression of family empowerment. The following aspects of maternal trauma experiences and survival were explored in the interview: community response to trauma, social networks as supports for trauma recovery, survival skills, and perceived levels of individual empowerment in relationship to trauma survival. Data from the interviews were tape-recorded, transcribed and analyzed by manual techniques. The Family Empowerment Scale (Koren, DeChillo & Friesen, 1992) was administered and informants' responses were used to support and clarify the qualitative interview data.

Rationale for Qualitative Research

The nature of this research problem is best addressed through qualitative research. Qualitative research develops concepts, insights and understandings from patterns in the data rather than collecting data to assess preconceived models or theories (Taylor & Bogdan, 1996). Since the maternal experience of trauma in relationship to family empowerment has not been explored in previous research, qualitative methods provide an appropriate framework by which to allow the data to emerge.

Qualitative methods produce descriptive data – people's own written or spoken words and observable behavior. Qualitative research is concerned with

the meanings that people attach to things in their lives. Qualitative research develops concepts, insights and understandings from patterns in the data. Informants are viewed holistically, respectfully, and in their everyday lives. Qualitative methods are designed to ensure a close fit between the data and what people actually say and do (Taylor & Bogden, 1995).

For research involving family-based services, qualitative methods allow researchers to "look at intangible issues of importance to practitioners, including the 'meaning' of service; how families experience family-based services; and whether families feel empowered by them (Pecora, et al., 1995)." These methods may be more congruent with clinical ways of knowing and evaluating peoples' experiences (Pecora, et al., 1995).

Qualitative approaches are congruent with family-based services principles. Evaluation undertaken from the qualitative perspective produces a comprehensive view of what is important from the perspectives of major participants in the helping process. Maximum power remains with the informants, who shape both evaluation questions and results. The most important advantage of qualitative methods for the family-based services field is that the interpretive results are less reductionistic than quantitative methods (Pecora, et al., 1995).

Additionally, there has been feminist support for the use of qualitative methods in research. Feminist enthusiasm for qualitative research stems from the understanding that many aspects of women's experience have not been articulated or conceptualized within social science. Feminists have advocated for

the use of qualitative methods that permit women to express their experiences fully and in their own terms (Epstein Jayaratne & Stewart, 1991).

Other feminist researchers have argued however, that it is not the method of research, but the ways in which research participants are treated and the care with which researchers attempt to represent the lived experience of the research participants that are of central concern. An inclusive view on methods, which has been increasingly accepted in feminist research, takes the form of promoting the value and appropriate use of both qualitative and quantitative methods as feminist research tools. Combining methods, or "triangulation," permits researchers to capture a more complete, holistic and contextual portrayal of the lived experience of the informants. Triangulation is effective because the weaknesses in each single method are counterbalanced by the strengths of the other (Jick, 1979; Epstein Jayaratne & Stewart, 1991).

Perspectives on feminist research methods increasingly emphasize multiplicity, inclusivity, and plurality of voices and methods (Myers Avis & Turner, 1996). It is essential for researchers to be aware of the values and assumptions inherent in particular research methods and that researchers examine their work for its underlying values and assumptions (Riger, 1992). Feminist researchers acknowledge the power within the researcher role, and recognize that they are part of a larger political system, to include those surrounding the research endeavor (Myers Avis & Turner, 1996).

Innovative feminist research methods are characterized by the researcher's awareness of her own personhood and involvement (Reinharz,

1992). Feminist research frequently includes the researcher as a person, emphasizing the researcher's involvement in conceptualizing and implementing the research (Myers Avis & Turner, 1996). The clinical experiences of this researcher, also a family-based services therapist, have inspired this investigation that examines the relationship between trauma and family empowerment for mothers in family-based services.

Relationships between the researcher and research informants are at a minimum, highly respectful, open and nonexploitive. Feminist research often involves a high degree of researcher-participant rapport and effort to level the power hierarchy between researcher and the research participant (Myers Avis & Turner, 1996).

Feminist perspectives and family-based services principles are synchronous with emphases on respectfulness, lived experience and holistic conceptualizations. Both draw distinctions regarding power hierarchies embedded in the research process, and seek to level them. Qualitative methods and triangulation of data can accommodate these perspectives and principles. Utilizing qualitative research and triangulation will provide an opportunity to examine women's interpretation of their experiences with trauma, family-based services and family empowerment.

Feminist Interview Method

The use of semi-structured interviews has become the principle means by which feminists have sought to achieve the active involvement of their informants in the construction of data about their lived experience. Open-ended research

explores people's views of reality and allows the researcher to generate theory. Feminist interview research produces nonstandardized information that allows researchers to notice differences among people. Interviewing offers researchers access to informants' ideas, thoughts and memories in their own words, rather than in the words of the researcher. This is a particularly important method for the study of women because in this way learning from women is an antidote to centuries of women's knowledge and experience being ignored or oppressed (Reinharz, 1992).

Interviewing women is consistent with female socialization processes of asking people what they think and feel. Interviewing is also consistent with many women's interests in avoiding control over others and developing a sense of connectedness with people. Feminist interview studies modify social science concepts and create important new ways of seeing the world. By listening to women speak, understanding women's membership in particular social systems, and establishing the distribution of phenomena accessible only through sensitive interviewing, feminist interview researchers uncover previously neglected or misunderstood worlds of experience (Reinharz, 1992).

This project seeks to inform family-based services providers of the needs of mothers who have survived trauma in relationship to family empowerment outcomes. This project also aims to be relevant to families who endure multiple stresses with mothers who survive trauma by incorporating relational and societal barriers to women's power and freedom into the exploration of family empowerment. It is important to enlist women's participation to inform mental

health services systems of care of women's strengths and needs that exist in the contexts of their daily lives.

Sampling

Feminist research perspectives declare that the inclusion of women's voices is the most important aspect in sampling. Recognizing women's experience serves as an antidote to decades of research in which women's perspectives have been left out or obscured. Existing imbalances are addressed by giving voice to those who have been excluded or silenced in the past and by studying those who have not been studied previously (Myers Avis & Turner, 1996).

The purpose of this sample selection seeks to place women's interpretation of their family empowerment experiences at the center of inquiry. Family-based services literature acknowledges the multiple stresses experienced by its consumers, and describes many cases involving violence against women (Berg, 1994; Boyd-Franklin & Hafer Bry, 2000; Lindblad-Goldberg, Dore, Stern, 1998; Pecora et al., 1995). Women who have lived these experiences have not had the forum to discuss the impact of their trauma experiences on their participation in family-based services with family empowerment outcome. This sample has been selected to add women's knowledge and experience to the existing family empowerment research.

In an interviewing study, sample size is something that should be determined toward the end of the research, and not at the beginning. Generally, there is an inverse relationship between the number of informants and the depth

to which you interview each (Taylor & Bogden, 1998). "To the question, 'How many interview subjects do I need?' The answer is simply, 'Interview as many subjects as necessary to find out what you need to know (Kvale, 1996; as cited in Taylor & Bogden, 1998).'" The amount and quality of the information gleaned from 16 interviews was sufficient to address the topic of inquiry for this study.

The sample was selected by purposive sampling, a nonprobability sampling technique (Pecora et al., 1995). Purposive sampling was used to identify mothers participating in family-based services at Ionia County Community Mental Health who self-report a history of physical and/or sexual abuse and being the primary parent to their emotionally impaired child or children.

The sample consisted of 16 mothers participating in services offered by the family-based services, Family Intervention Team (FIT) at Ionia County Community Mental Health. The criteria for informants included: mother participating in family-based services with identified emotionally impaired child or children, mother reports that she is the primary parent of the identified child or children, and mother self-reports a history of surviving physical and/or sexual abuse to her family-based services therapist. Mothers in the sample were all over 18 years of age and participated voluntarily.

Informants ranged in age from 28 to 52 years old. Eleven of the women were employed in service or paraprofessional positions, either full or part-time. The number of years of completed education for the informants ranged from 9 years to 15 years, with a mean of 12.7 years. Twelve women reported to have

Medicaid coverage for their children, while six out of those 12 women also have Medicaid coverage for themselves. Fifteen of the women reported that they are currently involved in a relationship with a male partner.

Between the 16 mothers, there were a total of 63 children. The children ranged in age from 6 months gestation to 33 years old, with a mean age of 12.79 years. Mothers reported that 43 out of the 63 children had experienced either physical and/or sexual abuse. Four mothers reported having abused their own children in the past. Twelve of the mothers reported having been abused by a perpetrator who also abused their child or children. Eight of the children in the sample were reported to have been conceived out of rape. All informants reported having at least one child who was violent, physically abusive, or threatening in their homes. Four of the children in the sample were suspected of juvenile sex offending.

All sixteen mothers that comprised the sample reported that their abuse experiences were traumatic. Twelve of the women listed more than one perpetrator of abuse in their histories. Eight of the women reported being abused incestuously. See Table 3.1 for sample information and abuse histories.

All informants reported satisfaction with the family-based services in which they were participating. The length of time that mothers and their families had been participating in family-based services spanned from 3 weeks to 4 years, with an average of 1.1 years. The amount of contacts that a family-based therapist had with each family per week, appeared to be under-reported, at an average of 1.5 contacts per week.

Table 3.1: Sample

Informant	Age	Years of Ed.	No. of Children	No. of children with abuse history	Child(ren) were abused by perp. who abused mother	Mother's abuse history CPA=child physical abuse CSA=child sexual abuse (includes rape of a child) ADV= adult domestic violence (adult is physically assaulted) ASA=adult sexual abuse (includes rape of adult)
1. Amy	32	14	5	5	Yes	CPA: stepdad, stepmom, foster parent CSA: Stepdad ASA: Stepdad ADV: Stepdad INCEST
2. Betty	35	12	2	2	No	CSA: mother's boyfriends
3. Carla	40	13	7	3	No	CPA: uncle CSA: stepgrandfather, family friend ADV: Husband INCEST
4. Dani	38	9	5	4	No	CPA: mother CSA: stepfather INCEST
5. Eve	31	12	5	3	No	CPA: aunt, cousin CSA: uncle, cousin ADV: boyfriend INCEST
6. Fran	33	14	4	2	Yes	ADV: ex-husband CSA: brothers INCEST
7. Grace	28	13	4	3	Yes	CPA: father ADV: exfiance, child's father, CSA: Uncle, neighbor ASA: acquaintance, husband INCEST
8. Helen	33	12	7	1	Yes	CPA: parents CSA: babysitter, family friends, uncle ADV: ex-husband INCEST
9. Iris	42	14	3	3	Yes	ADV: ex-husband
10. Jen	30	13	2	1	Yes	CSA: dad, grandpa ADV: ex-boyfriend INCEST
11. Kim	37	15	3	2	Yes	CPA: father ADV: ex-husbands CSA: neighbor's friend
12. Laura	52	10	5	4	Yes	ADV: 2nd husband (ex)

Table 3.1 (cont'd)

Informant	Age	Years of Ed.	No. of Children	# of children with abuse history	Child(ren) were abused by perp. who abused mother	Mother's abuse history CPA=child physical abuse CSA=child sexual abuse (includes rape of a child) ADV=adult domestic violence (adult is physically assaulted) ASA=adult sexual abuse (includes rape of adult)
13. Mia	41	12	3	3	Yes	CPA: dad ASA: unknown perp. ADV: husband, ex-boyfriend, ex-husband
14. Nora	31	12	2	1	Yes	ADV: ex-husband
15. Olivia	43	14	3	3	Yes	ADV: ex-husband ASA: ex-husband
16. Patti	38	14	3	3	Yes	CSA: neighbor ADV: husband

Selection of Informants

Informants were recruited by their therapists, based on maternal self-reports of a history of physical and/or sexual abuse; and self-identifying as the primary parent to the child or children having an emotionally disability. Family Intervention Team (FIT) therapists at Ionia County Community Mental Health were provided with letters (see Appendix G) to give to current families participating in FIT services. The letter was from the Family Intervention Team to inform families of the study and invite all mothers who are abuse survivors to participate. A recruiting advertisement (see Appendix H) was also made available to all families as a follow-up to the letter. Both the letter and the advertisement clarified eligibility, that participation was voluntary, and that receipt of FIT services would not be affected by participation. Interested subjects were given the option to either phone the researcher with any questions, have the researcher phone them, or to set up an appointment time via their therapist. The researcher and the FIT therapists informed potential research participants that their choices about participation in the study would not affect their receipt of services in any way.

Compensation

The majority of families receiving services from the Family Intervention Team are reportedly living in poverty. Mothers who participated in this study each received a $10 gift certificate to Meijer's Supermarket as compensation for their time.

Human Rights Protections

Talking about trauma experiences may prove to be difficult for some women. The researcher specified to informants, with both spoken and written words, that they could withdraw their consent to participate at any time during this study. At the time of data collection, all informants were involved in therapy, and were reminded to contact their therapist or this researcher if they experienced emotional duress from their participation in this study. They were reminded of the agency after-hours crisis telephone service available to consumers of family-based services as well.

Confidentiality

The researcher and Family Intervention Team therapists were the only people able to identify eligible participants. In this case, all clinicians were bound by legal and ethical standards of confidentiality, not to mention standards of care declared by Ionia County Community Mental Health.

The informants' identities were kept confidential and reports of research findings do not associate informants with specific responses or findings. Data are not identified by informants' names or any other identifying information (i.e. specific demographic information). Only the researcher and the transcribing resource heard taped interviews. All written and audio-taped materials are kept in a locked filing cabinet to further ensure confidentiality. Informants were requested to consent to the use of research findings and requested to sign a consent form (see Appendix E). The transcriber also signed a confidentiality form (see Appendix F).

As previously noted, there were potential psychological risks involved in this research project due to discussion of trauma that may have proven distressing to some informants. Steps were taken to maintain confidentiality of informants. Research informants are referred to by pseudonyms in this study, and other identifying information has been altered. Research participants were informed that at any time they could withdraw from the project or decline to answer any question. All informants signed consent forms, which explained the project and participants' rights. The researcher verbally stated and explained the consent form to each informant and gave them the opportunity to look it over and ask questions prior to beginning the questionnaires and the interview. Fifteen of the women consented to have their interviews audio-taped. The informant who did not agree to the audio-taping requested to participate in the interview with the researcher taking field notes only. Informants were reminded of their therapists' availability, the researcher's availability, and the after-hours crisis line if they experienced emotional difficulty following their participation in this study.

Data Collection Procedure

Data were primarily collected through the use of semi-structured interviews. Interview data will be discussed and supported with supplemental data gathered from three questionnaires.

Instrumentation

A demographic questionnaire (see appendix A) was used before the beginning of each in-depth interview. This questionnaire included questions regarding ages of informants, ages of children, socioeconomic status, living

arrangements, and family-based services participation. An abuse questionnaire (see appendix B) designed by the Family Intervention Team was then administered. This questionnaire targeted the types of abuse experiences that the mother and other family members have had. Both the demographic questionnaire and the abuse questionnaire were used to describe the characteristics of the sample, which included information about family history of abuse experiences.

The Family Empowerment Scale (Koren, DeChillo & Friesen, 1992) (see appendix C) was the final questionnaire that informants completed prior to the interview. It was administered to address the level and expression of family empowerment for the informants in this study. Discussion of the scale will follow.

The Family Empowerment Scale (FES).

The FES was designed to assess empowerment in parents and other family caretakers whose children have emotional disabilities, by providing a snapshot view of empowerment at one point in time (Koren, DeChillo & Friesen, 1992).

The FES consists of 34 items designed to reflect two dimensions of family empowerment (Figure 3.1): 1) the level of empowerment, and 2) the ways that empowerment is expressed (Koren, DeChillo & Friesen, 1992). With regard to the first dimension, there are three domains in which parents and family caretakers can express and achieve empowerment: their immediate families, the service system as it directly affects their children and families, and the community as it affects their children and families in general. Expressed

empowerment within the immediate family pertains to a sense of efficacy in handling difficulties at home and managing daily circumstances. Empowerment with respect to the service system involves parents' working actively with the professionals and agencies that provide services to the family and identified child to obtain appropriate services. Community/political empowerment signifies efforts to improve services for families and children in general; primarily involving parents' advocacy for children in general (Koren, DeChillo & Friesen, 1992; Elliott, Koroloff, Koren, & Friesen, 1998).

According to the second dimension, there are three ways to express family empowerment: 1) Attitudes: what a parents feels and believes; 2) Knowledge: what a parent knows and can potentially do; and 3) Behaviors: what a parent actually does. Each of these types of expressed empowerment can occur within each category of the level dimension. Figure 3.1 displays the conceptual framework and item stems for the Family Empowerment Scale (Koren, DeChillo, & Friesen, 1992).

Factor analysis was done to examine the correspondence between the factor structure and the conceptual framework for the FES. The findings from the factor analysis generally provided support for the items on the level dimension of the conceptual framework. The strongest factors were defined mainly by items that were associated with only one category on this dimension – either family, service system, or community/political. However, the correspondence of factors to the expression dimension of the framework was minimal. Only one factor was defined by a core of items from the knowledge category of the expression

dimension. Empirical distinctions among attitudes, knowledge and behaviors were overshadowed by stronger differences among the levels of empowerment. Therefore, the results from the factor analysis support the strategy of scoring the FES based on the level dimension of the instrument (Koren, DeChillo, & Friesen, 1992).

The development of the FES (Koren, DeChillo, & Friesen, 1992) followed standard scale construction techniques. The FES analyses were based on responses from 440 parents of children less than 21 years of age. The majority of the parents in the sample were female (94%), white (92%), and the biological or adoptive parent of the child (89%). Reliability was addressed through an examination of the internal consistency (r = .87 to .88) and temporal stability of FES subscores (3-4 weeks stability) (Koren, DeChillo, & Friesen, 1992; Early, T. J., 2001). Validity was addressed through panel ratings of item content with respect to the empowerment framework, factor analysis of item responses, and analysis of group differentiation based on subscores (Koren, DeChillo & Friesen, 1992).

There continues to be discussion regarding the conceptual framework of the FES. Singh et al. (1995) holds the view that the concept of empowerment is still in development and little consensual agreement on its' nature and definition exists. Because strong support for the expression dimension was lacking, Singh and associates (1995) did not follow the Koren, DeChillo, & Friesen (1992) conceptual framework. Through factor analysis, four components of the concept of empowerment were found and redistributed among the three subscales of the

level of empowerment dimension more strongly supported by Koren, DeChillo & Friesen (1992). The four-factor solution that emerged was: systems advocacy, knowledge, competence, and self-efficacy (Singh, et al., 1995). Despite concerns over the developing conceptual framework, empirical analyses of the FES produced positive findings on its psychometric properties, suggesting that key aspects of parents' and other family caregivers' empowerment can be measured in a valid and reliable fashion (Singh, et al., 1995; Koren, DeChillo & Friesen, 1992). For the purposes of this study, the FES will be used in accordance with its' construction by Koren, DeChillo & Friesen (1992).

The framework of the FES has substantial relevance to evaluating the effects of service interventions (Elliott, Koroloff, Koren, & Friesen, 1998). In the process of the collaborative relationship between mental health service providers and consumers of mental health services, a critical first step is the recognition by professionals that parents are competent, valued, and knowledgeable, especially regarding the needs of their children. It is the professional's responsibility to restructure the service delivery system so that families may increase their social power and be able to access the services and resources that they need. One way to measure how well the professionals have made the mental health service delivery system more family friendly is by measuring family empowerment (Singh, et. al, 1995).

Figure 3.1: The Family Empowerment Scale and Item Stems.

	Level		
	Family	Service System	Community/Political
Attitudes	- I feel confident in my ability to help my child grow and develop. (4) - I feel my family life is under control. (9) - I believe I can solve problems with my child when they happen. (21) - I feel I am a good parent. (34)	- I feel that I have a right to approve all services my child receives. (1) - My opinion is just as important as professionals' opinions in deciding what services my child needs. (18) - Professionals should ask me what services I want for my child. (32)	- I feel I can have a part in improving services for children in my community. (3) - I believe that other parents and I can have an influence on services for children. (17) - I feel that my knowledge and experience as a parent can be used to improve services for children and families. (25)
Knowledge	- I know what to do when problems arise with my child. (7) - I am able to get information to help me better understand my child. (16) - When I need help with problems in my family, I am able to ask for help from others. (26) - I have a good understanding of my child's disorder. (33)	- I know the steps to take when I am concerned my child is receiving poor services. (5) - I am able to make good decisions about what services my child needs. (11) - I am able to work with agencies and professionals to decide what services my child needs. (12) - I know what services my child needs. (23) - I have a good understanding of the service system that my child is involved in. (30)	- I understand how the service system for children is organized. (10) - I have ideas about the ideal service system for children. (14) - I know how to get agency administrators or legislators to listen to me. (22) - I know what the rights of parents and children are under the special education laws. (24)
Behaviors	- When problems arise with my child, I handle them pretty well. (2) - I make efforts to learn new ways to help my child grow and develop. (27) - When dealing with my child, I focus on the good things as well as the problems. (29) - When faced with a problem involving my child, I decide what to do and then do it. (31)	- I make sure that professionals understand my opinions about what services my child needs. (6) - I make sure that I stay in regular contact with professionals who are providing services to my child. (13) - I tell professionals what I think about services being provided to my child. (19) - When necessary, I take the initiative in looking for services for my child and family. (28)	- I get in touch with my legislators when important bills or issues concerning children are pending. (8) - I help other families get the services they need. (15) - I tell people in agencies and government how services for children can be improved. (20)

Figure 3.1 Conceptual framework and item stems for Family Empowerment Scale. (Numbers in parentheses indicate item numbers.) (Koren, DeChillo & Friesen, 1992).

In-depth Interviews.

In-depth, semi-structured interviews are open-ended interviews that explore people's views and ways of knowing in their own terms (Reinharz, 1992). In-depth, semi-structured interviews were conducted with each informant as the primary data-gathering tool. A semi-structured interview guide was used (see appendix D). Interview questions were developed to address each research question to allow women's voices of knowledge and experience to reflect their realities. Figure 3.2 displays the interview questions as they correspond the nine research questions proposed for this study. How do mothers' trauma experiences and survival affect their participation in intensive family-based services?

Figure 3.2: Research Questions Connected to Interview Questions and the FES.

Research Questions	Interview Questions
1. How do mothers' trauma experiences and survival affect their participation in intensive family-based services?	1. How do you feel you trauma experiences may affect how you live your daily life? 2. How might your trauma experiences affect your participation in FIT services? 3. In what ways do your trauma experiences affect your ability to trust or feel safe in therapy?
2. How do mothers' perceptions community support for their families with emotionally disabled children relate to maternal experiences with community response to trauma?	1. How did the community respond (e.g. court police, schools, etc.) to your trauma? 2. How has the community responded to your child(ren)'s behavioral and emotional needs? 3. How has the community response been the same in each situation? 4. How has the community response been different in each situation?
3. What is the relationship between mothers' social support networks that help them cope with trauma experiences and natural supports that mothers' turn to for help in coping with family problems involving their children?	1. Who did you turn to for help or comfort when you experienced abuse? 2. Who do you turn to now when you need help coping with your child(ren)'s behaviors? 3. How come these people are the same (or different)?
4. How do survival skills of mothers who are trauma survivors affect the process of "partnering" with mental health professionals to achieve increased family empowerment?	1. (Define survival skills.). What survival skills do you notice that you have? 2. How do your survival skills help you work with your therapist and participate in FIT? 3. How do your survival skills help you know what your family needs and set goals? 4. What do you need to feel safe, connected and respected in your relationship with your FIT therapist?
5. How do mothers' personal perceptions of autonomy, empowerment, and connection affect the process of family empowerment?	1. What are your strengths? 2. What expectations do you have for yourself and how do you accomplish them? 3. How do you feel about yourself in connection with other people?
6. What is the level and expression of family empowerment for mothers who are trauma survivors?	1. FES Level Dimension (scored) 2. FES Expression Dimension (conceptual)
7. What do survivors perceive that they need to address in their trauma recovery that could help them gain further family empowerment?	1. Where are you in you recovery from your trauma experiences? 2. What are the things related to your trauma experiences that you still need to work through or deal with? 3. What do you think the role of FIT should be in helping you through this? 4. How will your continuing to recover from trauma help you and other members of your family?

Figure 3.2 (cont'd).

Research Questions	Interview Questions
8. What do survivors perceive that they need from family-based services in order to achieve greater family empowerment, thus becoming a more effective parent to their emotionally impaired child?	1. (Define Family Empowerment.). What do you need from FIT to help you increase your family empowerment? 2. What do you need from FIT to help you become a better parent? 3. What is your role in helping your family achieve its' goals?
9. What do mothers who are trauma survivors perceive to be their successes and competencies reflected as outcomes of the family empowerment process?	1. How have you worked together with FIT to help your family? 2. What has gotten better for you and your family as a result of your partnering with FIT to improve things? 3. What changes have you and/or your family made that you are most proud of?

Validity

Qualitative methods are designed to ensure a close fit between the data and what people actually say and do. By observing people in their daily lives, interviewing them about what is on their minds, and looking at the documents they produce, the qualitative researcher obtains firsthand knowledge of social life unfiltered through operational definitions or rating scales (Taylor & Bogdan, 1998). Qualitative methods provide more accurate and valid information about informants' experiences as they have the potential to offer a forum for different experiences of the world to emerge without succumbing to power imbalances and imposed categories (Epstein Jayaratne & Stewart, 1991).

Another feature of qualitative data is their richness and holism. Data have strength in potential for revealing complexity and providing "thick descriptions" that are vivid, nested in real context and demonstrate truth in ways that impact the reader (Miles & Huberman, 1994). With their emphases on people's lived experience, qualitative data are well-suited for locating meanings that people construct about their lives and connecting those meanings with their social contexts (Miles & Huberman, 1994).

The use of triangulation enhances the validity of the study (Miles & Huberman, 1994). Triangulation permits researchers to capture a more complete, holistic and contextual portrayal of research participants in their contexts by gathering both qualitative and quantitative data (Epstein Jayaratne & Stewart, 1991; Jick, 1979). The use of mixed methods is a way to offset disadvantages of one method with the strengths of another (Jick, 1979). A

combination of methods should result in a more powerful research product, which effectively tests theory and is convincing as well (Epstein Jayaratne & Stewart, 1991).

This project utilizes the triangulation of qualitative and quantitative data to confirm research results to a greater degree. Discussion of scholarly literature adds further validity to this study. This researcher has cited information from other sources and discussed their relevance to this research.

Data Analysis

Qualitative data analysis is a dynamic and creative process. Throughout analysis, the researcher attempts to gain a deeper understanding of what she is studying and continually refines her interpretations (Taylor & Bogden, 1998). Qualitative data analysis begins with the collection of the first interview data and facilitates the development of the emerging research design (Pecora et al., 1995). Working hypotheses (Lincoln & Guba, 1985) about the uniqueness of the situation emerge from initial data and serve to ground theory (as cited in Pecora et al., 1995) about family empowerment in the evolving study. Inductive data analysis, from the specific to the general, is preferred in the early stages of evaluation. Later as the evaluation reveals patterns and major dimensions of interest, the researcher focuses on verifying what appears to have emerged (Pecora et al., 1995).

These data were organized and analyzed in steps. First, the researcher listened to each tape. The researcher then transcribed nine of the tapes. A hired transcriber, who was instructed by the researcher, transcribed the other five

tapes. The interviews of fourteen of the informants were transcribed verbatim. All transcripts were read while listening to the tape to check for accuracy and fix errors, and to help the researcher become more familiar with the data.

Two informants did not have taped interviews – one informant's tape failed due to a recording error, and the other informant requested that she not be audiotaped. For these two cases, field notes were written, typed, and organized by the researcher.

Data included accounts of women who are trauma survivors and are participating with their children in family-based services. These accounts were gathered through interviews and questionnaires. Data analysis was done by hand.

Qualitative data were analyzed from the specific raw units of information to subsuming categories after the data had been collected. This entailed coding the data and refining the researcher's understanding of the subject matter (Taylor & Bogden, 1998). Key events and patterns were organized into themes anchored in concepts significant to guiding theory and linkages to the research questions.

The constant comparative method developed by Glaser and Strauss (1967) and later modified by Lincoln and Guba (1985), whereby every data unit is compared with every other data unit, was used. From a conceptual standpoint, significant themes were linked by the research questions to gain understanding of how trauma history relates to a mother's participation in family based services. Guided by the research questions, through sorting and comparison of these conceptual linkages, relevant themes emerged and data units were brought

together into provisional categories with similar content (lumping). Decision rules or definitions of categories were linked to the research concepts and questions to justify the inclusion of each data unit in that particular category. Some data units were thus included in more than one category. Decision rules were used to justify the inclusion of the data unit into categories and also to make sure that the categories were internally consistent (as cited in Pecora et al., 1995).

A graph was created that grouped every informant with emerging themes from each interview, to the concepts of inquiry that were linked by the established research questions. Women's experiences with the following themes were examined and coded accordingly for their influence on the family empowerment process: 1) community support and response, 2) social networks and natural supports, 3) survival skills affecting relationships with family-based services, 4) levels and expressions of family empowerment related to individual expressions of empowerment, and 5) perceived successes and competencies. This process of coding provided an overview of the relationship between women's trauma histories and their experiences as participants in family-based services. These five themes were then expanded into nine themes, all of which linked directly to the research questions. The graph was re-examined with the interview transcripts and FES scores for a "fit" with level and expression of empowerment. One new coding theme emerged, which led to the final coding system (see figure 3.3).

Themes were then examined for how they connected to each other. Three categories (or sections) of themes were noted: relational perceptions, the

family empowerment process, and the FES linked to qualitative data. These thematic categories will be discussed as findings in Chapter Four.

Data collected from the questionnaires were used as collateral evidence and analyzed for fit and synchrony with the qualitative data. Descriptive statistics (means and ranges) were used to represent and summarize quantitative data for this sample of informants (Shavelson, 1996). Family Empowerment Scales (Koren, DeChillo & Friesen, 1992) were scored by the researcher and used to supplement qualitative information. Scores were then examined for high and low trends, as well as their fit with the qualitative interview data. Due to the limited sample size in this study, no inferences are made to the family-based services population.

Figure 3.3: Coding Scheme

100 Effect of traumatic abuse experiences on daily life
101 Style of coping
102 Protection of children
103 Trauma affecting family-based services participation
104 Safety/trust of FIT therapist

200 Community Responsiveness
201 Community response to trauma
202 Parents' response to trauma as obstacle to community response
203 Retribution
204 Community response to their children's needs
205 Changes in community responsiveness
206 Changes in self in access to community support

300 Social/Natural support for mom and children
301 Had help/comfort when abused
302 Abuse isolating/Mother felt alone
303 Social networks and natural supports for mother & children

400 Survival Skills
401 Perceived survival skills
402 Survival skills related to therapy experience and process
403 Survival and parenting

500 Individual empowerment
501 Perceived of strengths
502 Expectations of self
503 Connection to others

600 Trauma recovery
601 Thoughts on recovery
602 Specific trauma-related issues that need to be addressed
603 The role of family intervention in helping with trauma recovery
604 Healing of mother seen as help to family

700 Family-Based Services Needs
701 Perceived family-based services needs – general needs
702 Parenting needs
703 Mother's role in family goals

800 Family-Based Services Successes
801 What has gotten better
802 Best achievement in services

Figure 3.3 (cont'd).

900 FES scores – The Level Dimension
901 Level of family empowerment
902 Level of service system empowerment
903 Level of community/political empowerment

1000 Expressed Empowerment and the Conceptual FES
1001 Expressions of attitude
1002 Expressions of knowledge
1003 Expressions of behavior

CHAPTER FOUR

FINDINGS

General Overview

This study explored the family empowerment process for mothers who have and are surviving traumatic abuse while participating in family-based services with their children. Sixteen women discussed their lived experiences with trauma survival, parenting children with emotional difficulties, and their participation in family-based services. The stories of these women exemplify that they are far more than the obstacles that they have faced and that they continue to face. Their stories all demonstrate their will to survive, courage, creativity, strength, and hope. Many have lived through the atrocities of abuse, and yet they continue to move forward, love their children, and work towards a better life. Some have fallen prey to anger, isolation, and desperation; abusing their own children, or acting out against others. All have experienced oppression, isolation and obstacles to their development. All have made attempts to overcome some of their hardships by voluntarily participating in family-based services and asking for help. The goal for family-based services intervention is family empowerment. By examining the experiences of 16 mothers from in-depth interviews and questionnaires, I learned how their experiences of traumatic abuse can affect participation in family-based services and the developing family empowerment process.

Figure 4.1 displays the process of data analysis as it emerged from the research questions to the interview questions. Women's responses to interview questions then were categorized into themes and corresponding sub-themes. From the themes, data were organized into three thematic categories (major sections).

This analysis is presented according to the three major sections. The first section, **Relational Perceptions**, underlines women's understanding of themselves and their relationships through the lenses of surviving traumatic abuse and parenting children with emotional/behavioral difficulties. Section one also discusses four themes that capture important relational information mentioned consistently in the interviews. The second section is titled: **The Family Empowerment Process**. This section addresses information specific to the family empowerment process and women's perceptions of gaining knowledge, skills and resources helping them improve quality of life for them and their children. Four themes identified with family empowerment and based in the research questions emerged in section two. The third section links relational perceptions with the family empowerment process through discussion of Family Empowerment Scale scores. This section specifically focuses on connecting qualitative relational and empowerment information to high and low scores. This section is titled: **FES Scores Linked to Relational Aspects of Abuse Survival**.

Figure 4.1: Process of Data Analysis.

THEORY-DRIVEN	THEORY-OPERATIONALIZED	FINDINGS	FINDINGS	FINDINGS
Research Questions	**Interview Questions**	**Themes**	**Sub-Themes**	**Thematic Sections**
1. How do mothers' trauma experiences and survival affect their participation in intensive family-based services?	1. How do you feel you trauma experiences my affect how you live your daily life? 2. How might your trauma experiences affect your participation in FIT services? 3. In what ways do your trauma experiences affect your ability to trust or feel safe in therapy?	Effect of trauma on daily life.	1. Style of coping. 2. Protection of children. 3. Trauma affecting FBS participation. 4. Safety/trust of FIT therapist.	Relational Perceptions
2. How do mothers' perceptions community support for their families with emotionally disabled children relate to maternal experiences with community response to trauma?	1. How did the community respond (e.g. court, police, etc.) to your trauma? 2. How has the community responded to your child(ren)'s behavioral and emotional needs? 3. How has the community response been the same in each situation? 4. How has the community response been different in each situation?	Community responsive-ness.	1. Community response to trauma. 2. Parents' response to trauma as obstacle. 3. Retribution 4. Community response to children. 5. Changes in community responsiveness. 6. Changes in self in access to community.	Relational Perceptions
3. What is the relationship between mothers' social support networks that help them cope with trauma experiences and natural supports that mothers' turn to for help in coping with family problems involving their children?	1. Who did you turn to for help or comfort when you experienced abuse? 2. Who do you turn to now when you need help coping with your child(ren)'s behaviors? 3. How come these people are the same (or different)?	Social / Natural support for mother and children.	1. Had help/comfort when abused. 2. Abuse isolating/ mother felt alone. 3. Social networks/ natural supports for mother and children.	Relational Perceptions

Figure 4.1 (cont'd).

THEORY-DRIVEN	THEORY-OPERATIONALIZED	FINDINGS	FINDINGS	FINDINGS
Research Questions	**Interview Questions**	**Themes**	**Sub-Themes**	**Thematic Sections**
4. How do survival skills of mothers who are trauma survivors affect the process of "partnering" with mental health professionals to achieve increased family empowerment?	1. (Define survival skills.). What survival skills do you notice that you have? 2. How do your survival skills help you work with your therapist and participate in FIT? 3. How do your survival skills help you know what your family needs and set goals? 4. What do you need to feel safe, connected and respected in your relationship with your FIT therapist?	Survival skills.	1. Perceived survival skills. 2. Survival skills related to therapy. 3. Survival and parenting.	Relational Perceptions
5. How do mothers' personal perceptions of autonomy, empowerment, and connection affect the process of family empowerment?	1. What are your strengths? 2. What expectations do you have for yourself and how do you accomplish them? 3. How do you feel about yourself in connection with other people?	Individual empower-ment	1. Perceived strengths. 2. Expectations of self. 3. Connection to others.	Family Empowerment Process
6. What is the level and expression of family empowerment for mothers who are trauma survivors?	1. FES Level Dimension (scored) 2. FES Expression Dimension (conceptual)	1) Level and, 2) Expression of FES	1. Level of family empowerment. 2. Level of service system empowerment. 3. Level of community/ political empowerment. 4. Expressed attitudes. 5. Expressed knowledge. 6. Expressed behavior.	FES Scores Linked to Relational Aspects of Abuse Survival

Figure 4.1 (cont'd).

THEORY-DRIVEN	THEORY-OPERATIONALIZED	FINDINGS	FINDINGS	FINDINGS
Research Questions	**Interview Questions**	**Themes**	**Sub-Themes**	**Thematic Sections**
7. What do survivors perceive that they need to address in their trauma recovery that could help them gain further family empowerment?	1. Where are you in you recovery from your trauma experiences? 2. What are the things related to your trauma experiences that you still need to work through or deal with? 3. What do you think the role of FIT should be in helping you through this? 4. How will your continuing to recover from trauma help you and other members of your family?	Trauma recovery	1. Thoughts on recovery. 2. Specific trauma-related issues. 3. Role of family intervention. 4. Healing mother help to family.	Family Empowerment Process
8. What do survivors perceive that they need from family-based services in order to achieve greater family empowerment, thus becoming a more effective parent to their emotionally impaired child?	1. (Define Family Empowerment.). What do you need from FIT to help you increase your family empowerment? 2. What do you need from FIT to help you become a better parent? 3. What is your role in helping your family achieve its' goals?	Family-based services needs	1. Perceived general FIT needs. 2. Parenting needs. 3. Mother's role in goals.	Family Empowerment Process
9. What do mothers who are trauma survivors perceive to be their successes and competencies reflected as outcomes of the family empowerment process?	1. How have you worked together with FIT to help your family? 2. What has gotten better for you and your family as a result of your partnering with FIT to improve things? 3. What changes have you and/or your family made that you are most proud of?	Family-based services successes	1. What has gotten better. 2. Best achievement.	Family Empowerment Process

Overview of Emerging Themes by Section

Section One: Relational Perceptions

The four relational themes that arose consistently in the informants' responses were: 1) the effect of trauma on daily life, 2) perceived community responsiveness, 3) social/natural support for mother and children, and 4) survival skills.

Theme one, The Effect of Trauma on Daily Life, speaks to the remnants of abuse that the women in the sample deal with everyday in their perceptions of themselves and their relationships with others. Theme one provides a glimpse of how women live their lives both because of, and in spite of having been a victim. Theme one also addresses how the effects of trauma interface with obtaining and participating in intensive services for the women and their children. **Theme two, Community Responsiveness**, addresses similarities and differences with how women perceive the community response to their abuse experiences, versus how they perceive community response to their children's emotional and behavioral difficulties. Women's statements regarding retribution for their perpetrators were also considered. For women in the sample who are survivors of childhood abuse, the community response theme includes perceptions of their parents' awareness and responsibility in linking them with community resources. Subsequently, informants' perceptions of their responsibilities as mothers to link their children to community resources are also noted. **Theme three, Social and Natural Support for Mother and Children**, looks at the support that women received as victims of abuse, and then at the support that they receive as

mothers of emotionally impaired children, noting the perceived differences and similarities. **Theme four, Survival Skills**, identifies what survival skills the women notice that they have, and how these survival skills affect their family-based services experience. This theme examines the role of survival skills in therapy participation, goal-setting, and feelings of safety with their therapist. Survival skills are also considered for their effects on parenting.

Section Two: The Family Empowerment Process

The second section, examines the family empowerment process as experienced by the informants. This section consists of four empowerment-related themes discussed in the interviews. These are: 1) individual empowerment, 2) trauma recovery, 3) family-based services needs, and 4) family-based services successes.

Theme one, Individual Empowerment, speaks to the women's perceptions of efficacy, autonomy, connection, and personal worth. **Theme two, Trauma Recovery**, addresses informants' ideas about trauma recovery, the healing process, and how the healing process may relate to overall family health. **Theme three, Family-Based Services Needs**, addresses the needs of family-based services consumers for this sample. Mothers' roles in facilitating the achievement of family goals are also taken into account. **Theme four, Perceptions of Treatment Successes**, privileges women's perceptions on treatment outcomes and women's pride in their personal and family achievements.

Section Three: FES Scores Linked to Relational Aspects of Abuse Survival

The third section highlights noticeable high and low informant scores on the Family Empowerment Scale and how these scores lend support to qualitative interview data. Both dimensions, respectively the level and expression of empowerment, were investigated. First, informants' FES scores were graphed according to **level of empowerment**. Scores were coded based on high and low levels of empowerment on the family, service system, and community/political subscales. On a second graph, item-stem scores were displayed in accordance with the conceptual framework for **expressed empowerment** (Koren, DeChillo, & Friesen, 1992). High and low scores were again examined the expression of attitude, knowledge, and behavior and cross-sectioned with each level of empowerment. Qualitative data were then examined for how well they "fit" with the FES scores for level and expression of empowerment.

Relational Perceptions

Effect of Traumatic Abuse Experiences on Daily Life

Style of coping.

The purpose of this research is to explore how the effects of maternal trauma survival interface with parenting emotionally impaired children and subsequently relate to participation in intensive family-based services that have the goal of increasing family empowerment. To even begin to understand how the remnants of traumatic abuse experiences may affect how surviving mothers participate in services, it seemed necessary to first inquire about women's daily

lives. As an introduction to these women's stories, I asked, "How do you feel your trauma experiences may affect how you live your daily life?"

I was interested to know how much the women thought about or acted in ways that were related to the trauma they had experienced. Every response was indicative of the women actively processing their abuse experiences and coping accordingly.

Amy, survivor of many years of ongoing childhood abuse and domestic violence stated, "I feel that I question people's reasoning for helping me sometimes or reasoning for being there sometimes. I feel that I question a lot of things."

Iris, survivor of domestic violence noted, "Today? They have very little effect anymore." I asked Iris if her abuse experiences used to have more affect and she stated that they "definitely did." When I asked her what changed for her, she stated:

> Time, reading, and understanding. I have done some of my own research and it helps to understand the cycle, the power and control thing. It actually started during the last year of being with him (abuser) and for a couple of years after. Everything I could get ... I read. I talked to some other people that have been through things.

Jen, survivor of childhood abuse and domestic violence:

> I don't think they affect me as much anymore, but maybe just to keep going forward. I don't want to be where I once was before and I don't want any of my kids to be there either. So, just daily wake up and just look forward to that day and not .... I deal with the day-to-day stuff, I guess, like more positive -- from the not so positive past.

When I asked Jen how did she get past the "not so positive," she replied, "I really don't know – my will to live, I guess. Just go on. I guess I have always enjoyed life."

Helen, Norah, Mia, and Laura all reported having issues with men. Mia, survivor of childhood abuse and domestic violence noticed, "It affects it a lot. It's like I'm not going to be helpless again. I don't like being helpless or dependent on a man."

Laura, survivor of domestic violence:

> Well, I don't get involved with men. I mean, I don't have a relationship with men. Right at this particular time, I don't care to .... I don't see anybody; you know, any males or anything. Although, ever so often I would like to just have a relationship enough to go to the movies or out to dinner or something like that with someone. But, I'm always looking for that bad side of the man. You know, and if I know somebody that I might be the least little bit interested in, if they exhibit anything then I'm, "no way." I don't want nothing to do with them.

Protection of children.

For many of the women, their style of daily coping was merged with how they deal with their children. Many incorporated their childhood experiences into how they wanted to parent their children differently than what they, as children had experienced. Carla, survivor of childhood abuse and domestic violence, spoke quite directly to the question, "How do you feel your trauma experiences may affect how you live your daily life?":

> I think your entire outlook .... I grew up with alcoholic parents and I don't want to see my children go through the same thing that I went through so I make it a point not to fall into that. I like to drink a little bit. I like to have beer and wine – that sort of thing – like beer and brats, you know. But, also to teach my children, you know, that if we have a beer ... we kind of put it scripturally, that drunkenness is not allowed. And really reinforce that. My mother was very sexually active through her entire life and I don't

> want my kids to think that's acceptable ... it makes it very difficult on a daily basis. Even when I think about my mom, I still teeter-totter on, how should I think about her? I want the kids to know her, yet I don't want them to have a relationship with her, I don't want them to see me accept her as she is, yet we have to have some kind of a relationship with her.... There's just – it's like a constant mental torment.
>
> I'm cautious as to who I allow into our little circle. I won't do daycare. I very rarely let anyone baby-sit my children. My mother knew that my grandfather was sexually abusive. He'd abused her, yet she let me stay weeks in that home knowing full well .... He sexually abused four or five other females in the family .... And, I mean, that's ignorance, that's just .... My mentality, though it may be childish, is that all of them deserve some kind of punishment for allowing that. For knowing stuff before and not saying, "No, you know, (Carla) shouldn't be staying there. She's 10 years old and that's not a safe environment," or "If she stays there, you know, don't stay the night." Or, "If she goes to see her grandmother, it's when grandfather has gone to work." Something, anything ... but they allowed it to go on for me.

Kim, survivor of abuse and domestic violence, also talked about protecting her children from the abuse that she experienced as a child:

> I know I've learnt off mine, so they've (abuse experiences) helped me actually .... It's like – I don't know – it's like an experience that I kind of made stop so my kids don't go through it too. Because I don't want them to go through what I've went through.

I asked Kim what she did differently with her children. She stated, "Oh, like things they do. I kind of talk to them and try to work it out. Where, when I was a kid, we would've got the belt or gotten beat or whatever."

Dani, survivor of childhood abuse, simply stated:

> I try, I stop and think about what I do with my kids before I do it or say it. Like if I'm going to get angry with them, I stop and I think about it and I don't say something to hurt them – like my parents did me.

Grace, survivor of multiple incidents of childhood and adult abuse, talked about trying to protect her kids. She also discussed difficulties she has with her children that she sees as related to her abuse history. She stated that her abuse

experiences have affected her, "in a lot of ways," and she gave the following example:

> I have lots of trouble with my kids cause I have a tendency to lose my temper and um, taking it out on them. I see a cycle going on. It's like I'm mad, and I may lose it .... I get so tempted to beat their butts. That's an understatement. I fight it, but it's hard you know. It's extremely hard. And then absolutely, if I see any abuse going on, I just really blow up. When (husband) had spanked (her 8 year old child) too hard one day, and I almost beat the living tar out of him (husband) for it. Instead I screamed bloody murder at him.

I asked Grace about getting so mad and feeling like she is about to lose it, and she stated:

> I feel guilty and ashamed and all that. It's not very fun. I'd love to be able to not have this temper trouble. Been working on it and that's all I can do – keep working on it.

Trauma affecting participation in family-based services.

From discussions of how trauma affects them in their daily lives, we went on to talk about whether or not women noticed their abuse histories affecting how they participate in the family-based/Family Intervention Team (FIT) services. Three women in the sample either could not identify how their trauma may affect them in services, or felt that their trauma histories had no effect on how they participate in services. The majority of the women noticed that their abuse experiences did affect their participation – either driving them towards services or keeping them guarded. Betty, survivor of childhood abuse, simply stated, "I talk it (the abuse experiences) out."

Carla felt that her trauma experiences drove her towards family intervention:

> I think for me, it's a positive. It drives me towards .... With especially the adult females in my family who kept everything under the rug, I saw where, you know, what good does that do – you know, if you hide that? If

> (FIT therapist) comes and I don't tell him that we're having problems, "Oh, everything's fine," he can't do anything. There's no .... Then you might as well just end services.

Iris felt that having been through her experiences and survived, she was stronger, and that helped her participate in family intervention:

> Well, it helps. Just the knowledge makes you stronger, besides, the passing of time. Besides, he (abusive ex-husband) lives several states away, so I don't have anything to fear anymore. Having the understanding of some of the things that caused that and that cause a person to act that way helps me understand how I can help my children better. I hope.

Laura explained how she was connected with a therapist after her daughter Shelly had started seeing a therapist due to Shelly's behavioral problems following their escape from Laura's violently abusive ex-husband:

> I can't remember who the first one (therapist) that Shelly had, but it wasn't the FIT team. We'd go over there and she'd have therapy. I felt that I needed it because ... after I was away from him (abusive ex-husband), I found myself not sleeping good, waking up in the middle of the night and constantly checking the doors to make sure they were locked, you know. I couldn't be in a room that I didn't have another way out of a room. I had to have another way out. So, I realized that this was really, really bothering me, you know. I thought that when we left I was going to leave and all the problems was going to be there and they weren't going to follow, but they followed .... Matter of fact, it was a relief to go through with therapy and just get it all out.

Grace noted her need for services, but also worries stemming from her own childhood about what she might have to lose:

> I talk about it, um, ask for advice, for instance how to better deal with my rug rats .... I try to be pretty open and honest, but sometimes I remember back when my mom lost us kids. It's like, wait a minute, if I do that I might lose my kids.

Amy voiced her feelings of caution:

> ...you get a little bit leery of what is going to happen when you do tell somebody something, especially when you have been abused as long as I have.

Olivia, domestic violence survivor, described her concerns about her judgment with people and protecting her children, keeping her cautious with family intervention services:

> I'm more cautious about it. But at the same time, I'm an awfully trusting person, unfortunately sometimes. I don't always know when to look out.

I asked Olivia what she was most cautious about. She replied:

> I'm very cautious when they (therapists) come near my kids. It doesn't bother me with them in my home, but I don't allow them alone with my kids. This (today) was the first time that (therapist) has ever seen them without me, per se. (The therapist) has seen them in school and seen them here, which was okay, but that was the first time (the therapist) actually took him (child). I did allow (mentor) to take (child). My judgment, I'm afraid of my judgment ....

Trauma experiences affecting safety & trust in therapy with FIT therapist.

Despite some of the earlier, more cautious statements about their participation in family-based services, all but four of the women remarked that they feel quite safe in sessions with their FIT therapist. Explanations for this trust varied amongst the women. Some could explain it no further than they just felt safe. As Eve stated of her female therapists:

> I really don't have a problem with that because it's not like talking to a man, to where my past experiences was dealing with a man ... I had a lot of mistrust of men, but not so much towards therapists, so... it's a little bit different.

Grace explained:

> I feel pretty much safe with most therapists. They're about the only thing that's been pretty much consistent in my life. Even through all the abuse, I've been seeing therapists since I was five (years old).

Olivia added:

> I feel very safe with talking about things and making my feelings known because I feel if I am, then I have a better chance of helping them

> understanding my kids. You've got to understand too that I've had a couple of years of real intensive therapy to get here.

Of the four who talked about feeling guarded with their therapists, three explained a process of gaining trust. Of the three, each woman appeared to be at a different place in her ability to trust her therapist. Amy said stated most succinctly, "It took me awhile to feel even safe with talking to you guys (FIT), I mean I felt a little stand-offish, I think." When I asked what helped her to feel more safe in therapy, she stated:

> Mainly I think it was getting to know you guys to where I could have some type of rapport to where I knew that you guys were on my side -- you know -- that you knew what had gone on and you weren't going to feel that I was a bad person because of it, I guess.

Mia was the only informant who did not endorse feelings of safety and did not identify a process of gaining trust. Instead, she specifically mentioned couples sessions being difficult for her. She and her husband were in the process of separating. Though they were yet living under the same roof, Mia was extremely unhappy with him and felt oppressed in their relationship. In regards to feeling safe in therapy, she stated:

> I feel like sometimes I get bombarded. My husband will sit here and plays the perfect husband. It irritates me because the problems are there. If I try to bring them out into the open, my husband won't talk to me for two days .... Sometimes I just feel picked on.

Mia, who did not want to be audio-taped, stated she felt as though her reactions stem from her past abuse experiences. She said that her dad and her violently abusive, first-husband "got along super good." Her dad was very traditional and her mom waited on him hand and foot, to which she stated, "It's sickening and it

don't work for me." When her therapist and husband appear to get along well, it brings back that situation.

Community Responsiveness

The literature discussed in Chapter One noted that trauma experiences can elicit a sense of disconnection between the abuse victim and her community. The response of the community therefore has a powerful influence on the resolution of the trauma. A community response should take action to assign responsibility for the harm and repair the injury, meaning that responses of recognition and restitution are necessary to rebuild the survivor's sense of order and justice (Herman, 1997).

Family empowerment literature states that, "empowerment" implies a process that enables persons to gain control over their lives by influencing their interpersonal and social environments (Hasenfeld, 1987; Parsons, 1991; Rappaport, 1981; Zimmerman & Rappaport, 1988).

This theme, Community Responsiveness, examines how women who have experienced traumatic abuse and a breech of trust with their communities, respond to family-based services' encouragement and facilitation of connecting and influencing families' social environments.

As addressed by the informants, themes of community response to trauma; and community response and involvement with their children seemed to counter each other. Most women in the sample appear to have separated the community response to their trauma from the community response to their children's emotional and behavioral needs. This response appears to be related

to several factors including women's acknowledgement that they make a difference in their children's connection to the community. The women overwhelmingly felt alone and helpless when experiencing abuse as children, and as adults experiencing abuse, they were "terrified," or "isolated." For some women who felt let down by community, family, or both, a secondary theme of retribution emerged.

Community response to trauma.

The majority of women felt that they were let down in some aspect by the community. If they did receive some positive community support, someone else, either in the community or in their family, let them down or became an obstacle to their getting help. Most women who were survivors of childhood abuse did not tell anyone about the abuse.

Amy stated:

> Ah, really the community didn't respond well at all. I mean, I kind of felt that I was being let down in a sense because there wasn't anybody there for me. And you know as far as my family went they weren't there, and my own mother really, so I felt very let down and that's why it took me so long to actually get to actually trust somebody – even in a clinical type of manner ....

Betty did tell her mother that her mother's boyfriend was sexually abusing her. Evidently the police were called and charges were filed. Betty told of her experience from when she was six years old:

> The court didn't do nothing. I just went and did the lie detectors test and then he (mom's boyfriend) wouldn't and they told me that if I went on the stand and told what happened, then I would get – then my mom would get custody of my brother (fathered by the boyfriend). But, it's like, I was scared. I wasn't going to go up on the stand in front of a bunch of people.

Dani explained that her stepfather had sexually abused her and her sister for years. When asked if there was any response or involvement by community agencies, she replied, "My stepfather was a police officer at the time, so there was no help at all." Dani continued by saying that there was no one she was able to tell, and when I asked what kept her silent, she replied, " ... he threatened to kill my mom if we told anybody."

Eve was the only survivor of childhood abuse who stated that she felt supported by the community and from the police. When she was sexually abused as a child by a relative with whom she lived, she was removed from the home of that relative and placed in foster care. However, she said the abusive relative never saw consequences because the abuse was never proven. In another abuse incident when Eve was raped by a cousin, she went to the hospital, and the police became involved. The perpetrator went to jail for only a year, because he pled to a lesser charge. Despite some community follow-through that occurred in Eve's situation, she noted a lack of just consequences for her perpetrators and later she discussed retribution. Eve also relayed the following story of additional community response that occurred the day after she had been raped:

> ... I got ready for school and I went to school and um, that was kind of hard because with being a minor they couldn't print my name in the (city news) paper or whatever. But they printed in the paper about the incident and they had – because he (perpetrator) was an adult – he was at least 18 – so he was an adult so they could print his name. And so there was this boy that um, I had to sit by in chemistry class and he had seen it in the paper. Well all's he had to do was spot the last name and then (he) turns around and looks at me and he was like, "Well it wouldn't have happened to been you, would it?" Because it gave my age but it didn't give my name. So I ran out of the classroom.

The three women who were satisfied with the community's response viewed it as a process, and were all adults in domestic violence relationships. However, again there were drawbacks. Iris explains:

> Once I finally went to the authorities they were very helpful. The police department was very helpful. (Counseling Center) was very helpful. The court system was not real helpful. Of course, I wasn't healed and strong back then either. But, when I went to court, I wouldn't tell the truth because I knew if I did, I was a dead woman when I walked out the door. ... I did exactly what he (abusive ex-husband) said. I stood up there and told him (the Judge) it had never happened before, there was no problem, and that he (ex-husband) never hit me.

I asked Iris what the Judge did and if he believed her. She replied, "Uh-huh. What else are they going to do?" She stated that her ex-husband's consequence was community service:

> He helped build a wooden playground at a park and he had already done that the year before, so ... it was like a big, fun thing for him.

Parents' response to trauma as an obstacle to community response.

In circumstances of childhood abuse, a subset of seven women described a parent as an obstacle to community response. The women felt that the identified parent's response, or lack of response, served to keep them locked in abusive relationships.

Jen explained:

> As a child for me, there wasn't (any community involvement). I don't know if it was that my mom was unaware .... I was going to say, it's not like my mom was this horrible, evil person, but just her ability -- and she's hardly ever worked. I mean, she didn't finish school. There's a lot of things about my mom I just didn't want to be and, however it was -- recognizing issues, you know, going on right under her nose.

Carla talked about her childhood abuse experiences and how she told her mother many years later when her abuser died:

> We were in that (perpetrator's) home. We were sitting and everyone's just kind of looking towards the bathroom door. And the subject was brought up about (a family member reported to have tragically died in the bathroom), and my mom looked at my aunt and she said, "You know, I had some horrifying experiences in there myself." She said, "I'd been taking a bath and he (abuser) walked in there." And my aunt looked at her and she just started to cry and she says, "Yeah, I know, I went through it too." And I just looked at them and thought, "You assholes." "Yeah," I says, "Yeah, I had some bad experiences too." And they were like, "Really?" and I'm thinking, "I'm like 10 or 11 years old. What the hell is wrong with you?" You know, I had that mentality when I was a kid. I would be absolutely appalled at adults who couldn't just seem to get things normal.

Helen described her parents' response to her childhood sexual abuse experiences perpetrated by the babysitter:

> Well, at first they ... it all came to head because this guy was babysitting us once when I was like 10 years old and my dad caught him at it. They had to deal with it .... Well they believed me and then we went to all the courts and everything. Then, my dad told me not to say anything.

She went on to explain the her perpetrator did get convicted:

> He did, but not for me. He was doing it to his three-year old daughter at the same time. His ex-wife caught him at that. So, he went to prison for 11 years for that.

Retribution.

Though no interview questions pertained to retribution, a number of women did make reference to wanting their perpetrators, and/or those who failed to protect them, to pay a price for their wrongs.

Fran, whose interview transcript consists of field notes due to a recording error stated that her abusive ex-husband "got his just desserts." She went on to explain that she heard from her ex-husband's brother that his next wife was

mean to him, beat him up and cheated on him. Fran stated that her ex-brother-in-law said that her ex-husband had it so good with her, and now he got abused by his next wife. "He got what was coming to him," Fran remarked.

In reference to being raped by her uncle, Grace explained the court's response and her idea of retribution:

> ... it was the prosecuting attorney – looks right at me and says, "You know what, we're not even going through with this because I think you are a slut and I think you know it. And it's going to cost the county too much money." And he (perpetrator) never went to court. I never bothered after that – it's like, "Why bother?" I'll take care of them on my own time and I'll make sure their punishment fits the crime. My uncle took something important from me, so I took something important from him. I robbed him blind for about $50,000.

Eve made several references to retribution and wanting her perpetrator, as well as the perpetrator of her children, to pay a price. Of one of her abusers, she states:

> ... at least he did do some time. But the way that I look at it is, um, one day that he's going to wind up having something come his way in his life and then he's gonna – it's basically gonna be like a pay back type of thing towards him. And, it's actually happened because he's got kids now. He's married and has kids. And his brother, my other cousin, raped his daughter. So, now he knows what my family had to go through because of something like that – the same thing that he did. So he's dealing with the same thing right now that my family had to go through.

Community response to children's needs.

The majority of the sample reported a favorable response towards their children's needs by the community, and more specifically by the Family Intervention Team. Five women reported some dismay with the community response, which they connected to a lack of acceptance and understanding by

both natural and community supports for their children's mental health diagnoses and emotional disabilities.

Dani stated her favorable impression of community response to her children's needs:

> I think it's a lot better nowadays, as opposed to what it was then, because there's more help for kids. Just like the FIT program. I don't think there was anything like that when I was younger.

Grace stated:

> Oh, they've jumped. It used to be that you couldn't get any help at all, and now I say, "Hey I need help with this kid." Boom (snaps her fingers), (Child Protective Service Worker – Prevention) is right there. Boom (snaps her fingers), you're right there. Just (snaps again) say the word. Somebody's willing to help.

Patti stated:

> Somebody's been called in for whatever is needed. Like when (child) tried to jump off that balcony, they called people from here (FIT).

Kim explained her frustrations in feeling like her child's difficulties were misunderstood:

> (The police) would come over whenever I needed them. Like if (child) Frankie wouldn't get up and get ready for school, I'd call them and they'd come and say, "Now Frank, get up and go to school." He'd get up and listen to them. But like Community Mental Health and stuff told me basically to get the law involved in them and then you get the courts to step in. Well the law was doing really good with him, but when the courts step in, they didn't want to deal with his bi-polar, or his, you know, mental problems. They just wanted to put like he was just an out of control kid in the community.

Nora explained her feelings that people just don't know what to think of her daughter's behavior:

> Actually it's just kind of, like with my neighbors with her – They're like, "What's wrong with your daughter?" And I had to explain it, you know. What do I do? Other people, like the day she was with the cop –

> everybody was out looking at this little girl like, "What in the world?" But actually for the most part, living in a small community like this is not as bad as I thought it would be.

Olivia relayed her experience of people's response to her children:

> I have heard adults call my kids names, especially with Mike. They call him a freak, weirdo, retard. You know, he's not. You know, he has difficulties. You have to deal with him differently, but any adult should be able to do that. Any adult that wishes to could do it. Instead, they throw mean things at them because their kids might get something. You see, a lot of adults look at it that way. They look at it in the school of me keeping my kid in regular school. How dare I? It might just pull their kid down. You know, it's like, I want to say so bad, "Why don't you check his grades? This kid is smarter than your kid! So what if he can't comprehend socially in the ability that your child can? Your child can't comprehend the ability to catch and grasp the other things that he can." So they complement each other really. But, because of a parent's ignorance and unwillingness to see this, they cut a kid short.

Changes in self and access of community support.

A few women noted that their active role in helping their children to connect with community supports has made a difference. Jen explained it most eloquently that as an abused child, she did not see any intervention, but when it came to her own son needing help, she has made sure there's been a lot of involvement and a lot of participation. Jen explained, "I've lived it, and like I said, I didn't want my kids to have to live through it either. I did what it took to get off that road."

Social networks & natural supports for mothers and children.

In this sample, all informants were abused by people who were a natural part of their relationships. As displayed in Chapter 3, Figure 3.1, perpetrators were typically parents, family members, friends, husbands or boyfriends. Mia and Kim were the only women who reported in her abuse history that, in addition

to having abusers who were part of their daily life, they were each raped by someone that they didn't know. Having most perpetrators taking part in their families and social networks, most women felt very alone, and that they had few options for help or support in their situations. Many reported being threatened, terrified, and isolated. Amy was in a severe physically and sexually abusive situation in her home from the time she was a toddler up until her escape at age thirty.

Amy stated:

> When it was going on, I didn't feel like I had anybody to turn to really. ... I was too scared to say anything. I was afraid of what he might do if he (abusive stepfather) found out that I did say something to somebody.

When Amy was able to escape and tell people, she was dismayed to find out that extended family members had known all along. Amy explains:

> When I found out that my family had known about it but didn't do anything, that it was kind of like, it should have actually changed, but it didn't because everybody already knew about it. You know, that upset me a lot because I thought, "If you knew, why the heck did you guys just stand there and let it happen?" You know, a lot of them said, "Well you never come to us." Well I was too terrified. If I knew that one of my friends or anybody was going through what I had gone through, the first thing I would have done was got them the help, whether they said they wanted it or not. So, I mean that's what really .... I mean, it still hurts me to actually think about it because it's like, "What type of family could just sit there and just let it happen and know about it and not do anything?"

Dani, who was physically abused by her mother and sexually abused by her stepfather as a child, talked about turning to her sister for comfort:

> I guess maybe my sister, cause we went through the same thing (on-going abuse). So, I guess we talked to each other but we really didn't help each other because there wasn't much we could do.

Fran, Grace, Helen, Kim, Mia and Olivia all simply stated that there wasn't anyone for them to turn to. Some women did have some help or support throughout their abusive situations. Laura's situation is the most striking and unique example of natural supports coming together to end the abuse and isolation:

> Well actually if it wasn't for my (adult daughter) Sarah, I don't know where for sure .... I think I would have been away from him, but it would have took me longer. Sarah, after she had left the house, said she went to Job Corps. She was in Job Corps for two years. What money she got, she saved. She come back and at this point ... I was in fear that he (ex-husband) was going to kill me or one of the kids. It was that bad. Sarah come back from Job Corps and she handed me a $1500 check. She says, "Mom, I want you to take this money. I don't want you to tell him, but I want you to take this money and find a place and get away from him before he kills you or kills Shelly or Rachel (kids at home)." The last straw with him was that the girls were little and he was trying to put plastic up on the windows. He expected those little kids to hold plastic at the very top of the window and they couldn't. There was no way. They were too short. So the plastic kept slipping. He picked up a hammer and he threatened to kill Shelly and Rachel. He told them that if they told me, he would make them stand there and watch him kill me and then kill them .... Well, when he left the house, Shelly come to me and she says, "Mom, I'm not suppose to tell you this but ...." She told me what happened. Then Rachel, her older sister ... I says, "Rachel, you come here, I want to talk to you." I asked her, "What happened?" She started crying. She was terrified. She told me the same thing. I told the girls that, I says, "This is it." You know, Sarah had given me this money. I said, "We're getting out." I said "Don't worry. Don't say nothing to him. As soon as I can find a place, we're gone." Basically, we ran away.

Laura went on to explain that her sister helped her escape when her ex-husband was not home. She moved into a house in which her friend's father was the landlord. Laura went on to describe additional support for her recovery from her sister and her best friend:

> Then, my sister moved in ... I was having so much problems with depression and anxiety .... My sister, she basically took over my identity for a while. I could not cope. I was working at the time and I don't even

know how I held a job. I look back on it now and I don't know. I worked every day and stuff, but I couldn't write a check out. So, she'd write a check and I'd sign my name. If there was any business to take care of over the telephone, she would make the phone calls. She completely took over my identity. I was just ... trying to cope as well as I could and going to therapy and stuff. There was at one point I got so bad that...well, the girls even, you know, Rachel and Shelly went to stay with my first husband. ... I would go to work, I'd come home, take a shower, put my pajamas on in the middle of the wintertime. I had every door, every window, locked. I would not answer the phone and would not answer the door to anybody -- anybody. That was at my worst point. I just felt like rolling up at that particular point and dying because I couldn't handle anything .... I look back on it now, I was bad.

I had a girlfriend; she'd come to the house. Matter of fact, she's my best friend. I don't know today where I would be without her. She'd come to the door and she'd knock on the door almost on a daily basis and wouldn't answer the door and stuff. Finally, one day she come and she knocked on the door. It was during fair week here in town. She knocked on the door and she says to me "Laura, you'd better answer this door. If you don't I'm gonna break this door down and I'm gonna beat your ass." She said, you know, and I'm thinking, "Maybe I'd better answer this door," you know. I'm in my pajamas. She comes in. She says, "Get dressed." I looked at her and I says, "Why?" She says, "We're going to the fair." I tried to think of every excuse I could imagine not to go to that fair. She says "Nope, you're gonna get dressed or I'm gonna dress ya and we're gonna go to that fair." She made me get dressed, put me in her van and we went to the fair and walked around. She kept a real close eye on me, you know. We walked around the fair. Then, when we got done, she brought me back home. I did feel better. She started coming over two/three times a week and getting me out of the house. "You know," she says, "You can't keep doing this." She'd force me. If I didn't feel like it, boy, she'd force me that I had to go. I think she had a lot to do with, you know, my recovery. To this day, she's my best friend.

Most informants talked of noticeable differences in their approach to getting help or support for their children, as opposed to what support they had for themselves during their abuse experiences. Amy, who earlier mentioned that her family did not intervene for her during her abuse, reported that she is now able to turn to family for help with her children. Though Amy explained her extended family's willingness to help her with her children, she appeared to have difficulty

with their apparent reasoning that they would have been willing to help her out of her own abusive situation if she would have asked.

She explained the difference as:

> I think – well now they'll actually help me if I'm having problems, you know they're there for me, where they weren't before. Their biggest thing is that I did not turn to them for help, but I did not even know if I could trust anybody. I didn't know who to turn to, and I didn't know who to trust. I mean, it was a big thing .... A lot of it, I think is because they've got it in their mind that I was just staying there (in the abusive home) to actually punish my mother. Which doesn't make any sense to me. I mean, the only reason that I stayed there when I was younger is because I was afraid that he was going to kill her (Amy's mother). So, I mean, it just doesn't make any sense for them to feel that way, but that's what they've got in the back of their mind, I think.

All but two women expressed having support with their children that differed from what they had available to them during their abuse. The majority had new people in their lives such as husbands, boyfriends, and friends; in addition to having the perpetrators out of their lives. Carla and Patti, however, were currently working on their marital relationships where their husbands had been physically abusive towards them on occasion. Patti's husband was in jail (for abusing their son) at the time of the interview, and he was not allowed to have contact with their son. Mia was in the process of separating from her physically abusive husband.

Both Laura and Patti, who did discuss drawing on the same supports for themselves and their children, had lived in domestic violence situations. Both were being abused during the same time frame as their children by the same perpetrator. Both reported positive social and family support for them and their situations. All but two informants listed natural supports available to them with

their children's emotional and behavioral issues. The two women who did not list any natural supports listed only community agencies as supportive or helpful. Both reflected their disdain for the lack of support they received from their family systems.

Carla explained:

> There was no one to turn to because like I said, I grew up in not just an immediate family, but the extended family of – they were either alcoholism or sexually active or just – just they were liars ... they couldn't be trusted ....

Nora elaborated on her situation:

> Actually it's me, Tom (second husband), and the children. We have a few friends here and there. Me and Tom have both gotten burned by people too many times. We don't trust people. Not even my parents. His parents live (out of state). It's kind of bad sometimes because it's just the four of us. But, in a lot of ways, I wouldn't have it any other way.

Survival Skills

During the qualitative interview process, I talked with the informants about survival skills, to inquire as to what skills they notice may have helped them survive their abuse histories. My other purpose for asking about survival skills was to find out what survival skills the women had integrated into their behavioral repertoire, and how these affected their participation in FIT services.

Perceived survival skills.

I introduced the topic by asking each informant if she had ever heard the term, "survival skills." Many informants reported that they had not ever heard of the term. I provided each woman with a hand-out (see Appendix I) that briefly defined survival skills. I verbally stated examples of survival skills such as hypervigilance, dissociation, and compartmentalization, describing each skill in a

positive light, as something that helped them get survive the abuse, or kept them safe. After brief explanations, I asked, "What survival skills do you notice that you have?" Many women chose their responses from the examples that I gave, so I followed-up by asking them if there were other skills that may have helped them to survive – skills that I had not mentioned. Many incorporated the care and protection of their children into their survival.

Norah explained her survival skills:

> See, I'm good at that. (Husband) Tom's not good. Tom has a lot of anxiety. He has a terrible problem with anxiety. I just forget everything. I tend to just forget. I mean, honestly, I forget everything.... I can like – I don't know what it's called – but like, I know a lot of people can't live alone. I can live alone. I couldn't live without my kids, but I could live without a man. Survival skills – I mean – I just do a bad time. Whatever has to be, has to be.

Olivia talked about her survival skills quite creatively, stating, "They're definitely skills that you need to survive and you just kind of make your own as they go and what fits the situation." When I asked what she noticed were her survival skills, Olivia stated, "Being quiet – being very quiet and being unnoticed. I noticed my kids can do that. I never noticed they could before."

When I explained hypervigilance to Olivia, she stated:

> Oh yeah, that's a very easy one, you know. You have to always know what the mood's gonna be so you know what to expect. If you know it's going to be eggshells you're gonna be walking on, you just keep the kids clear and go somewhere else. Stay away from the situation and hide from it. I learned those real well .... Well for me when he would always think I was an inmate. Like, he would hold me up against the wall by my throat, you know. I was very good about just saying, "Yes, sir. No, sir," and never yell. Never yell.

Kim described her skills, particularly responding at first to dissociation;

> I do that (dissociation), like when I'm in my room and I'm stressed ... I'll start thinking of nice places and stuff, and I end up actually falling asleep and I go there and it's called my getaway place .... I've got a lot of survival skills actually. I don't know if they all would fall under these or not. But, I think I'm a survivor, because I've come this far with me and the kids. And, I feel I've done a good job and that takes good survival skills.

I asked Kim what had helped her come this far, and she replied:

> Learning from my experience – like what I went through. Kind of helps me keep (the kids) on task of ... what road to go down or whatever. Like with (daughter) – she has a boyfriend that was a lot like her dad. Then she tells me that her relationship ain't my problem. I say, "Yeah it is when you're heading down my road. I'm going to kick you off my road (laughs). It's my road. I don't want you going down that road (laughs again)." ... I try to steer (the kids) out. Then they get mad at me cause then it's like it's .... I'm in their business, but then it's like well, "I wouldn't be in your business but I see you going down that road and I call it my road now." They can't go down my road.

Survival skills related to therapy experience and process.

Informants gave mixed responses as to how survival skills may prove useful to them in therapy experiences. A few of the women stated that their survival skills were not helpful in therapy sessions, for varying reasons.

Amy stated:

> I don't really need to use those in therapy though .... I can pretty much you know, be open now, where I couldn't before.

Helen noted:

> No. I really didn't get a lot of counseling. When I talked to (former outpatient therapist), we were just trying to build up the trust issue .... I don't let people close to me.

A few informants stated they didn't know if their survival skills were useful to them in therapy or not. Carla gave the example:

> I don't know. I'm stumped on that one because I think sometimes when you've lived through trauma, through years and years and years and years and years, you slip in and out of that like somebody shifting gears on a

> bike, and you might ask somebody, well what gear are you in while you're doing this or doing that. Well I don't know, I just know to .... I may slip in and out of that so well that I don't even realize.

A number of informants felt that their survival skills moved them forward in getting help for their families.

Jen stated:

> I am so on alert. I feel that I am on top of things, you know. I recognize things going on with (child) early enough and I'm hoping that, that's enough to help him. To have all these people involved and....

Grace explained:

> It's hard to swallow my pride (laughs). I don't think I could handle it alone. It's hard to say that but I used to think I could do everything by myself. Now it's like, okay, now I need help. Don't want to accept it at first, but I usually do.

A few women discussed actively using survival skills in session to help them protect themselves or cope with therapy issues. Dani gave the example:

> Well (I use them) a lot now, because we have what is called a parent meeting, where me, my husband, and his ex-(wife) have to go in a room and we have to sit there and talk to each other. And now her (the ex-wife's) thing is like to throw my parents up in my face, so I find myself just kind of staring off in the distance or doing the dissociation thing – I connect with, like, a clock and watch the clock ticking around so I kind of just hear what she says, but it's like I try to block out what she's saying.

<u>Survival and parenting.</u>

During interview discussions about survival skills and family/parenting needs, issues, and goals, it began to emerge that women use their survival skills, as well as their knowledge of survival skills, to help them in parenting their children, or identifying when their children are under stress.

Carla explained how she uses her survival skills to help her in her parenting:

> I kinda revert into myself. Like I tend to pull everything in and then I can sit and focus and I can look. I can look at (child) and go, "Well she's ... not looking quite right today, something might be ...." I can step out of the internal situation, and get far enough out of it so I can focus and see what's going on, rather than, um, you know if you don't use that as a survival skill, you're kind of stuck in the torment of the day, and you get caught up in it and you can't get far enough away from it to see what the problem is.

Grace spoke along similar lines:

> Well, I don't like seeing my kids the way I was and that's the biggest key to it right there. I don' t want to see them go through what I went through. So, I just, fight the fight to keep getting it better for them. I am -- sort of almost like the fight -- emotional, physical, whatever -- It's all a fight to survive. And I do it as good as possible. And it's taken me a long a time to change my ways too cause I was such a little turd (laughs). Now, I'm trying my darndest, keeping my butt clean, working to live. ... I used to lock my kids in their rooms so I wouldn't abuse them, cause I'd get sooo angry that I'd want to beat them and I'd lock them away from it, but it was also locking them in and scaring them and that's abusing them too. And, (Child Protective Services Worker) brought that to my attention and she says, "You know I don't see actual abuse going on, I see emotional abuse going on, and I don't like that. I want you to work on that." And I thought she was just full of shit. I didn't want to admit it, but then a couple of times I started seeing what she was saying, you know, putting them in their room for so long, they were just little kids you know -- they don't realize it's because mom's temper's out of control. They think it's because mom doesn't love them and wants to put them away from her. And I started realizing that and said, "Wait a minute, no!" I ended up ripping the doors completely off their rooms. I went completely drastic on them. I'd send them to their rooms and tell them I didn't want to see them pop their head out but their doors were off. If they had to go potty, they didn't have to beat on the door to go, they would just "going potty" and I'd let them. So it was a big difference and a lot of it's because of (Child Protective Services Worker). She was right there for us. She's been with our family since I was fourteen.

Amy noted that her knowledge of how she survived the abuse gave her clues as to how her kids were dealing with things:

> I figured out a lot of the kids' ... how they were actually dealing with the whole situation that way. ... especially the older girl ... she was doing a lot of the same things that I had done ....

Dani gave a similar example:

> I think with me going through it, I can spot the things that my step-kids go through and I can see, like if they've been abused violently or like physically or whatever, and even emotionally, I can really tell if it's happened because of the things that they do. ... it's like it makes me more sensitive to what they are going through ... I think it helps my step-daughter the most. I'll just tell her about some of the things I went through and let her know that she's going to make it through. She's got somebody she can talk to, and that I'll be with her no matter what – no matter whatever happens. I'm like a support group – a support system for her if she ever needs to talk to me.

Relational perceptions, as explained by this sample of informants, are often shaded by remnants of having survived abusive experiences. Trauma survival appears to be one lens through which women may view their world and relationships. However, as many of the informants have noted, they continue to make strides to overcome their pasts and create better futures for both themselves and their children. They have shown that trauma and survival experiences can and do impact relationships on various levels (e.g. partner, family, extended family, friends, community, etc.), and in various ways, both positive and negative.

The Family Empowerment Process

Individual Empowerment

Perceived strengths.

Women in the sample did talk about their strengths and what they do well. Two common threads emerged out of the many strengths listed. These had to do with having a strong-will or the ability to keep going; in addition to having the ability to relate to and care for their children.

Amy described her strengths:

> I am very strong-willed. I think if I wasn't, that I would have caved a long time ago. ... I've gone through a lot of stuff throughout my very short life. I've gone through more stuff than a lot of people could handle -- just one thing (alludes to that many people would have trouble handling one abusive incident). And, I think my biggest thing is my strength, my ability to just pick up and keep going, you know. And a lot of things lately have been piling up on me and I just kind of just pick up and just keep going, you know. You can't change it, and you're just going to have to live with it.

Jen stated:

> I'm a pretty strong person – strong-willed person. I feel I'm a pretty confident person. I have my moments but ... I'm pretty educated and literate... artistic, cause my life's so creative.

Olivia said:

> ... my willingness and my ability to keep on going no matter what. My ability to not stop until I get where I think I need to go.

In reference to her strengths, Kim concentrated on her children:

> My kids are my strength. They keep me going. Probably if I didn't have them I'd probably would just curl up in a big ball....

Laura focused on her children as well:

> Well, I think I'm a good mother. I'm a good grandma. I'm a good cook. ... I can make good judgments where my children and my grandchild are concerned. Better now than what I was able to in the past. I'm good with money. I pay all my bills ... I'm on a limited income, but you know, I meet all the needs that my kids need. Maybe not all their wants, but all their needs are met. You know, they have medical care. You know, if anything happens they are right into the doctor or right into the hospital or whatever. I try to work with my daughter on parenting skills with her child. I help her out a lot with (grandchild). Gee, I don't know. I've got a lot of strengths that, I don't know. I've improved a lot. I don't know if that's a strength, but I have really come a long way from what I had been before.

Expectations of self.

When I asked the informants what sort of things they expected from themselves and how they go about accomplishing those things, many gave similar responses having to do with making changes in their lives to make things

better for them and their children. Eve echoed the feelings of many women in the sample when she said:

> I would basically say (that I) deal with family situations, try to change them, make the kids better people ... bring them up as better people, as well as myself. I mean even though I'm an adult – I still have a lot of growing to do as well as an adult. ... growing, helping the kids with what I know as a parent and if I don't have an answer or whatever like that, try to get answers, whether it be through someone else, or however.

My conversation with Grace was also indicative of the feelings of many of the women in the sample.

Researcher:

> What expectations do you have for yourself and how do you accomplish them?

Grace:

> My expectations are, just keep going. Keep improving our lives somehow.

Researcher:

> How do you do that?

Grace:

> Working, getting therapy, following up on the kids' education – that type of thing – just really being involved as much as possible. I don't want to see them feeling unloved, so I'm right there at the school if there's a problem, and I make it a point to show them mom is there.

Researcher:

> Was your mom involved like that?

Grace:

> NOOO, and neither was my dad, and I want them (the kids) to see the difference. Which they do, but they've never lived with both my parents. And they see (that) neither one of my parents really help and then they see mom (Grace) and mom is just like (snaps fingers twice) right there as soon as something gets up, I'm there. They're seeing that and I think they

really appreciate it. You can see it. I go to school functions even if they ask me not to. They're like, "Mmmommm... (laughs and says something that is not clear)." "I'm proud of you. I'm gonna speak up and I'm gonna hoot and holler."

Researcher:

Do you see them feeling, I guess, differently, or better than you did as a child that age?

Grace:

Oh yeah, by the time I was seven, I was feeling like nobody wanted me, and my kids know they're wanted, because they'll tell me who wants them the most. And they'll try to get through that part. And, (middle child) he, I think he's quite a bit bonded with mom (Grace) -- hardcore. And (older child), I think she's just in one of those stages where it's like, "Okay, yeah mom loves me but I'm going to start to turn into a teenager and my friends are more important." So she's at a strange age. Her friends are important to her and I understand that so ... and (youngest child), he's still the baby. And in a way I kind of show him. Just like he knows, no matter how old you get, mom's still right here, mom's still calling you her baby. You know, they each have their special place.

Connection to others.

Connection to others has a role in both trauma recovery and family empowerment. The sample was split with their feeling of connection to others. About half the women felt it was very easy for them to get along with others. Many referenced doing well with talking to people at work. The other half reported some difficulties in meeting and talking with people. Some reported feelings of shyness. Others stated they just generally don't like having to deal with people.

Carla explained:

I think I'm easy to get along with. I know that I have a sense of humor. I know that I can associate well with people, but I don't like people (laughs loudly). I grew up with too many of them that I didn't like. ... It's difficult to try to start a safe relationship not knowing um, what people are really

> like because you end up .... What is there about a three month zone where you can fake it with anybody? ... in dating relationships or friendships or anything -- you know you kind of put on the best that you can but what happens after that you know, whatever your limit is two, or three, or four months, or something, that um .... I mean you can use movies as examples where people dated people for, for a year and then after they got married and living in that situation found out that they were in an abusive .... You know, so um for me it's just -- I think that I can get a long with other people but I'm very leery.

Dani stated:

> I have a really hard time even talking to people and getting to know people. Since I got my job as a _____, I open up a lot more because I meet different people that I don't know. But before it was really difficult for me to meet strangers. It was like almost impossible.

Amy noted:

> I think I am a very easygoing person normally, to get a long with, I mean, I can actually normally get along with anybody. Because I am that type of a person that you know, I like to actually -- even the people aren't really being real nice to me -- I mean, I'm the type that ... just kind of kills them with kindness. You know, I'm not going to be rude and obnoxious and I think I that I interact with people well. That' why I do my job well.

Fran stated that she felt good about herself in connection with others. She said that she can talk to people without difficulty. She can smile and not show that she's stressed, even on her worst day – no one would even know. She feels that she can be herself more around family – that "it's okay to be bitchy or grumpy then." She contrasted her people skills on the job with the people skills of her boyfriend, stating, "People know it when he's grumpy."

Helen was very clear about not wanting to be around others:

> I don't ... I try not to associate with anybody. He is the friend maker (refers to husband). He goes out and makes all the friends. ... I would rather be at home. If I didn't have to go out, I wouldn't. I would stay right here in my house.

Norah stated:

> I mean, it takes me a while to get to know people. When I first meet somebody, I'm pretty shy. No, actually, no, I don't like crowds. I don't do crowds well.

Trauma Recovery

Thoughts on recovery.

Most women viewed the recovery from abuse as a life-long healing process. Women reported being at various places along that journey, from not wanting to deal with it to feeling as though they had dealt successfully with it and were now trying to find ways of improving their families' lives.

Amy stated:

> I'm doing better but I still know that I've got some ways to go. I think that the healing process, I believe that you go through the rest of your life. Because I mean you can go through any type of counseling, you can go through any type of program -- it's not gonna make all that's gone wrong go right, you know, it's still gonna be there. So I guess you know, your whole life is going to be a recovery program. You know, because you're just slowly knowing that it's better now. You don't have to worry about that. You don't have to wake up in the morning and wish you didn't wake up and you know ....

Dani became tearful while she and I talked about her struggles in dealing with her abuse history:

> Actually from the experiences themselves, I don't even think I'm halfway there. I don't know if there is a halfway point. I survive them. I've gotten through it now, but I don't think, I've actually gotten all the way.

Researcher:

> How does it ... how often is it in your mind or, how often do you think about it?

Dani:

> Everyday. It's never gone.

Researcher:

> It's never gone. Is it -- I assume it's upsetting to you everyday?

Dani:

> Yeah (her eyes fill with tears).

Researcher:

> How do you get through that?

Dani:

> Usually I'll just read a book or go for a walk or spend time with my kids to just let them know that it's going to stop here. The violence doesn't continue. It did stop and that I made myself a better person because I was able to make it stop.

Researcher:

> Okay, so by doing things -- like how you feel are the right way to do them as a mother -- um that's kind of how you get through some of the things that are right up there still ....

Dani:

> Yep.

Grace explained about her healing process:

> ... A long way off. Oh yeah, I'm further than what most people would be but, I still have a lifetime of getting through it. It's going to last my whole life, I know it. That's probably why it's not affecting me as much, but I do .... I've got to deal with this for the rest of my life -- having me -- and I don't want it to hang out there so I've just got to focus on it, getting through it!

Fran briefly noted that in the recovery process she was:

> Nowhere, cause right now, I really don't deal with them.

In talking about her recovery process, Jen described a lack of closure related to her father who had abused her as a child. Jen explained that she was:

> Close to a ten-year anniversary ... yeah, it's just ... being on a better road. There's always things to work through (unclear). I don't know how to explain it - it's an anniversary in a sense, but then it's also been 20 years into not having seen my real father. And after living 10 years of sexually abused, I still want to know whether he's dead or alive. ... and I'm kind of to the point where forgiveness isn't all that hard to you. You're never going to forget, but in the same sense, I can't, I can't just swallow the fact that I have a father that I lost track of and I don't have clue one as to whether he's dead or alive .... I think I'm getting to the point where I'm around the end of the circle and I'm on the stretch of, you know, things have been going fairly good, and I'm even having issues with my own kids now, and I'm past my issues -- and I'm past my issues as a kid.

Kim described long-standing issues with her dad, who was also her abuser:

> I don't know if you ever really get over them. I live and I deal with them, but there's times that, like when I get really stressed, they bother me. Cause then you feel like, If this wouldn't have happened or that wouldn't of happened, maybe you would've gotten, here, there, better at this, or better at that, or .... I don't know if I've ever really healed from my dad, because to this day, I don't even claim him as my dad. I tell my mom, "That's not my dad." I don't even want to talk to him or deal with him.

Kim then talked about trying to learn from her experiences and take a different route. Related to her attempts to do this, she said:

> He's (dad's) kind of made it kind of hard I think too -- to like trust men completely, because I've seen what he did to my mom and what he's done to my brothers and sisters. He never really .... He was abusive, but he was more abusive towards them, because they were older and I was the baby, but I seen that. It bugs me cause sometimes like right now, like if I hear loud noises in the house at night, it really scares me, cause that's what would happen. I would be sleeping when I was a kid, I'd wake up and I'd hear loud noises and it was usually my dad beating my mom up. ... so, yeah, the kids think it's funny cause I'm joking or whatever, but, they don't know the whole story or even all the stuff ("blood ...") the first time I was eeewww (laughs) ....

Specific trauma-related issues that need to be addressed.

Women also talked about specific things that they felt they needed to address over the course of their recovery. All but one woman discussed things

that still bother them. The majority talked about unresolved feelings stemming from the abuse. As Amy described:

> I think a lot of it that I've got to deal with is the fact that I let people make me feel guilty. ... like my family. I let people make me feel that I was the bad person -- that I was the person that you know, at eight years old, obviously made everything happen in my life. You know, and uh, I guess I need to forgive myself for actually letting it (the abuse) go on as long as it did because you know yes, it was very uh, hard to get out. When I did get out it was like this thing had been taken off my chest, that I couldn't breathe for so many years. When I could actually go someplace and not tell somebody that you know, that I had to go to the store for this and that and I had to be back in 10 minutes. You know what I mean. That type of situation where I was my own person, for once in my whole life. And that was very, it was very, lifting, you know because I could actually say I'm finally free and then I had to get to the part where I had to free my children. So, I guess my biggest thing was when I walked out and didn't turn back because you know if I would've, I probably would've thought, you know, "Well what about my kids," you know but I couldn't, because if I did I would have never gotten out of there. The kids would've never been safe, so ....

Dani stated that she needs to work on her self-esteem:

> I have a lot of problems with low self-esteem. Um, just thinking I'm ugly ... thinking I'm a bad person because of the things that they had told me.

Eve talked about her feelings of anger:

> I think I still have um, just that, that pinch of anger-ness. It's kind of like, to this day if I ever seen them people again .... It was like, it's like I would just, I would want to just put my hands around their neck. But, I think as long as I um, you know, never have contact with these people or never see them again, then, then I think there's just a like just that angry-ness. That little bit of anger towards them that I'm probably never gonna um, ever have let go because I know that that would be a person that 'd rather hurt me or hurt my family or something like that ....

Helen remarked that she would like to deal with everything that happened to her, "eventually." Her husband, who, with her permission was present for part of the interview, added some thoughts:

> I'm not there yet. I know I'm going to have to. Because, until I do, I'm

never going to get anywhere. But, it's just too hard. Right now, I'm not strong enough, I think. ... it's not just the strength, it's the emotional aspect. I'm always under stress. I have a very high threshold for stress. (Husband adds, "She's under stress if she's sitting down on the couch reading a book."). I go to bed exhausted every night.

The role of family intervention in helping with trauma recovery.

Many informants had identified their children or family as the focus of change to be facilitated by the family-based services' Family Intervention Team (FIT). I asked informants what the role of FIT should be in helping through those issues of recovery that they would like to address. About half the women felt that FIT did not have a role in helping them with their recovery, and listed various reasons. Many listed other therapists who they see or had seen individually as having that role. Much of the focus, again was on helping the children. A few women specified that the role of FIT was to make connections from the abuse histories to moving forward and making better choices.

Carla explained her feelings that family intervention should have a big role in making connections:

> It's gotta be a big one, because you're the only ones out there right now that can make the connection. But, you know they've got enough history and what not to -- kind of like what you're doing -- you know to gather the history to see where, where we can go. I don't know sometimes I wish (FIT therapist) would give me more information on, who we are or how we are, from his perspective. So that I kind of have an idea of where we're going from here. (Carla pauses to talk to her toddler.). ... rather than just, well you know, "You guys are doing okay, " to give me a more, um, clinical aspect? To say, "Well all right here's a chart and these are the people that we deal with and you're, you're kind of in this category, and we feel that you know, if we can get you heading in this direction, rather than you're kind of you know tending to go this way .... Because I can't always look at the whole situation, you know. ... that now, if I'm in the way, tell me I'm in the way. Don't wait for me to catch on -- just kick me in the butt. And that's what I would like to see more.

Helen felt that the role of FIT should be focused on the child. To follow is our discussion:

Researcher:

> What do you think should be the role of FIT (Family Intervention Team) in helping you with any of your recovery?

Helen:

> Well, none. Because, we are trying to deal with (identified child).

Researcher:

> Okay, so you feel like the kids really need to be addressed. If you felt like it was something that you were needing help with or you were ready to address, would it be something that you would ask for of the FIT team?

Helen:

> Yeah. Cuz I keep thinking if I don't address my own emotional problems, how am I doing to help my kids now?

Researcher:

> Yeah, it's a hard thing because it is kind of, you know, like you said, it's emotionally, like, really taxing to kind of work on it. At the same time, it's kind of like a catch-22, I bet.

Helen:

> It is.

Jen felt her it was FIT's job to recognize any correlations between her abuse history and her son's emotional and behavioral issues. She alluded to not wanting to be blamed:

> I don't want to say that you shouldn't have had a role in it and (unclear) my experiences, because to some extent, going into all that, that I knew my experiences may have been related events. But my son's experiences are, and I would feel that it would be FIT's job to recognize that .... Those correlations of what was going on with him and with what I had been through in the past. So I guess just the ability to recognize any correlation if there is any without directly attacking my experiences.

Patti wanted help putting it all behind her. She stated:

> ... give us some ideas on how to get our minds off these things. Some extra ideas that I haven't already thought of or something. ... I think the main thing is putting it behind us.

Dani felt that there was no real recovery from her history of traumatic abuse:

> I don't think you ever really, fully, recover. It's just like ... a scabbing over. It's just there. But, it doesn't hurt as much anymore unless something's touched upon that clicks in your head. Maybe ... just some simple thing that could be said. It doesn't necessarily have to be just directly. Just any little thing that somebody could say clicks it back in your head so, I don't think there's ever a recovery from that. I don't think you can.

Healing of mother seen as help to family.

Whatever they believed about the recovery process, or about the role of FIT, women noted that their helping themselves in the healing process would help their families as well.

Amy gave the example:

> I think that will help a lot because once I can actually heal myself, I can actually help them (her children) better knowing how I went about doing so, it'll help them. Not to mention maybe even them seeing me how I'm healing and getting .... That might help them, to where you know they can get through it a lot easier. Luckily they have not gone through it as many years .... But it's still is traumatizing to them because actually in my life, I was almost hardened to the fact that it was going on, where they didn't have the cha - really the chance to harden. They just kind of was wondering what the heck was going on.

Eve stated:

> I think it's basically just dealing with every day and learning from new experiences. I guess that's basically what it is, is learning from experiences that corrects my mistakes and so that I'm not repeating my mistakes and just making life more stressful.

Helen said that if she were to begin to recover from her trauma, she thinks she "would be a better mother." I asked her, "How do you imagine yourself being a better mother if you worked through some things?"

She replied:

> I would be more open with my kids. I don't like to be touched and I don't like to touch. I don't even like to say, "I love you." I know the kids need to hear it. Otherwise, they'll grow up like me and not believe they're loved at all. So, I think, I maybe should start addressing issues now, so then that way they are not adults saying this to you or to (outpatient therapist).

Olivia remarked:

> I think I need to do that just for them to get better. It has to be a joint effort.

Patti talked about her recovery being of help to her children, and to her abusive husband:

> Um, if they see me trying to get over these things, it will help them try to get over it too .... I think it'll probably make him (husband) more want to get some help so that he won't do this anymore. And I think he has actively come to that conclusion that he needs some kind of help.

Family-Based Services Needs

During each interview, informants were asked their ideas and perceptions about family empowerment as a goal for family-based service intervention. Conversations about family empowerment, per se, were introduced by the researcher. Each informant was provided with a written (see Appendix I) and verbal explanation of family empowerment. The researcher answered any questions that informants had regarding the family empowerment concept. It was the understanding of this researcher that each informant grasped the

concept of family empowerment as an overall goal of healthy family-functioning for families and professionals working together in family-based services.

Perceived family-based services needs – general needs.

Informants gave various responses to the question, "What do you need from FIT to increase your family empowerment?" A number of women responded with some specific request or answer that was not necessarily something that a therapist could successfully bring to the table (e.g. "a house," or, "a new husband."). Many discussions of empowerment came down to one related theme. However large or small the women envisioned it, they all wanted continued support from the Family Intervention Team to facilitate their strides towards positive control of their lives and increase the quality of their families' lives.

Once again, Amy summed it up quite well:

> I think I just need to mainly get um .... The big thing is getting control of what's going on and that's the hardest part with the kids because that's what they're fighting against. They're fighting against me getting control and anybody else helping me get control. They're fighting against everything possibly because they don't want me to have that control. You know they're like – they like the idea of actually being able to do what they want and they're not understanding that, you know, they're just going to have to deal with it. ... and with me getting my life in order to where I'm actually getting control of myself and my children – you know they're fighting real hard against it.

Dani's needs primarily focused on dealing with her stepson:

> I guess the main thing that I think we would need is just little every day-to-day things to get through with my stepson ... just better ways to maybe help him get through without so much of the anger, and the hostility towards everyone.

Researcher:

What day-to-day things? Like maybe the therapist giving you ideas ... like what do you mean?

Dani:

I know she (therapist) does a lot to help, but sometimes I don't feel like it's enough, cause it's still there. The kids are afraid of him (identified child) and uh, sometimes I feel intimidated by him and it's just like sometimes I don't exactly know where to go to get that help ... I talked with the probation officer and they say this and I'll tell them that sometimes I think maybe he'd be better off in out of home placement, for just even a little while, and they say "no." But yet everybody -- the kids are all afraid of him.

Researcher:

So maybe like more help in just somehow dealing with that, with the kids' fear and ah, getting more specific tips, I guess? Or things that you can do or ....?

Dani:

Yeah, You know then they'll tell me that he has this medicine he takes daily and I have to make sure he takes it, but with him it's not that easy. If you hit a wall with him, you're there and he could set there forever, and just shut everything off, and it's like you know, what do you do from there? What point do you take from there, if he just shuts down in total refusal. Where do you go from there? Instead of the head to head confrontations, how do you avoid those? And you know, what do you do when they're there?

Fran made the statement, "Take my oldest child away." She said that she needed some out-of-home placement or foster care for her daughter. Fran talked about the rest of the family being afraid of her oldest daughter, but also of Fran being afraid that she would harm her daughter, or just leave the home.

The content of Grace's request was far different and less crisis driven than Fran or Dani's statements.

Grace stated:

> Basically, just keep listening. That's the big thing. Sometimes we won't directly say what we need and we talk about it, cause sometimes we don't know exactly what it is we need. Sometimes we need to bounce our ideas off you and have you just kind of pick up on it, you know. And it helps that you guys have got the experience, because your therapists, so .... Well, for instance I was having trouble with (identified child) with the discipline for so long. I kept complaining about it, and venting about it and we finally decided to get him in to see the shrink and see what we could do about it. Things were going pretty good and he started mellowing out. So that's like what I'm talking about. Cause I didn't come right out and mention it. We talked about the possibility and make it happen. (Researcher mentions that the children got mentors also.). That was really neat. I am so glad about that. They (kids) loved that idea. They don't want to go with out a mentor for even a day. They like having that!

Kim explained what she needed to help increase her family empowerment:

> Just help me I guess be a stronger person, and... be supportive of me and let me -- basically that it's not my fault or whatever -- that we're at today where we're at because of me. Or something I've done. That's what the courts try to put off – that (probation officer)!.

Olivia gave some insight about her need for support from FIT. At the same time she also discussed her anxiety about having to handle stressful situations with her children by herself:

> Support. That's the big one. The support of knowing that someone is actually there. For a long time nobody was there. I did find out that (FIT therapist) will come running really fast and does come running. That was really nice to know because there was a few times that nobody, you know, he wasn't there. I had to talk to someone else. Sometimes, even though I know that I can deal with a situation, but in the middle of the situation...when (child) gets into whatever you want to call his little fits he can be very difficult. One time he tried to put his hand through the wall on me. I called and it was nice to have someone there to talk to me. At the same time, right then, I had wished so bad that someone could have just come and help me deal with it at the same time. Even though I knew that the talking did calm me down enough to deal with it, I still wish that I could have had the time away. The one time that (FIT therapist) came running when (child) got really bad. He came running right over. That was the first time (FIT therapist) did that. I mean, there's only been a few times where (child) ... but it was really nice to know that if it really got down to it, he did come and was there for me. It has been a long time since anyone has been there for me. My boyfriend can't exactly be there for me right

> yet. I mean, he can be a phone call away, but he lives down in (city). I mean, we're there on weekends, but that's the end of it.

Parenting needs.

Since families are eligible for family-based services based on the risk of need of identified child or children, parenting is often a focus of family intervention. One question in the structured interview focused on parenting needs specifically. The researcher asked, "What do you need from FIT to help you become a better parent? With a few exceptions, women explained that they needed support from FIT; and knowledge about different parenting strategies, parenting techniques, and child development. The exceptions to this theme were from women who stated that they did not need anything from FIT regarding their parenting. Mia felt that she was the best parent that she was ever going to be, and Fran stated it was "too late for that."

Iris' thoughts on parenting are reflective of what most women felt:

> (I need) the knowledge, the information, the access to the information and the help that is there. Well, there have been many, many things that I have been able to ask (therapist). There have been a bazillion questions on different things on understanding Joe's (child) disorder, understanding his behaviors and why those behaviors are there. And with (treatment center) as well, it has helped to learn how to coach Joe better.

Kim stated:

> Probably just coming -- overcoming obstacles that we're going through cause I feel I'm a good parent, but there's always more that you can learn and achieve as a parent. Cause it's like an everyday learning process for me.

Mother's role in family goals.

Women in the sample all had ideas on what their particular role was in helping their families and children to work towards improvements in mental

health and family functioning. All informants endorsed their willingness to participate in services with their children. Women discussed providing their children with guidance and consistency, while being the driving force behind the family making improvements.

Grace stated:

> I'm the leader. I'm also the most consistent person in the family. We've had dads come and go ... and being that one consistency seems to be that big role. ... that's my job! ... love it! It's hard, but if it was supposed to be easy it wouldn't be any fun!

Iris noted:

> My role is to help give good guidance, help build self-esteem and help have the kids involved in the right things, whether it be sports or social situations.

Laura discussed:

> Well, I try to keep things .... I make suggestions with Shelly. I try to keep things going around the house. I will sit down and I'll talk to her. You know, if something's going on that I'm not too happy with and stuff like that, I'll sit down and try to discuss it with her. Once in a while, we still kind of "butt heads" – is what I call it. You know we'll have a big disagreement you know, or something like that, but nothing out of the norm. You know, it's just normal ....

Patti explained:

> I think that if the kids hear me say we're going to do such and such. And, keep to that. I think it gives them the power to set their own goals and keep them too.

Family-Based Services Successes

What has gotten better.

Fifteen women identified things about themselves, their families, or their children that have either improved or changed over the course of services. Seven of the women mentioned mentors and other community supports as

having had a role in the changes that have taken place. Helen was the exception, in that she was not able to note any changes or improvements ("Not yet."). Helen had been engaged in the Family Intervention Team services for three weeks at the time of the interview. Her family had received the least amount of intervention in the sample.

Iris stated that "a lot" had gotten better:

> Everyone in the house, I believe, has a better understanding of Joe (child), including Joe. I think we've all learned some new skills that we didn't have before on, oh golly, negotiating maybe, and communication.

Jen also noticed changes in her child, and with how the family responds to him:

> Just how we deal with issues that come up with Brendan (child) or any of the kids. ... communication. I'd have to say behavior. Um, how to put it? He (child) has more personality. Like, you know what I mean? He seems happier now finally.

Mia explained that she understood more of her child's needs and how to handle him. She had become involved with NAMI (National Alliance for the Mentally Ill) as well. She found that one of the books they recommended as extremely helpful to her. She got it out for me to see. It was called, The Bipolar Child, by Demitri and Janice Papolos. Mia believed that with this knowledge, she had begun to notice her child's moods, and paid more attention to his lows.

Amy reflected on changes that have occurred and related them to the mentor services that her children are participating in:

> I know the mentoring has been a big help because the kids like the fact that you know, they can get out and do something and, ah, like I said, have something all to their selves. But yet, even though (two of her children) gotta share (a mentor), it doesn't matter because they don't have to go the same day. But you know, it's funny is Carrie (child) was bored because Casey (child) wasn't with her yesterday ....

Researcher:

What else has gotten better for you family?

Amy:

> The girls are helping out a lot more. My house is not trashed like it used to be. They are, Carrie cleaned up her whole room by herself yesterday .... She did the dishes. You know, it's little things like picking up the yard or, picking up things to where it doesn't have to make a mess that helps out the most. You know, when you're working all day, even with a job like I do, you're still stressed out from the day, and you go home and you know the house is trashed, you gotta work all night to clean it, you know, that doesn't help at all because you're so frustrated because you're just tired. And there are times that I got such headaches because of my sinuses when all I want to do is lay down, and I gotta go home and cook this and do that, and do that, and you know when Celia (child), she'll take over in the cooking if I ask her to, you know. "Can you, you know, can you make the girls something, you know this or that for supper?" and you know she'll do it. So if I don't feel good, you know .... But I mean there was a time when they wouldn't do nothing. They would throw their stuff all around, they would step all over stuff, break stuff, and they would not pick up nothing. They're helping a lot more then they used to.

Best achievement in services.

Informants identified a number of achievements of which they were quite proud, and that they related to their participation in FIT services. The majority of the sample gave examples of improvements in family communication and cohesion. Others gave very specific examples of things that they had done which relieved some stress in the home (e.g. one parent quit smoking inhibiting home access to lighters and cigarettes for a child who had been fire-setting). Amy explained her family's achievements:

> I think we've gotten closer to each other. You know, where we could actually talk without screaming at each other -- actually have a conversation. And like I said, I think with their helping in the house now, they're actually ... they're actually wanting their home to look good. They don't want to live in a mess and I think that's showing me that they're ... that they're getting better with their self esteem, because I mean, they

want people -- when they come over -- to see a nice house. They want to actually say, "This is my home and not a mess." And I think that's pretty good that they finally care, you know.

In my conversation with Carla about changes her family has made, she noted:

I think that the kids have learned to process their anger more with working with (FIT therapist), especially (female child) .... (Carla tends to her children who are playing outside, then returns to the conversation.). Okay, tell me where we were.

Researcher:

Ah, what changes have you made that you and your family are most proud of? You said the kids were processing anger better.

Carla:

Um, and I think that I can just put mine right off the shelf and just say, "You know, I don't need to be angry about this anymore." Learning and learning new skills. Um, what else? Ask me again and I'll have another answer.

Researcher:

What changes have you and your family made that you are most proud of?

Carla:

(Pauses) For some reason I think there's better communication and I'm not sure really which end that came from -- if it was the way that I talked to them (the kids), or that they actually started to listen. Something in there changed for the better -- better communication. Um, I think too because we don't have um, a family unit with grandparents and uncles and aunts, and neighbors and what not -- we're not in that -- that when you have people like (FIT therapists), who are like professional aunts and uncles, is what it's like. You know, they come in, in a form of perfection, and set an example for the kids to look at other than me. And say, "Well, you know we should behave more like uncle (therapist's name) said," or you know or like, "(FIT therapist) told me that I could try this." So, having that intervention of the perfect role model has helped the children too. (Unclear) ... couldn't we choose to have aunts and uncles and cousins like that? (laughs) ... professional perfectionists, yeah.

Kim stated:

> I don't know, I'm pretty proud of the as far as we've come, cause it was actually getting to the point it was pretty bad. It was like a daily base thing of, "Who's going to call the cops first?" or whatever. So, I'm pretty proud that we've all stuck together – like we're all getting through this together.

Norah:

> Actually, I'm more proud of (child). She is learning. She is learning there is consequences for her actions. ... no, she has always had consequences. She has always had them, but I've never been consistent with them. I'm doing better. She has really been so much better. I can't believe, I mean, just medication ... I say that to people if they do a study or whatever, listen, because I'm telling you the truth. The medications, Adderall and Ritalin are not answers for kids. They are not the answers for kids.

Qualitative Connections to FES Scores

As discussed in Chapter 3, the FES was designed to reflect two dimensions of family empowerment (Figure 3.1, p.82): 1) the level of empowerment, and 2) the ways that empowerment is expressed (Koren, DeChillo & Friesen, 1992). With regard to the first dimension, there are three domains in which parents and family caretakers can express and achieve empowerment: families, service system, and the community. Empowerment within the immediate family pertains to a sense of efficacy in managing difficulties at home and daily circumstances. Empowerment with the service system involves parents' working actively with the professionals and agencies that provide services to the family and identified child in order to obtain appropriate services. Community/political empowerment signifies efforts to improve services for families and children in general; primarily involving parents' advocacy for children in general (Koren, DeChillo & Friesen, 1992; Elliott, Koroloff, Koren, & Friesen, 1998).

The second dimension of the FES demonstrates three ways to express family empowerment: 1) Attitudes: what a parents feels and believes; 2) Knowledge: what a parent knows and can potentially do; and 3) Behaviors: what a parent actually does. Each of these types of expressed empowerment can occur within each category of the level dimension. Figure 3.1 displayed the conceptual framework and item stems for the Family Empowerment Scale. In an analysis of the FES, empirical distinctions among attitudes, knowledge and behaviors were overshadowed by stronger differences in the levels of empowerment, and the current system of scoring based on the level dimension was supported (Koren, DeChillo, & Friesen, 1992).

This section will examine connections between FES scores and qualitative interview data. High and low FES scores on the **Level Dimension** will be examined for association and support of qualitative data. This section will also examine the conceptual **Expressed Dimension** of Empowerment, to look for evidence in the qualitative data that connect with the conceptual framework of the Family Empowerment Scale.

The Level Dimension

Level of family empowerment.

Table 4.1 displays informants' FES scores. The greater the score, the greater the amount of empowerment. On the family and service system subscales the highest number of points one can obtain is 60 points for each scale, while the lowest number one can score is 12 points. On the community/political subscale, the highest number of points a respondent can

obtain is 50 points and the lowest score is 10 points. Table 4.2 displays the sample mean for each level of empowerment.

High scores on the family subscale indicate a sense of efficacy in managing difficulties at home and daily circumstances within the immediate family (Koren, DeChillo, & Friesen, 1992). On the family subscale, Laura and Iris had the highest scores of the sample (see Table 4.1). Neither woman was abused as a child. Laura and Iris had each escaped domestic violence situations, taking their children with them. Both reported trying to escape a few times before successfully being able to separate from their abuser. Laura and Iris talked of having strong family connections and support, but having been isolated from that during their abusive situations. One apparent difference was that Laura is now a single mother, while Iris has remarried.

Both women discussed feeling as though they have done well with trauma recovery. Iris had stated that she has gone as far as she can with her recovery. She stated that she is "fine" and rarely has to deal with trauma issues for herself. Laura continues to work with a therapist on issues that "pop up" for her, but she stated she has "done a good job" with recovering from her abusive experiences. Laura and Iris shared an acknowledgement that their children had suffered from the domestic violence situations, and that their children continued to struggle with what they had lived through. They appeared to speak similarly of their approaches to supporting and guiding their children through both good and bad times.

Iris spoke in a calm, and positive matter about the effects of domestic violence on her family life. Iris often talked about seeking knowledge, and gaining understanding for herself and her children.

Iris explained her thoughts on parenting:

> My role is to help give good guidance, help build self-esteem and help have the kids involved in the right things, whether that be sports or social situations.

She discussed improvements in her family:

> Everyone in the house, I believe, has a better understanding of Joe, including Joe. I think we've all learned some new skills that we didn't have before on, oh golly, negotiating, maybe and communication.

Iris noted her feelings of anger left towards her abuser, Joe's father:

> ... it's not like I want to do anything to him or get any kind of revenge or anything like that. I just, I think the anger is mostly ... I mean, it's somewhat for myself, but I'm angry because it has hurt my children. It has affected their lives. I am a big girl, I'm strong, I'm past it. But, I see how it affects my children. That makes me angry. Joe, especially, has a lifetime to deal with it. I worry about the other ones as well. But, Joe has such severe problems from it.

Laura explained how things have gotten better in her family:

> I think Shelly and I are having a better relationship. We still have our disagreements, you know and stuff like that, but I think we're getting along a lot better. Well, I stick beside Shelly. You know, I mean I help her out and everything. I try to give her a lot of support now with this stuff that's going on with (Shelly's boyfriend) right now. She's kind of in the dark. She's 16-years-old, so I'm supporting her with this. Things are getting better. Her past behaviors were pretty bad at one point and now they're getting a lot better. Working with the FIT team has helped.

Laura stated that she was most proud of learning new parenting skills:

> Well, I'm always trying to learn parenting skills. I always try to learn something new. You know and I have taken parenting classes to which that helped a lot. But, you know, I am always open to other suggestions, other ways, you know for parenting. I think that helps a lot. Listening more, rather than ... I used to listen to part of what she (Shelly) would say

and not all of what she would say. Of course, she was just as guilty of that as I was. Now, I'm listening to the whole thing and that helps a lot. So, I'm kind of proud of the fact that I can give her (Shelly) the support she needs and we're having a better relationship and stuff.

Table 4.1: FES Scores -- Displayed Level of Empowerment.

Informant	**Family** *(score/60)*	**Service System** *(score/60)*	**Community/ Political** *(score/50)*
Amy	49	55	37
Betty	49	48	**42****
Carla	42	55	21
Dani	40	53	33
Eve	42	44	30
Fran	**34^^**	45	27
Grace	48	48	35
Helen	35	43	**13^^**
Iris	**58****	56	36
Jen	44	44	29
Kim	53	59	40
Laura	**58****	**60****	40
Mia	53	**60****	41
Norah	**34^^**	39	21
Olivia	46	46	35
Patti	35	**37^^**	24

** indicates high score for the sample
^^ indicates low score for the sample

Table 4.2: Mean Sample Scores for FES Levels

Level of Empowerment	Mean Score for Sample
Family	**45**
Service System	**49.5**
Community/Political	**31.5**

On the family level subscale of the FES, Norah and Fran had the lowest scores of the sample (see Table 4.1). Both women had survived domestic violence situations as adults. However, Fran reported having been sexually abused as a child. Norah reported spending time in and out of psychiatric hospitals and foster homes during her childhood. Both women reported a tenuous relationship with their mothers, while both received help from their mothers to get out of their domestic violence situations. Both women had daughters who had been abused during a domestic violence incident. Both reported that their daughters had acted out aggressively towards them. Despite their daughters' aggressive behaviors, both women talked about being fiercely protective of them. Norah's daughter was much younger than Fran's.

Fran and Norah both sounded hopeless about certain dynamics in their immediate families. Fran's sense of hopelessness was connected to her daughter, who was the identified child on the FIT case. In her interview, which was not recorded, she made remarks such as, "Take my oldest child away." She felt strongly that she needed her oldest child out of the home for a while, and alluded several times to feeling as though she was not getting the help that she needed.

Norah was quite hopeful when it came to her daughter. Norah validated the abusive experiences that she and her daughter lived through with her abusive ex-husband/daughter's father. She acknowledged ongoing improvements in her daughter's behavior, and in their mother/daughter relationship. She discussed her distrust of services due to her past experiences,

but stated she felt that she was happy with services the family was receiving from FIT.

Norah's sense of hopelessness appeared to be most connected to her past and difficulties that she felt she could never resolve with her own mother. From what she said in the interview, it seemed Norah was still dealing with a loss of control in her family of creation, whenever her mother got involved:

> ... my mother. There are things that really bother me. Like, she's raising my (sister's kids), because my sister (mumbles) .... But I mean, that is their (refers to her children) Grandma and these are her grandkids too. ... she knows that we don't have a lot. There is things that bug me, like she buys those kids thousands upon thousands worth of stuff. What do my kids get? A $20 swimming pool and a bike. It's always been that way with me and my sister both. I am the one who, I think is pretty normal as normal can get, you know. ... but, I look at it this way, you know some of my life experiences ... I was in Pine Rest, I was in foster care, I was in Forrest View, I was in foster care, I was married at 19, I had a kid and was divorced by the time I was twenty-one. I still didn't get on drugs. My mom didn't raise me. I'm not the one who's addicted to cocaine, I'm not the one who's an alcoholic (refers to sister). I'm not the one who has had three drunk drivings. Maybe I shouldn't compare. I'm not the one sitting in prison. So, survival skills?

When I asked Norah if she felt FIT should have a role in helping her through some of the things with her mother that are really bothering her, she stated:

> No, those are issues that will probably never be away, you know what I mean? My mother is my mother. I don't have a close relationship with her and I never will. I don't trust the woman. That sounds terrible. I don't trust my own mother. Those issues with my mom, you know, they're dead. They (services) couldn't help me when I was 13 and they're not going to help me when I'm thirty-one. I know what my mom is like. You know what I mean? They don't know my mom and my mom, like, with my sister; now she's trying to be close to me because my sister is in prison. It's not going to work that way. I have grown up to the point where I don't depend on my mom. I used to try to get her approval and I know I'm never gonna. So, what's the use in trying? With me and Tom fighting this weekend because he's having problems with the kids, she's on the phone talking to Tom instead of talking to me. It's like, "Mom, you don't even know what's going on in my house. Don't even start criticizing what's

going on here when you don't know. You can sit here and say all this stuff about Tom, but you don't know what's going on here."

Level of service system empowerment.

As illustrated in Table 4.1, on the service system level of the FES, both Laura and Mia obtained the highest scores in the sample, while Patti scored the lowest. The qualitative information, provided by Laura, Mia, and Patti, in many ways fit with the Koren, DeChillo & Friesen's (1992) concept of service system empowerment. Empowerment at the level of the mental health service system involves parents' working actively with the professionals and agencies that provide services to the family and identified child in order to obtain appropriate services (Koren, DeChillo, & Friesen, 1992).

Laura, Mia, and Patti had in common that they survived domestic violence situations. Laura had long escaped her abuser. Mia had long escaped her abusers, however she was in the process of leaving her current husband, who had acted abusively towards her as well. Patti on the other hand, was separated from her abuser by the courts and he was placed in jail (following his physical abuse of their child). Both Laura and Mia both gave evidence of negotiating the mental health service system and advocating for their children. Both were involved in mental health-type panels or organizations. Both were active and purposeful in how they negotiated the system for their children.

Patti did not have as much to say during her interview, and in some ways seemed more passive when it came to obtaining services for her family. She made statements such as, "Somebody's been called in for whatever is needed. Like when (child) did try and jump off that balcony, they called people from here

(FIT)." Patti did however, call the police when she found that her husband had physically abused her child. In reference to the police intervention she stated, "...yes they were very helpful. I basically, I think what I wanted was for him to get some help and that's what he did." Patti later talked about wanting to put this issue behind her and move on. She had plans to re-unite with her husband following his trial. Patti's style of dealing things was often to try and disconnect herself – either reading a book or trying to get her mind off of things. Another theme that emerged for Patti was that when things got difficult, or crisis driven, she "called for help," letting the services take over from there. So, even though Patti was quick to call for help, the majority of the power appeared to stay with the service providers who then swooped in to stabilize things.

Level of community/political empowerment.

Community/political empowerment signifies efforts to improve services for families and children in general; primarily involving parents' advocacy for children in general (Koren, DeChillo & Friesen, 1992; Elliott, Koroloff, Koren, & Friesen, 1998). On this level of empowerment for this sample, Betty had the highest empowerment. Helen's score was the lowest (see Table 4.1).

In Betty's interview, which did not reach the same depth of the majority of the interviews, I found no qualitative evidence of community or political empowerment to support her high score. It is possible that the interview questions were not formulated in a way that would adequately spark discussion about informants' efforts to improve services and advocacy for children in

general. It is also possible that Betty misunderstood some questions or over-reported her advocacy in the community.

Helen did speak about community issues that affected children in general. Her input will be paraphrased so as to keep her confidentiality. Helen mentioned two community circumstances that had to do with housing – both emergency and subsidized. She talked about feeling frustrated, disappointed, and unheard when it came to issues having to do with her family and other families in the community. In one circumstance she stated she, "threw a fit." But as far as the community housing resources responding to her fit, she noted that, "something should have been done about that and nothing ever was."

Expressed Empowerment Dimension and the Conceptual FES

Expression of attitudes (see Table 4.3).

For the **expression of family attitude**, it was not surprising that Iris scored high and Fran scored low, based on qualitative data previously discussed pertaining to the level of family empowerment. Iris felt strongly about providing her child with guidance, help and support. Fran, though she was protective of her children, felt very hopeless and lost when it came to parenting her older daughter.

For the **expression of service system attitude**, a number of women scored high. As a survivor, Amy explained with a poignant example about what she felt and believed about the role of the service system in her life:

> I think you guys (FIT) are doing good ... I've had no problems with that, because a lot of my problems, if I've got a problem, you know I will talk to you guys the next day. Like I had that problem with what my aunt and

> stuff was saying. ... you could see that I was visually upset about it and you know if I do get upset, I know you guys are there.

Amy believed that by surrounding herself with the service system, she was protected from her abuser and was no longer isolated or "away from the pack," as she put it. She earlier stated that it was a process for her to gain trust in anyone, and she was able to gain trust in the service system. Once that trust was achieved, Amy explained how she and her children were protected by having services around them:

> ...and I'm not by myself, I'm not alone – that's the biggest thing. Because that's where predators feed – on people like myself. That's because they know if you can get them alone to where nobody wants to be around them, nobody wants ... segregate them from everybody else. It's just like you know, a zebra. You know, out in the wild and you got these animals that want to eat, to attack 'em and kill 'em and that's the type – they're on the prowl for people that are weak and for people that are away from the pack. And that's exactly what these people do, is they segregate you from family, from everybody else. They don't allow you to be with anybody that's going to give you the help you need to make sure that they can do what they want, get away with it, and you're too terrified to say anything because you don't know who to go to.

Eve scored low on service system attitude. Eve verbally acknowledged that she felt supported by the service system. She said, "I actually had a lot of support throughout my situation." However, as discussed earlier in this chapter, there were many times that Eve brought up the idea of retribution for both her abusers, and for the person who abused her children. The idea that Eve's abusers were not justly punished for their crimes could support her low score on attitude towards the service system. Also her difficulties with a former FIT therapist, which she stated had been resolved, may have inhibited her score as well.

It followed from previous discussion that Helen scored low **expressed attitude on the community/political level**. Laura and Kim both scored high on their attitude towards the community/political level for children in general. Kim's interview did not have qualitative data to support her high score regarding feelings towards advocacy for children in general. Laura, however mentioned her involvement in a community-linked panel. This is the only data to support her high score.

Table 4.3: FES Expressed Attitude Scores by Subscale.

Informant	**Family** *(score/20)*	**Service System** *(score/15)*	**Political/ Community** *(score/15)*
Amy	14	**15****	13
Betty	17	11	13
Carla	12	13	11
Dani	12	14	10
Eve	14	**10^^**	10
Fran	**8^^**	12	10
Grace	15	13	12
Helen	13	13	**6^^**
Iris	**19****	**15****	14
Jen	14	13	11
Kim	16	**15****	**15****
Laura	18	**15****	**15****
Mia	15	**15****	9
Norah	11	12	10
Olivia	15	13	13
Patti	12	11	9

** designates high subscale score for sample
^^ designates low subscale score for sample

Expression of knowledge (see Table 4.4).

There were a few trends in the expressed knowledge dimension of the FES. Helen scored low in her **expression of knowledge on all three levels (family, service system, community/political)**, while Laura scored high on all three levels of empowerment. In her interview, Laura talked a good deal about knowing things now that she did not know when being abused by her ex-husband. She also stated that, "If I'm unsure about it, I found out."

Throughout her interview, Helen often stated, "I'm not there yet," or "I'm not strong enough," regarding working with therapists or services to improve her functioning as a parent. It would follow that if she was not ready to address her long-standing issues, she may not have the experience or knowledge of what she can potentially do when it comes to the three levels of empowerment.

Iris had a high score with her **expressed knowledge on the family level**. In her interview she stated that her trauma experiences had very little effect on her daily life. She noted some of the things that had made the difference for her and for her parenting approach with her children:

> Time, reading and understanding. I have done some of my own research and it helps to understand the cycle, the power and control thing. ... just the knowledge makes you stronger, besides, the passing of time. Besides, he (abuser) lives several states away, so I don't have anything to fear anymore. Having the understanding of some of the things that caused that and that cause a person to act that way helps me understand how I can help my children better. I hope.

Mia's interview data supported her high score for **expressed knowledge on the service system level**. Mia noted her involvement in NAMI, and her advocacy for her son to insurance companies and service providers. She talked

about reading up on her son's diagnosis, and made various attempts to educate his teachers about his behavior and what he needed.

Norah's qualitative information was again somewhat consistent with a low knowledge score on levels of family and service system empowerment for the sample. Though Norah reported that things were improving for both she and her daughter, she also discussed a time in the not so distant past, when she really didn't know what to do with her child, or who to call:

> Oh, back when all this stuff started I called ... if I have problems now I would call (FIT therapist). If (child) has got problems at school, I call the school. I talk to either her teacher or the counselor at school that she deals with. Back in October (2001) I called, cause I mean, I didn't know what to do really. When you've got a child who is hitting you and, you know, beating the parent up, you call protective services and say, "I need this child out of my home or I will hurt her." I told protective services... (Who replied,)"Well, there's nothing we can do, she is not being abused." When I called the cops, they didn't even do anything. They came over, but they didn't file a report. They didn't file nothing. Kent County did, but I kind of let that one go because we moved to Ionia County. Kent County did file some kind of report. I did press charges against her for doing that kind of stuff. Nothing ever came of it in Ionia County here. Now it's changed. Like I said, we took her off the meds and that was a big thing. I really honestly believe anybody that will think about Ritalin that early had better think twice. The downs are awful. I mean, just terrible.

For expressed **knowledge on the community/political level**, there is not sufficient qualitative data to confirm or discount Iris' high score or Helen's low score.

Table 4.4: FES Expressed Knowledge Scores by Subscale.

Informant	**Family** *(score/20)*	**Service System** *(score/25)*	**Political/ Community** *(score/20)*
Amy	18	21	14
Betty	16	20	16
Carla	14	16	7
Dani	13	20	16
Eve	13	19	13
Fran	12	17	11
Grace	17	20	14
Helen	**10^^**	**15^^**	**4^^**
Iris	**20****	21	16
Jen	14	19	12
Kim	19	24	15
Laura	**20****	**25****	**19****
Mia	19	**25****	16
Norah	**10^^**	**15^^**	6
Olivia	14	18	14
Patti	11	14	8

** designates high subscale score for sample
^^ designates low subscale score for sample

Expression of behavior (see Table 4.5).

For **expressed behavior on the family level**, Laura scored the highest. As earlier mentioned, Laura's interview gave evidence of her actively parenting her daughter, and making specified efforts to improve family functioning.

Patti scored low on her expressed behavior on the family level. This score was consistent with her qualitative interview data. As discussed earlier, Patti did not appear to be active in her family, often "calling for help," or trying to put things behind her.

Helen also had a low score on the family level. Again this may be reflective of Helen's not being ready or able to trust and begin to do the work to help herself and her family recover from their traumas and losses.

Six women had a high score for **expressed behavior on the service system level.** Their scores seem to be an accurate reflection of their expressed behavior in qualitative data. Amy, Dani, Iris, Kim, Laura, and Mia, all spoke of their desire for services, their participation in services, and their continued contact and cooperation with services. Laura who in her interview described various active connections she had made with therapists, child protective services, doctors, parenting classes, and the like, explained it best:

> I know I can go and .... Well I'm still seeing (FIT therapist), you know. I've been with her a while now and stuff. I trust her. You know, so there isn't anything that I don't feel that I can't go to her and say, "Hey, you know, I'm having a problem with this or that," or "I feel I'm having a problem."

Norah and Patti both had the low scores of the sample. Qualitative data do not adequately support these scores. Specifically, neither Norah nor Patti

talked about being inconsistent with what they actually do. Norah in fact, stated that both she and her child were doing better. Patti's interview however, leads me to believe that she may passively rely on the service system to act when she calls for help.

Qualitative evidence to support or discount Carla's low score of **expressed knowledge on the community/political level** is lacking, as is qualitative evidence to support or discount Betty's high score. I am uncertain how to interpret Helen's score, as previously discussed, Helen was the woman who "threw a fit" when she felt something was not right with a housing situation in the community. Therefore there is some evidence to discount Helen's low score of expressed behavior on the community level.

Table 4.5: FES Expressed Behavior Scores by Subscale.

Informant	**Family** *(score/20)*	**Service System** *(score/15)*	**Political/ Community** *(score/15)*
Amy	18	**15****	10
Betty	16	10	**13****
Carla	16	12	**3^^**
Dani	15	**15****	7
Eve	15	12	7
Fran	14	12	6
Grace	16	11	10
Helen	**12^^**	11	**3^^**
Iris	19	**15****	6
Jen	16	11	6
Kim	18	**15****	10
Laura	**20****	**15****	7
Mia	19	**15****	6
Norah	13	**9^^**	5
Olivia	17	11	8
Patti	**12^^**	**9^^**	7

** designates high subscale score for sample
^^ designates low subscale score for sample

Summary

For the purposes of this study, the focus of the qualitative interview was geared towards empowerment at the level of family and service system. The FES scores at the family and service system level appeared to support the qualitative interview data. Expressed empowerment cross-sectioned with family and service system levels also supported qualitative data.

Associations between interview data and the FES community/political levels of empowerment were either not present or quite weak. It is important to remember that this level of empowerment has to do with parents' advocating in their communities or politically for services for "children in general." It is difficult to hypothesize about the lack of qualitative data at that level, which may be simply a function of the interviews' concentration on women and their own families in the community, as opposed to children in general. Given somewhat lower scores on this level (when adjusting for fewer item-stem questions), and the severity of the situations for many in the sample, it may also follow that community/political empowerment is not as attainable for them at this time. It is reasonable that many of these women may likely focus on managing difficulties and overcoming obstacles in their own families before attempting to advocate for children in general. Needless to say, factors of the interview, the informant's lives and their basic needs, the rural community, and how the Family Intervention Team facilitates community/political empowerment mostly likely have influenced both the interview data and the FES scores on this level.

CHAPTER FIVE

DISCUSSIONS AND CONCLUSIONS

Revisiting the Purpose of the Study

The purpose of this study was to identify and explore the process of family empowerment for women who have survived traumatic abuse. One goal was to provide a forum for the voices of women who are survivors, who are parenting children with emotional and behavioral difficulties; and who are participating in intensive family-based services in their community. Another goal was to examine the eco-systemic effects of mothers' trauma survival on the family empowerment process. These goals were achieved by interviewing 16 women participating in Family Intervention Team (family-based services) with their families as provided by Ionia County Community Mental Health. In support of qualitative interview data, additional data were gathered from a demographic questionnaire, an abuse history questionnaire, and the Family Empowerment Scale (Koren, DeChillo, & Friesen, 1992).

The concept of family empowerment is inherent to family-centered practices of care embraced by family-based services (Pecora, et al., 1995). These practices focus on family strengths, possibilities and supports, rather than on deficits (Koren, DeChillo, & Friesen, 1992). This research suggests that trauma survival has implications for clinical practices that support family empowerment outcomes. In this case, trauma survival was not viewed as a deficit per se, but as a circumstance to be seriously considered by family-based

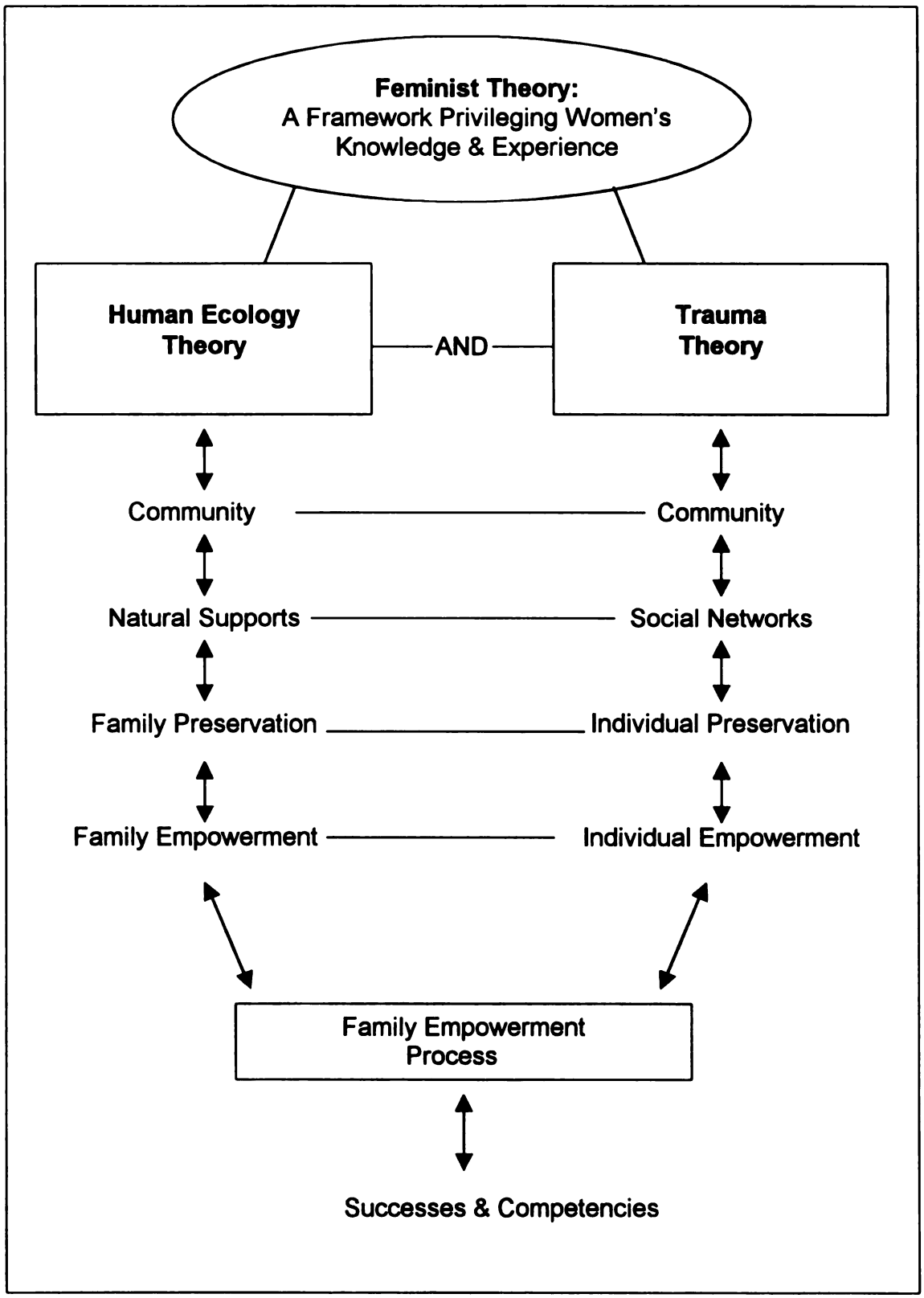
services professionals in their facilitation of the family empowerment process. Three overall thematic categories supporting the effects of trauma for women in family-based services were developed by this study: 1) Relational Perceptions, 2) Family Empowerment Process, and 3) The Level and Expression of Family Empowerment.

The implications of these categories, and their supporting themes will be discussed in this chapter. Chapter 5 is organized into six sections: Implications for Theory, Implications for Practice, Limitations, Recommendations for Future Research, Conclusions, and Personal Reflections.

Implications for Theory

Three theoretical foundations guided this study: human ecology theory with an emphasis on family empowerment, feminist theory and trauma theory. Figure 5.1, discussed in Chapter One (Figure 1.2, p. 35), supported the findings of this study. Women's knowledge and experiences reflected a fluidity between the experiences of surviving trauma and parenting a child or children with emotional disabilities. This study found that women's traumatic abuse experiences and experiences of mothering an emotionally impaired child or children connect within the family empowerment process of family-based services.

Figure 5.1: Feminist Theory Bridging Human Ecology and Trauma Theory.



Human ecology theory applied to developmental processes concerns the influence of transactions between persons and their environments. Individuals and their environments actively shape and influence each other in a recursive fashion. Many psychosocial researchers have designed interventions to counter and prevent environmentally-mediated risk factors associated with psychopathology (Rutter, Champion, Quinton, Maughan, & Pickles, 1995).

The informants of this study were mothers in families "at risk" that were experiencing multiple stresses. These mothers were consumers of family-based services in their community. They were referred to services due to an identified emotional disturbance of a child or children, and due to apparent risk of having children removed from the home by protective agencies. Family-based services intervention, with family empowerment as its' goal, was the intervention designed to counter the obstacles and crisis-driven nature of multi-stressed families such as these.

An eco-systemic model is the theoretical foundation for family-based services practices. Family-based services focus on expanding the family's available internal and external resources to nurture and care for a child with a serious emotional disturbance (Heflinger & Bickman, 1996, Lindblad-Goldberg, Dore & Stern, 1998). Family-based services professionals recognize and address dysfunction in the family system that likely interferes with the family's ability to maintain and nurture an emotionally disturbed child. Attention is also focused on establishing relationships between the family and community services, organizations, and institutions that can support and enhance their

efforts. Simultaneously, value is placed on forming a collaborative partnership between the therapist and the family, and meeting the needs of the family in their natural settings (e.g. home, community). Since the 1980's the treatment trend for families at risk has been to enlarge the treatment context by including all essential informal helpers (natural supports), and formal systems in collaborative treatment processes (Linblad-Goldberg, Dore, & Stern, 1998).

Family empowerment is a specific goal towards which the collaborative treatment processes of family-based services should aspire. In the context of human service delivery systems, family empowerment is defined as a process by which families access knowledge, skills, and resources that enable them to gain positive control of their lives and improve the quality of their lifestyles (Singh, et al., 1995).

It is my experience as a family-based services clinician, that the trend towards facilitating the increased involvement of natural supports into treatment planning has intensified with recent recession concerns about budget limitations and the funding of mental health services. The goal for family intervention team services is to facilitate both natural and community supports to wrap around the family. The hope is to increase family functioning, health, and resources in ways that allow the formal supports to move out (fostering autonomy, rather than dependence), and the family to then function in the community with the support of those who are natural to them.

As discussed in chapter one, the multiple stresses and crises of family-based services consumers are acknowledged. Woman and child abuse is

prevalent in case examples throughout the family-based services literature (Boyd-Franklin & Hafer Bry, 2000; Lindblad-Goldberg, Dore, & Stern, 1998; Pecora et al., 1995). Concepts related to empowerment have played and increased role in shaping services for families whose children have disabilities. Although family empowerment is often stated as a program goal, the concept lacks specificity (Koren, DeChillo, & Friesen, 1992). At this time, there are no specific adjustments to the model when multiple generations of abuse have served to isolate women and their children.

The findings of this research suggest that the theoretical concept of empowerment must seek to incorporate feminist principles and trauma theory to include the unique experiences and concerns of mothers who have survived abuse as displayed in Figure 5.1. These findings call upon theory and practice to address issues in family-based services that are specific to women, making gender and abuse-survival visible.

Relational Perceptions

A theme in the Relational Perceptions category that dominated this study was the role of natural supports in: victimization, support to survivor, access to community services, support for parenting, and abusing children. Table 5.1 illustrates the finding that, with two exceptions, all abusers were natural people to the women and their children in this sample. At the time that the women were abused, many perceived that they were alone and isolated. A number of women in the sample were blocked from connecting with services or from telling of their abuse by people who were natural to them. Some of the disconnection from

community stemmed from their fear of abusers' threats to harm them if they told. Some the disconnection also stemmed from the failures of those who should have protected them, or connected them with community resources.

Herman (1997) discussed that the core experiences of trauma are disempowerment and disconnection from others. The effects of trauma elicit feelings of guilt and inferiority, a sense of disconnection between individuals and their communities, and a struggle between isolation and clinging to others (Herman, 1997).

The multi-generational abusive systems in which these families developed must be considered in the literature that speaks to informal supports working in collaborative relationships with services. Operationalizing the concept of family empowerment must be implemented with great caution. In one sense, repairing breeches between informal supports and abuse survivors could have great potential for healing and restoration of individual and family function. In another sense, when the informal support is, in fact the perpetrator or a colluder in the abuse, restorative or collaborative action could set up the family system for re-victimization. Thankfully, many of the women listed natural supports separate from their abusive pasts (e.g. new husbands, boyfriends, friends). However, a number of women yet had people in their lives who were either abusive to them or their children, or had colluded with their abusers. These relationships must be considered with great care when operationalizing family empowerment facilitation.

Table 5.1: The Role of Natural and Community Supports

	Abusers of Informants (as related to the informant)	Support for Victim	Access to Services (at the time of abuse)	Natural support for Parent & Children	Community support for Parent & Children	Abusers of Children (as related to child)
Amy	Stepfather. Stepmother. Foster-parent.	No one.	Let down – no one there – afraid of stepfather	Family. Friends.	Schools very helpful.	Father.
Betty	Her mom's boyfriends.	Her mom.	Court (6 yr. old Betty scared to testify)	Husband.	Good.	Father. Mother.
Carla	Step-Grandfather. Family friend. Uncle. Husband.	No one.	No one helped.	No one.	Ionia County – Good.	Mother. Brother.
Dani	Mother. Stepfather.	No one. Child-sister.	No one helped. Afraid of step-father.	Friend with similar problems.	Better.	Bio-Mother. Brother.
Eve	Aunt. Uncle. Cousin. Ex-boyfriend.	Cousin & Minister's wife (child). No one (adult).	Lot of support for self. Feelings of injustice with abusers' consequence.	Boyfriend.	Good.	Mom's ex-boyfriend. Suspected father or father's girlfriend.
Fran	Ex-husband. Brothers.	No one.	To scared to tell. Police couldn't do anything.	Mom – somewhat. Mom's boyfriend.	Happy with FIT, but would like more help.	Father. Aunt. Uncle.
Grace	Father. Ex-fiancé. Child's father. Uncle. Neighbor. Acquaintance	No one.	Didn't do anything.	Husband. Mom. Friends. 2 ex-husbands.	They've jumped.	Father/ step-father. Mom's roommate Mom's ex-boyfriend.
Helen	Parents. Ex-husband. Cousins. Family-friends. Uncle.	No one.	Dad blocked Helen from pressing charges.	Husband.	So far, so good.	Father. Step-mother.
Iris	Ex-husband.	One girlfriend.	First she was isolated. Then, helpful - - notes her increased awareness.	Husband. Mom. Sisters & brothers.	Court, schools and mental health – very helpful.	Father/ step-father. Step-brother.

Table 5.1 (cont'd).

	Abusers of Informants (as related to the informant)	Support for Victim	Access to Services (at the time of abuse)	Natural support for Parent & Children	Community support for Parent & Children	Abusers of Children
Jen	Ex-boyfriend. Father. Grandfather.	No one. Child-friend.	No response (child) Police and friends (adult)	Husband. In-laws. Friends.	A lot of participation. Church, FIT.	Mom's ex-boyfriend. Stepfather. Stepmother. Half/Step-brother.
Kim	Father. Ex-husbands. Neighbor's Friend.	No one.	No help, no result for abusers.	Mom – can help but does not under-stand.	Police – helpful. Courts – attacking. FIT – better.	Father. Half-brother.
Laura	Ex-husband.	Adult-child. Sister. Friend.	Courts, Employer, Mental Health.	Adult-child. Sister. Friend.	Lots of support from FIT. Unhappy with schools.	Father/step-father. Half-brother.
Mia	Ex-husband. Husband. Ex-boyfriend. Father. Unknown Perpetrator.	No one. Spouse's friend defended her one time.	No response.	Nobody. Bosses' Brother.	Parents and schools don't help, and are blaming.	Father/step-father. Mom's ex-boyfriend. Stepbrother. Boyfriend.
Norah	Ex-husband.	Her mom.	Police response to the abuser. Mentioned Protective Services for child.	Boyfriend	Neighbors don't understand. But support not as bad as she had thought it would be.	Father.
Olivia	Ex-husband.	No one.	Not a good response. Had to do it all on her own.	Boyfriend	Adults don't understand – call her child a "freak."	Father.
Patti	Neighbor. Husband.	Her mom & Sister.	No response (child). Police and court response helpful (adult).	Anybody who will listen. Mom, sister, friends at work.	Somebody's been called in for whatever we've needed.	Father. Brother. Neighbor.

Central to the family empowerment concept is consumer "choice," meaning that it is up to each family member to interpret family context, needs and resources available to choose the best course of action for that particular person, in that particular family, at that particular time (MacMillan & Turnbull, 1983; Nash, Rounds & Bowen, 1992; as cited in Heflinger & Bickman, 1996). There is no simple answer to a quandary raised by the pairing of "choice" with an abusive family system. On one hand, with no specification of "choice" or family empowerment, community mental health is taken away from the community and its' members. Without choice, the system itself may act in arrogance and become abusive in it's own right. On the other hand, should perpetrators of violent abuse have choice in the treatment processes of their families and children? One might be quick to respond, "no," but in fact some of the surviving mothers in the sample had gone on to abuse their own children, and some of the child-victims in this sample have already taken victims of their own. These mothers were actively seeking help for themselves and their children. Impinging upon their "choice" would only serve as one more barrier to isolate women and their children – increasing risk and threats to development. In some cases of multi-generational abuse, it is quite clear who are the perpetrators and who are their victims. In other families, empowerment can be difficult to negotiate when victims become abusers and vice versa.

In adapting the family empowerment concept to the healing of a surviving family system, it may be necessary to specifically include the formal facilitation of creating new, non-abusive contacts and informal supports, in order to break the

repetitive cycle of multi-generational abuse. It also appears to be a necessity to have additional protective agencies involved in the family empowerment process. As discussed by the women in this sample, the police, child protective services, and the courts have played various roles in protection and prevention in partnership with mental health.

Heflinger and Bickman (1996) believe that, in support of the family empowerment construct, parents could benefit from programs that teach skills to promote access to needed information and resources. Self-efficacy should be a direct focus in efforts to promote family empowerment. Self-efficacy in this context is the parents' belief that their involvement in their children's mental health treatment will make a difference (Heflinger & Bickman, 1996). The relational perceptions of many women in this study, in fact supported that they felt they could make a difference in their children's lives and treatment. Many women identified that their own survival skills helped them identify what their children were going through. Women also identified that the affects of trauma on their own lives involved their doing things differently, in an effort to protect their children or keep them from harm (see Table 5.2).

The relational perception findings in this study support the theory of family empowerment as one way to support the family, bridging over obstacles and ending the isolation in which abusive situations most likely occur. At its' best, family empowerment conceptualizes a partnership between family and community, where treatment, resources, prevention, and when needed, protection; are supporting the preservation of the family system. At the same

time, the findings also call upon family-based services professionals to conceptualize and adapt their practices to address and include issues that are relevant to mothers who are survivors of traumatic abuse. This includes implementing a framework that is sensitive to women's issues and the obstacles that surviving women face in community, social, and, family systems.

Table 5.2: Self-Efficacy with Children

Informant	Effects of Trauma on Daily Life	Survival Skills
Amy	-- (did not report self-efficacy with children for these topics).	"I figured out a lot of the kids' ... how they were actually dealing with the whole situation that way. ... with the older (child) it was like, she was doing a lot of the same things I had done."
Betty	"If he ever touches my kids...."	--
Carla	"I don't want to see my children go through the same thing that I went through."	"I can step out of the internal situation and get far enough out of it so I can focus and see what's going on (with daughter) ...."
Dani	"I try, I stop and think about what I do with my kids before I do it or say it ... I don't say something to hurt them. Like my parents did me."	"I can spot the things that my step-kids go through ... It's like it makes me more sensitive to what they are going through ... I'll just tell her about some of the things that I went through and let her know she's going to make it through."
Eve	--	" I pretty much know how they're (the kids) are feeling – I can't say that I do know, but I have an idea."
Fran	"I am more protective of my kids."	Tries to set an example.
Grace	" ... ask for advice for instance how better to deal with my rug rats."	"I don't want to see them (the kids) go through what I went through. So, I just fight the fight to keep getting it better for them."
Helen	--	--
Iris	"Having the understanding of some of the things ... cause a person to act that way helps me understand how I can help my children better."	"Learning from those being the wrong kind of behaviors to have, but at the time, it helped me get through .... I think it helps me give the kids better guidance ...."
Jen	"... maybe just keep going forward. I don't want to be where I was once before and I don't want any of my kids to be there either."	"As an adult, I know what's right and wrong. It's my job to teach my children right from wrong and if they're doing wrong, it's my job to recognize that."
Kim	" ... it's like an experience I made stop so my kids don't go through it too."	" ... kind of makes me focus on the girls too, that they got a lot more to accomplish than settling down and that they need to get schooling and college and a good job and stuff."
Laura	"If I'm out and about, I watch people and stuff ... I don't want to get involved with people that ... put me in danger or my kids in danger."	"...if I'm unsure about it (in reference to issues with child), I found out ... or try to get in contact with somebody that would give me more information."
Mia	Food for her children comes first.	--
Norah	"I was going to be, you know, perfect parent. And actually I've come along way with that, accepting that my child needs help and that all counselors are not bad."	"I know what (child) needs. That's a given."
Olivia	" ... I'm more into not brushing aside what my kids may say and thinking twice about what they may be telling me ...."	"It was like, my first reaction was to step between and say, 'don't you touch my kid,' but he never touched them."
Patti	--	--

Family Empowerment Process

Recovery from trauma is based upon the empowerment of a survivor and the creation of new connections within the context of relationships (Herman, 1997). All people mature and thrive in a social context that has profound effects on how they cope with stresses (Van Der Kolk, 1996). Because traumatic life events damage relationships, people in the survivor's social world have the power to influence the outcome of trauma (Herman, 1998).

Findings showed that the majority of the informants viewed their recovery from trauma as a life-long process. The women had suffered abuses of varying severity. Informants were at different places in their recoveries, as to what and how well they were dealing with their experiences. Many women noted (see Table 5.3) that they had specific trauma-related healing left to do, but that family intervention could help them best by helping with their children, rather than focusing on their trauma experiences. Most however, felt that their healing and recovery would help their children to do better. About half the sample linked family-based services actively helping them to help their children.

The majority of informants noted successes of family-based services with their children or in their relationships with their children. All mothers endorsed that they were active participants in family intervention.

The findings suggest that the family empowerment could have the power to influence the outcome of trauma. A number of women reported working through trust issues with therapists and making supportive connections with both formal and informal supports in their communities. This study cannot infer that

women's participation in family-based services does indeed help women to reconnect and restore trust in their communities. Family-based services and family empowerment goals however conceptually support the re-building of basic safety and supportive respect, which is needed for a survivor to re-establish her sense of personal worth and autonomy.

Many women in this sample reported that their communities had let them down when it came to dealing with their experiences of abuse. At the same time, these women were able to talk about their abuse histories with their therapist (who referred them to this study) and me. The majority of the women discussed their additional involvement in wraparound, with various agencies and persons who were working with them in collaboration with the FIT team. So in some small way, the abuses that these women had suffered were being acknowledged by the community through family-based services. However what was not done at the time of the abuse, could not be changed. Quite often, there seemed to be very little sense of order or justice in the aftermath of the abuse experiences. I suggest that it is the loss of order, justice and restitution, that fuels the informants strong desire to make a better life for their children, and in some cases to hold the almost "street justice" belief that their perpetrator would or should get what he or she deserved.

Table 5.3: Trauma Recovery Connected to Family Empowerment in Family-Based Services.

Informant	Specific Trauma Issues	FIT's role in Recovery	How Healing will Help the Family	FIT's role in Family Empowerment Increases
Amy	"... I let people make me feel guilty."	"I know that you guys are there."	"... once I can actually heal myself, I can help (the kids) better ...."	"... getting control of what's going on and that's the hard part with the kids ...."
Betty	"None."	"No."	"Not to let it happen to my kids."	"Just counseling."
Carla	"... the emotional abuse and just being lied to ...."	"It's gotta be a big one."	"Anything that I can do to better me is going to better them."	"A new husband!"
Dani	"... just thinking I'm ugly. Thinking I'm a bad person because of things that they had told me."	"I thought more of a way of helping the whole family get through the problem."	"I don't think you ever really fully recover."	"... just little every day to day things to get through with (child)."
Eve	"... just that angriness."	"... just talking about things is actually what makes me feel better."	"... dealing with every day and learning from new experiences."	"... if there's something that I'm trying to deal with ... and I don't feel like I'm getting anywhere .. giving me advice on how I should deal with something ...."
Fran	1. Won't deal with it. 2. He got his just desserts. 3. I won't understand.	No role. She worked through these in individual counseling.	Protect her daughters – have them learn from her experiences and mistakes.	"Take my oldest child away."
Grace	Anger.	"... being there to listen."	"Keep it from happening again."	"... just keep listening."
Helen	"All of it eventually."	"Well, none, because we are trying to deal with (child). ... If I don't address my own emotional problems, how am I doing to help my kids now?"	"... I think I'd be a better mother."	"Maybe some ideas on how to deal with the kids so I don't get so frustrated to hit."
Iris	"... I still have anger towards him."	"I think I'm fine."	"It's helped me to be a better parent."	"... the involvement and support to continue."

Table 5.3 (cont'd).

Informant	Specific Trauma Issues	FIT's role in Recovery	How Healing will Help the Family	FIT's role in Family Empowerment Increases
Jen	"I'd still work on communication skills. Being able to talk. Get it out vs. just holding it to myself, keeping it a secret."	FIT's job to recognize correlations of what was going on with child, to mom's abuse history. "... without directly attacking my experiences."	"It'll benefit everybody hopefully."	"... resources, ... interventions, ... family counseling sessions, and individual (sessions) ...."
Kim	"... what my dad did to my mom."	"It's all like a circle ... what I learn from my skills and experiences helps with my kids ...."	"Hopefully it helps (the kids) not to go down the same road that I went."	"Just help me be a stronger person ... and be supportive of me and let me, basically that it's not my fault ... that we're at today where we're at because of me."
Laura	"Could be anything ... anything will trigger ...."	"(Therapist) listens to what I have to say."	"... hopefully (child) can learn something from me."	" ... if I have a problem ... I can contact people ... on the FIT team ... to give me suggestions or kind of help me to deal with things."
Mia	"I just got an attitude on men but I guess I'll always have that."	"No, it's past me."	"I just have to have my eyes wide open."	Counseling with the therapist and her child.
Norah	"My mother."	"No, those are issues that will probably never be away."	"It's just done."	"I need a house."
Olivia	"... there are some very old things. ... we had a death where we lost a child because of drinking. ... just him and my son were in the car."	"I think it can with my kids, but I'm not sure that I can go much further with it."	"I think I need to do that just for them to get better."	"Support. That's the big one."
Patti	"When I can feel him getting angry ...."	"... give us some ideas on how to get our minds off of these things?"	"... it will help (the kids) try to get over it too."	"Just knowing that somebody else is there is a big help."

Family Empowerment Scale: Level and Expression

Findings showed that qualitative data did link the FES in support of high and low scores on the family and service system subscales of the level dimension. Because FES scores are not anchored to any interpretive categories by the authors, it was most effective to look at the high and low scores for this sample and notice how these linked to qualitative data. It did not make sense to look at mid-range scores and try to link those with qualitative anecdotes interpreted to demonstrate a "medium" level of empowerment. It was difficult to draw any solid conclusions about the community/political subscale scores at the level dimension as most interviews did not address how parents advocate for children "in general."

The FES did appear to support qualitative data on the expression dimension at the cross-sections of family and service system subscales with expressed attitude and knowledge. It was again difficult to draw conclusions about expression on the community\political subscale. When it came to the expressed behavior, I could not translate spoken qualitative information to confirm or deny the behavioral expression of empowerment.

Additional analysis of data demonstrated a pattern in the FES scores for women who had survived childhood incest. On average, incest survivors had lower family empowerment on the family subscale (mean = 41.75) than those who did not report incest as part of their abuse history (mean = 48.25) (see Tables 5.4 and 5.5). Though the average score for incest survivors on the service system subscale was lower (mean = 48.38) than scores for survivors of

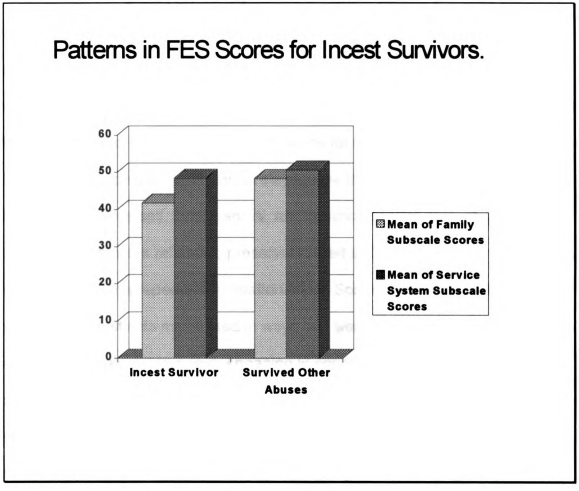
other abuse (mean = 50.63), the difference was not as large. Women who survived incest appeared to have greater differences between their family subscale score and their service system subscale score for the level dimension of empowerment. For the sample of sixteen women, there was an average of 4.75 points between their family score and service system score. This means that on average, service system empowerment scores were 4.75 points higher than family scores for the sample. Eight women in the sample experienced incest as an abuse experience. Their service system subscale scores averaged 6.63 points higher than their family scores. The remaining eight women did not report incest. Their service system scores averaged 2.88 points higher than their family scores. This finding suggests that women who have survived incest may feel more empowered in the service system than in their own families who betrayed them with a devastating form of abuse. However, the highest service system subscale score for incest survivors is yet lower than the highest for survivors of other abuses. This may reflect a more cautious process of gaining trust with the service system as described by a number of incest survivors in their interviews. Because the sample size is quite small, and of similar demographics, it is difficult to make inferences based on this finding. It is feasible that the incest survivors may have other unrecognized variables in common that affected their scores as well.

Table 5.4: Patterns in FES Scores for Incest Survivors.

FES Family & Service System Subscales	Incest Survivor	Survived Other Abuses
Range of Family Subscale Scores	34 – 49	34 – 58
Range of Service System Subscale Scores	43 – 55	37 – 60
Mean of Family Subscale Scores	41.75	48.25
Mean of Service System Subscale Scores	48.38	50.63
Average Score Difference between Family and Service System Subscales	6.63	2.88

FES scores are not anchored.
Possible range for scores on the Family & Services System subscales is 12 (low) to 60 (high).

Table 5.5: Display of Patterns in FES Scores for Incest Survivors.



Implications For Practice

The findings from this study demonstrate that women perceive the effects of traumatic abuse survival in their daily lives. Despite the various stages of recovery displayed by this sample of women (some had not even begun to heal, while others were quite advanced in their healing processes), it was evident that the experience of abuse has had implications for their relationships at the various levels of their ecology. Informants relayed how their experiences have affected how they perceive self, family, social, and community relationships. Survival skills, and behaviors related to preservation self and family were certainly a part of their behavioral repertoire in relationships. Sometimes these skills and preservation instincts manifested in ways that were healthy and beneficial to the women and their children (e.g. engaging in services, mothers noticing and addressing stresses that their children experience). Other times these skills were shameful, isolating and/or abusive for both mother and children (e.g. locking small children into their rooms for fear of abusing them, isolating themselves from other people, not being able to identify who they can trust).

The connection between trauma survival and perceived relationships demonstrated the effects on the family empowerment process as well. Most women felt let down by family members, social supports and their communities when they experienced abuse. Breeches in trust and disconnection were evident for women in connection to their trauma. However, most women maintained that they could make a difference in their children's lives and were

actively taking steps to ensure that their children would not have to go through similar experiences as they had.

The implications for family-based services professionals have already begun with the acknowledgement of women's experiences of abuse survival. It is the responsibility of the clinician to initiate therapeutic conversations with women as to how their traumatic abuse experiences have affected their connections or disconnections with themselves and their contextual relationships. Through the operationalization of the family empowerment construct, clinicians can facilitate the re-establishment of basic safety in contextual relationships, and support women in the development of their personal worth (Herman, 1997).

The clinician, as both a community representative and a witness to women's storied experiences of abuse and survival, could serve to facilitate a certain level of resolution for the trauma. Women's experiences of gaining knowledge, skills and resources within family-based services could potentially help them work through some breeches in trust and connection with the larger community. In turn, an application of the family empowerment process informed by the implications of trauma survival, could more effectively increase the level of family empowerment, benefiting both mother and children.

It is a disservice to survivors for clinicians to facilitate the family-empowerment process to "parents of children with emotional disabilities" without addressing the breeches in context that occurred due to traumatic abuse experiences. It is also a disservice to survivors to omit the risks to basic safety

and empowerment posed by perpetrators when they are active in the natural and community contexts of the survivor and her children.

In her work with incest survivors, Dinsmore (1996) calls it "collective denial," when helping professionals, family members, and/or friends minimize or deny the occurrence of incest, don't accept the harm that was done, or fail to respect the survivor's healing process. Collective denial functions to impede the recovery process. Behaviors of helping professionals that minimize and deny incest survivors' experiences include: missing cues, denying the truth of incest stories, and acknowledging the fact that the incest occurred yet failing to address it. Helping professionals can make a difference in halting sexual abuse from continuing for children and in facilitating the recovery process for women. It is detrimental to the recovery process when helping professionals choose not to do so (Dinsmore, 1996).

Similarly, as discussed earlier, in adapting the family empowerment concept to the healing of a surviving family system, it may be necessary to specifically include the formal facilitation of creating new, non-abusive contacts and informal supports, in order to break the repetitive cycle of multi-generational abuse. Protective agencies should be invited to participate as a support in the family empowerment process, if the woman so chooses. As discussed by the women in this sample, the police, child protective services, and the courts have played various roles in protection and prevention in partnership with mental health.

"Choice" remains a crucial component to an empowering parent-professional collaborative relationship (Heflinger & Bickman, 1996). Family empowerment at the level of the social service system means that it is up to each family member to interpret the family context, needs, and resources available and to choose the best course of action for a given family member at a given time (MacMillan & Turnbull, 1983; Nash, Rounds, & Bowen, 1992). In families where multi-generational abuse has occurred and risks for children's safety remain, it is crucial to acknowledge and address these issues with families and appropriate community supports (e.g. child protective services).

Evan Imber-Black (1989) suggests several principles for clinical work with women, families and larger systems. These principles are pertinent to the implications for practice suggested by this study: 1) Examine the implicit sexist, classist, and racist assumptions that are communicated from a referring larger system. Accept referrals in ways that begin to alter those assumptions, viewing problems from a systemic point of origin, rather than blaming the parent or family. 2) Examine the macrosystem formed by larger systems and the family for patterns of escalating complementarity and triangulation that serve to disempower women. Develop interventions that introduce symmetry among the team of participants, support women's effectiveness, and detriangulate women out of child-like positions who are arguing over "who knows best for her." 3) Examine disempowerming, eco-systemic beliefs that engender doubt in women regarding their own decisions and actions (Imber-Black, 1989).

Limitations

The goal of this study was to identify a relationship between trauma survival and the family empowerment process, and provide a forum for women's voices of their experiences with both. Despite limitations, use of triangulated methods did enhance this study's generalizability and validity by capturing more complete, holistic and contextual portrayals of participants in their contexts. The use of mixed methods offset the disadvantages of one method with the strengths of another (Epstein Jayaratne & Stewart, 1991; Jick, 1979).

This sample of women who are trauma survivors and participants in family-based services is not representative of all trauma survivors or all mothers in family-based services. This sample is limited by small size and similar demographic representation. The participants in this study were mainly white and of European ancestry. One woman voluntarily identified that she had Native American heritage. The demographic area represented was a small, rural community in mid-Michigan. Participants may face area-specific bridges and obstacles in their connections with formal and informal supports in the particular community where they reside.

The Family Intervention Team (FIT), who provides the family-based services in which the women were participating may not be representative of all family-based services providers. It is the practice of FIT to work in close collaboration with other community resources that work with families (e.g. child protective services, juvenile court, schools, etc.). In many interviews when women listed other community supports in which they were involved, I knew the

providers of these supports. It was clear from the interviews that the women perceived that I might know people from other agencies who were involved in their treatment teams. These types of community alliances and relationships seem more feasible in a smaller rural community, than in a larger city where there are more community resources and workers may not interact with each other quite as often.

It is also worth noting that I was recognizable to all the participants as a Family Intervention Team therapist. In addition, I had an established relationship with six participants due to my clinical role with FIT. I met the remaining 12 participants for the first time when they agreed to participate in the study, but even so, they were informed that I was also a FIT therapist. In some ways, this may have posed a limitation on what the women reported in the interview. It appeared at times that some of the women who I already knew did not provide as much detail about their abuse experiences or symptoms, assuming I was familiar with the details from my role as a FIT therapist. Similarly, in my role as a researcher, I was more hesitant about asking questions of those who I already knew. I wanted to be clear about my role as a researcher, so as not to have the interviews turn into therapy sessions. In all the interviews, I successfully kept a research boundary. The informants and I stuck to the interview questions discussing their experiences of survival and parenting within the process of family empowerment. However, my heightened attention to this boundary may have taken away from a more relaxed style of interview.

Prior to interviewing the participants I had wondered if the women would have been more hesitant to talk about disappointments with FIT because of my affiliation with the team. All women reported satisfaction with FIT to various degrees. Most women reported disappointment with the community and natural support response to their trauma experiences. Some of the participants with whom I did not have prior therapeutic relationship also appeared to voice limitations of the other services they were currently receiving. I am uncertain as to how having a prior therapeutic relationship affected the women who knew me and what they reported in their interviews. The fact that they volunteered to participate demonstrates that they had a certain amount of trust in the Family Intervention Team. For the most part however, I felt that my affiliation with FIT and existing relationship with the women was a strength. Even though the women that I knew did not go into as much detail about their abuse, our clinical relationship did not seem to inhibit how they addressed the interview questions that had to do with family empowerment, trauma survival, and process. In fact, I think that had I not been familiar to these women (either first-hand or through my FIT affiliation), I would not have gotten the depth of data that I did, and I may not have been granted a chance to do the interviews at all.

The participants of this study shared so many of their personal experiences, joys and sorrows with me for the purposes of this research. When agreeing to participate, it seemed all of the women talked about wanting to help others who had gone through similar traumatic experiences. This type of rapport and relationship is indicative of feminist interview research (Reinharz, 1992).

Future Research

The findings of this study contributed to the concept and operation of the family empowerment process for women who have survived traumatic abuse. Future research involving a larger sample with more ethnically and geographically diverse subjects is needed to address the prevalence of survivors in the family-based services population, as well as to make inferences regarding treatment and outcomes for survivors in the family-based services population.

Preliminary FES scores for incest survivors suggest that future research should examine the specific affects of incest survival on family empowerment process and outcome. Are the dynamics of incest such that the empowerment process may need to be facilitated differently than with other survivors?

Finally, larger scale studies may serve to measure the successes of family-based services in facilitating connections between survivors and their families with both formal and informal supports in their communities. This study drew a distinction with mothers' experiences of traumatic abuse and survival and how these experiences affect the family empowerment process. Though multi-generational abuse was acknowledged and discussed, as was the maternal connection to both formal and informal community supports, data were only gathered from the mothers. Multiple levels of data collection (e.g. interviews with other family members, therapists, juvenile justice workers, police, etc.) would surely provide for a more holistic picture. Multiple observations on trauma survivors/family-based services consumers collected from various sources over time may provide needed information about how survivors grow and change over

time with family intervention, while considering the effects of the personal characteristics of the sample. Hierarchical modeling may be most effective in addressing the nested nature of this developmental research (Bryk & Raudenbush, 1992).

Personal Reflections

I developed the idea for this study over the course of my work as a Family Intervention Team therapist in Ionia County. The amount of abuse and violence that my clients experienced and survived was unfathomable to me. The more time I spent talking with women who had often lived through such hurtful abuse, the more I began to wonder about the ways that victimization and survival could affect the family empowerment process that FIT strives to facilitate. As both a clinician and a researcher, this experience has been an emotional roller coaster of helping women to mourn losses and heal hurts; celebrate successes, strengths, and most of all, survival. It has been an honor for me to offer this forum to survivors, and to provide them with the opportunity to speak about their abuse experiences. This dissertation has been my way of publicly acknowledging the wrongs done to these women – some of which were allowed to continue for years. This research seeks to acknowledge women's experiences of oppression, violence and power imbalances that remain in our society. Most importantly, this research has sought to emphasize the creativity, vibrancy, and adaptability of women's spirits. In spite of all of the obstacles of abuse, many women managed to escape, free their children, and obtain community support. They broke the silence – they survived.

Of her work with incest survivors, Christine Dinsmore stated the following. I believe that this holds true for all survivors:

> My work with survivors has shown me that scars are necessary for the healing process to begin. Scars must not be considered synonymous with hopelessness and an inability to recover but rather as signs that one has made it through a terrible ordeal. Incest is traumatic, and it leaves scars. We must celebrate those scars (p.31).

REFERENCES

REFERENCES

Bandura, A. (1977). Self-efficacy: Towards a unifying theory of behavioral change. Psychological review, 84(2), 191-215.

Bandura, A. (1982). Self-efficacy mechanism in human agency. American psychologist, 37(2), 122-147.

Berg, I. K. (1994). Family based services: A solution-focused approach. New York: W. W. Norton & Company, Inc.

Berry, M. (1997). The family at risk: Issues and trends in family preservation services. In L. Ginsberg (Ed.), Social problems and social issues. Columbia, SC: University of South Carolina.

Boyd-Franklin, N., & Hafer Bry, B. (2000). Reaching out in family therapy: Home-based, school, and community interventions. New York: The Guildford Press.

Bricker-Jenkins, M. (1992). Introduction. In M. Bricker-Jenkins, N. R. Hooyman, & N. Gottlieb (Eds.), Feminist social work practice in clinical settings (pp. 1-14). Newbury Park, CA: Sage.

Bricker-Jenkins, M. (1992). The propositions and assumptions of feminist social work practice. In M. Bricker-Jenkins, N. R. Hooyman, & N. Gottlieb (Eds.), Feminist social work practice in clinical settings (pp. 271-304). Newbury Park, CA: Sage.

Bronfenbrenner, U. (1979). The ecology of human development: Experiments by nature and design. Cambridge, MA: Harvard University Press.

Bronfenbrenner, U. (1999). Environments in developmental perspective: Theoretical and operational models. In S. L. Friedman, & T. D. Wachs (Eds.), Measuring environments across the life span: Emerging methods and concepts. (pp. 3-28). Washington, D.C.: American Psychological Association.

Bryk, A. S., & Raudenbush, S. W. (1992). Hierarchical linear models: Applications and data analysis methods. Advanced quantitative techniques in the social sciences (Vol. 1). Newbury Park: Sage Publications.

Bubolz, M. M., & Sontag, M. S. (1993). Human ecology theory. In P. G. Boss, W. J. Doherty, R. LaRossa, W. R. Schumm, & S. K. Steinmetz (Eds.), Sourcebook of family theories and methods: A contextual approach. (pp. 419-448). New York: Plenum Press.

Cunningham, P. B., Henggeler, S. W., Brondino, M. J., & Pickrel, S. G. (1999). Testing underlying assumptions of the family empowerment perspective. Journal of child and family studies, 8(4), 437-449.

Curtis, W. J., & Singh, N. N. (1996). Family involvement and empowerment in mental health service provision from children with emotional and behavioral disorders. Journal of child and family studies, 5(4), 503-517.

Deveaux, M. (1994). Feminism and empowerment: A critical reading of Foucault. In S. Hesse-Biber, C. Gilmartin, & R. Lydenberg (Eds.), Feminist approaches to theory and methodology: An interdisciplinary reader. (pp. 236-256). New York: Oxford University Press.

Dinsmore, C. (1991). From surviving to thriving: Incest, feminism, and recovery. Albany, NY: State University of New York Press.

Dunst, C. J., & Paget, K. D. (1991). Parent-professional partnerships and family empowerment. In M.J. Fine (Ed.), Collaboration with parents of exceptional children (pp. 25-44). Brandon, VT: Clinical Psychology Publishing.

Dunst, C. J. & Trivette, C. M. (1987). Enabling and empowering families: Conceptual and intervention issues. School psychology review, 16, 443-456.

Dunst, C. J., Trivette, C. M., & Deal, A. G. (1988). Enabling and empowering families: Principles and guidelines for practice. Cambridge, MA: Brookline Books.

Early, T. J. (2001). Measures for practice with families from a strengths perspective. Families in society, 82(3), 225-232.

Elliott, D. J., Koroloff, N. M., Koren, P. E., & Friesen, B. J. (1998). Improving access to children's mental health services: The family associate approach. In M. H. Epstein, K. Kutash, & A. Duchnowski (eds.), Outcomes for children and youth with emotional and behavioral disorders and their families: Programs and evaluation best practices. (pp. 581-609). Austin, TX: PRO-ED.

Epstein Jayarantne, T. & Stewart, A. J. (1991). Quantitative or qualitative methods in the social sciences: Current feminist issues and practical strategies. In M. M. Fonow & J. A. Cook (Eds.), Beyond methodology: Feminist scholarship as lived research (pp. 85-106). Bloomington, IN: Indiana University Press.

Flax, J. (1990). Thinking fragments: Psychoanalysis, feminism, and postmodernism in the contemporary west. Berkeley: University of California Press.

Frankel, H. (1988). Family centered, home-based services in child protection: A review of the research. Social service review 62(1), 137-157.

Gallagher, J. J., Trohanis, P. L., & Clifford, R. M. (Eds.). (1989). Policy implementation and P. L. 99-457. Baltimore: Paul H. Brooks.

Gaudin, J. M., Polansky, N. A., Kilpatrick, A. C., & Shilton, P. (1993). Loneliness, depression, stress, and social supports in neglectful families. American journal of orthopsychiatry, 63(4), 597-605.

Gottlieb, N. (1992). Empowerment, political analyses, and services for women. In Y. Hasenfeld (Ed.), Human services as complex organizations (pp. 301-319). Newbury Park, CA: Sage.

Hasenfeld, Y. (1987). Power in social work practice. Social service review, 61, 467-483.

Heflinger, C. A. & Bickman, L. (1996). Family empowerment: A conceptual model for promoting parent-professional partnership. In C. A. Heflinger & C. T. Nixon (Eds.), Families and the mental health system for children and adolescents: Policy, services and research: Vol. 2. Children's mental health services. (pp. 96-116). Thousand Oaks, CA: Sage Publications.

Heflinger, C. A. & Dokecki, P. R. (1989). A community psychology framework for participating in mental health policy making. Journal of community psychology, 17, 141-154.

Held, V. (1993). Feminist morality: Transforming culture, society, and politics. Chicago, IL: University of Chicago Press.

Herman, J. L. (1997). Trauma and recovery: The aftermath of violence – from domestic abuse to political terror (Rev. ed.). New York: Basic Books.

Hobbs, N., Dokecki, P. R., Hoover-Dempsey, K. V., Moroney, R. M., Shayne, M. W., & Weeks, K. H. (1984). Strengthening families. San Francisco: Jossey-Bass.

Hodges, K. (1999). Child and adolescent functional assessment scale (CAFAS). In M. E. Maruish, (Ed.), The use of psychological testing for treatment planning and outcomes assessment (2nd ed.). (pp. 631-664). Mahwah, NJ: Lawrence Erlbaum Associates, Inc.

Hook, N. & Paolucci, B. (1970). The family as an ecosystem. Journal of home economics, 62, 315-318.

Hunter, R. W. & Friesen, B. J. (1996). Family-centered services for children with emotional, behavioral, and mental disorders. In C. A. Heflinger & C. T. Nixon (Eds.), Families and the mental health system for children and adolescents: Policy, services and research: Vol. 2. Children's mental health services. (pp. 18-40). Thousand Oaks, CA: Sage Publications.

Imber-Black, E. (1989). Women's relationships with larger systems. In M. McGoldrick, C. Anderson & F. Walsh (Eds.), Women in famlies: A framework for family therapy. (pp. 335-356). New York: W.W. Norton & Company, Inc.

Janoff-Bulman, R. (1985). The aftermath of victimization: Rebuilding shattered assumptions. In C. R. Figley (Ed.), Trauma and its wake: The study and treatment of post-traumatic stress disorder (pp. 15-36). New York: Brunner/Mazel.

Jick, T. D. (1979). Mixing qualitative and quantitative methods: Triangulation in action. Administrative science quarterly, 24, 602-610.

Koren, P. E., DeChillo, N., & Friesen, B. J. (1992). Measuring empowerment in families whose children have emotional disabilities: A brief questionnaire. Rehabilitation Psychology, 37, 305-321.

Lee, R. E., & Casady, M. A. (In review). An ecosystemic perspective of child well-being among low-income families.

Lee, R.E., & Stacks, A.M. (in review). In whose arms? The case for relational therapy in supervised family visitation when very young children are in foster care.

Lindblad-Goldberg, M., Dore, M. M., & Stern, L. (1998). Creating competence from chaos: A comprehensive guide to home-based services. New York: W. W. Norton & Company, Inc.

Littlejohn, S. W. (1989). Theories of human communication (3rd ed.). Belmont, CA: Wadsworth.

Maluccio, A. N. (1991). The optimism of policy choices in child welfare. American journal of orthopsychiatry, 61(4), 606-609.

McFarlane, A. C. & van der Kolk, B. A. (1996). Trauma and its challenge to society. In van der Kolk, B. A., McFarlane, A. C. & Weisaeth, L. (Eds.), Traumatic stress: The effects of overwhelming experience on mind, body, and society. (pp. 24- 46). New York: The Guilford Press.

Miles, M. B., & Huberman, A. M. (1994). An expanded sourcebook: Qualitative data analysis (2nd ed.). Thousand Oaks, CA: Sage.

Moroney, R. M., & Dokecki, P. R. (1984). The family and the professions: Implications for public policy. Journal of family studies, 5, 224-238.

Moxley, D. P., Raider, M. C. & Cohen, S. N. (1989). Specifying and facilitating family involvement in services to persons with developmental disabilities. Child and Adolescent Social Work, 6, 301-312.

Myers Avis, J., & Turner, J. (1996). Feminist lenses in family therapy research: Gender, politics, and science. In D. H. Sprenkle & S. M. Moon, (Eds.), Research methods in family therapy. (pp. 145-172). New York: The Guilford Press.

Parsons, R. J. (1991). Empowerment: Purpose and practice principle in social work. Social work with groups, 14(2), 7-21.

Patterson, J. M. (1996). Family research methods: Issues and strategies. In C. A. Heflinger & C. T. Nixon (Eds.), Families and the mental health system for children and adolescents: Policy, services and research: Vol. 2. Children's mental health services. (pp. 117-144). Thousand Oaks, CA: Sage Publications.

Pecora, P. J., Fraser, M. W., Nelson, K. E., McCroskey, J., Meezan, W. (1995). Evaluating family-based services. New York: Walter de Gruyter, Inc.

Pires, S. A. & Stroul, B. A. (1996). Family issues in health care reform. In C. A. Heflinger & C. T. Nixon (Eds.), Families and the mental health system for children and adolescents: Policy, services and research: Vol. 2. Children's mental health services. (pp. 1-17). Thousand Oaks, CA: Sage Publications.

Poertner, J., & Ronnau, J. (1992). A strengths approach to children with emotional disabilities. In D. Saleeby (Ed.), The strengths perspective in social work practice (pp. 111-121). New York: Longman.

Rappaport, J. (1981). In praise of paradox: A social policy of empowerment over prevention. American journal of community psychology, 9, 1-25.

Reinharz, S. (1992). Feminist methods in social research. New York: Oxford University.

Riger, S. (1992). Epistemological debates, feminist voices: Science, social values, and the study of women. American psychologist, 47, 730-740.

Rutter, M., Champion, L., Quinton, D., Maughan, B, & Pickles, A. (1995). Understanding individual differences in environmental-risk exposure. In Moen, P., Elder, Jr., G. H. & Luscher, K. (Eds.), Examining lives in context:

Perspectives on the ecology of human development. (pp. 61-93). Washington D.C.: American Psychological Association.

Scheel, M. J., & Rieckman, T. (1998). An empirically derived description of self-efficacy and empowerment for parents of children identified as psychologically disordered. The American journal of family therapy, 26, 15-27.

Shavelson, R. J. (1996). Statistical reasoning for the behavioral sciences. (3rd ed.). Needham Heights, MA: Allyn & Bacon.

Simon, B. L. (1990). Rethinking empowerment. Journal of progressive human services, 1, 27-39.

Singh, N. N., Curtis, W. J., Ellis, C. R., Nicholson, M. W., Villani, T. M., & Wechsler, H. A. (1995). Psychometric analysis of the family empowerment scale. Journal of emotional and behavioral disorders, 3(2), 85-91.

Singh, N. N., Curtis, W. J., Ellis, C. R., Wechsler, H. A., Best, A L., & Cohen, R. (1997). Empowerment status of families whose children have serious emotional disturbance and Attention Deficit/Hyperactivity Disorder. Journal of emotional and behavioral disorders, 5(4), 223-229.

Smith, D. E. (1987). The everyday world as problematic: A feminist sociology. Boston: Northeastern University Press.

Sprague, J. & Hayes, J. (2000). Self determination and empowerment: A feminist standpoint analysis of talk about disability. American journal of community psychology, 28(5), 671-695.

Staples, L. H. (1990). Powerful ideas about empowerment. Administration in social work, 14, 29-42.

Stroul, B. A. & Friedman, R. (1986). A system of care for children and youth with severe emotional disturbances (Rev. ed.). Washington D.C.: Georgetown University Child Development Center, CASSP Technical Assistance Center.

Stroul, B. A. & Friedman, R. (1988). Principles for a system of care. Children Today, 17, 11-14.

Taub, J., Tighe, T. A., & Burchard, J. (2001). The effects of parent empowerment on adjustment for children receiving comprehensive mental health services. Children's services: Social policy, research, and practice, 4(3), 103-122.

Taylor, S. J. & Bogdan, R. (1998). Introduction to qualitative research methods: a guidebook and resource. (3rd ed.). New York: John Wiley & Sons.

The Boston Women's Health Book Collective, (1998). Our bodies, ourselves for the new century: A book by and for women. New York: Simon & Schuster.

The Boston Women's Health Book Collective, (1992). The new our bodies, ourselves: A book by and for women. New York: Simon & Schuster.

Tretheway, A. (1997). Resistance, identity, and empowerment: A postmodern feminist analysis of clients in a human service organization. Communication monographs, 64(4), 281-301.

van der Kolk, B. A., & McFarlane, A. C. (1996). The black hole of trauma. In van der Kolk, B. A., McFarlane, A. C. & Weisaeth, L. (Eds.), Traumatic stress: The effects of overwhelming experience on mind, body, and society. (pp. 3-23). New York: The Guilford Press.

Vanderslice, V. (1984). Empowerment, a definition in process. Human ecology forum, 14(1), 2-3.

Walker, M. (1999). The inter-generational transmission of trauma: The effects of abuse on the survivor relationship with their children and on the children themselves. European journal of psychotherapy, counselling & health, 2(3), 281-296.

Wells, K. & Biegel, D. E. (1990). Intensive family preservation services: A research agenda for the 1990's. Final report presented at the Intensive Family Preservation Services Research Conference, September 25-26, 1989, Cleveland.

Yoder, J. D., & Kahn, A. S. (1992). Toward a feminist understanding of women and power. Psychology of women quarterly, 16, 381-388.

Zarski, J. J., Pastore, C. A., Way, L. A., & Shepler, R. N. (1988). Families at risk and home-based intervention: A therapist training model. Contemporary family therapy, 10, 53-62.

Zimmerman, M. A. & Rappaport, J. (1988). Citizen participation, perceived control, and psychological empowerment. American journal of community psychology, 16, 725-750.

APPENDICES

APPENDIX A

Demographic Questionnaire

1. Age_____
2. Education completed_____
3. Occupation_____
4. Estimated Income per Month_____
5. Do you and your children receive Medicaid? Yes No
6. How long have you lived in Ionia County?_____
7. How many people live in your home?_____
8. How many rooms are in your home?_____
9. How many children do you have?_____
10. What are their ages & genders?_____
11. Are you currently involved in a serious, intimate relationship? Yes No

If yes, 12 -- If no, 13

12. How long have you and your partner been together?_____
13. Are you married? Yes No
14. How long have you received FIT services?_____
15. How often do you and your children have contact with a FIT therapist?

_____

16. How satisfied are you with FIT services?

unsatisfied somewhat satisfied satisfied more than satisfied very satisfied

Comments_____

_____

_____

17. What other agencies or people are involved in your treatment team?

Comments_____

_____

_____

APPENDIX B

ABUSE QUESTIONNAIRE

Family Intervention Abuse Profile

Please indicate if any family member has experienced any of the following. When and where, if applicable. Document any additional comments on the back.

Family Member	Physical	Emotional	Sexual	Violence toward others	Suicide attempts or self-harm	Previous attempts, How	Previous hospitalizations	Other risk Behaviors
1.								
2.								
3.								
4.								
5.								

APPENDIX C

Family Empowerment Scale

Kathleen Jager
3612 Callihan Ct.
Lansing, MI 48910

February 18, 2002

Dear Colleague:

This letter confirms our permission to use the **Family Empowerment Scale** in your research. Enclosed is a copy of the original article, the instrument, scoring procedure, and a list of published studies that have used the scale. We're delighted that you are interested in using this scale and hope that you find it useful. We would be very interested to hear about your experiences and findings, particularly with respect to aspects of the scale that might be improved. Good luck with your study.

For further specific or technical information, please contact Dr. Paul Koren at (503) 725-4162 or by e-mail at korenp@rri.pdx.edu.

Best regards,

Denise Schmit
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FAMILY EMPOWERMENT SCALE

Instructions: Below are a number of statements that describe how a parent or caregiver of a child with an emotional problem may feel about his or her situation. For each statement, please circle the response that best describes how the statement applies to you.

1.	I feel that I have a right to approve all services my child receives.	NOT TRUE AT ALL$_1$	MOSTLY NOT TRUE$_2$	SOMEWHAT TRUE$_3$	MOSTLY TRUE$_4$	VERY TRUE$_5$
2.	When problems arise with my child, I handle them pretty well.	NOT TRUE AT ALL$_1$	MOSTLY NOT TRUE$_2$	SOMEWHAT TRUE$_3$	MOSTLY TRUE$_4$	VERY TRUE$_5$
3.	I feel I can have a part in improving services for children in my community.	NOT TRUE AT ALL$_1$	MOSTLY NOT TRUE$_2$	SOMEWHAT TRUE$_3$	MOSTLY TRUE$_4$	VERY TRUE$_5$
4.	I feel confident in my ability to help my child grow and develop.	NOT TRUE AT ALL$_1$	MOSTLY NOT TRUE$_2$	SOMEWHAT TRUE$_3$	MOSTLY TRUE$_4$	VERY TRUE$_5$
5.	I know the steps to take when I am concerned my child is receiving poor services.	NOT TRUE AT ALL$_1$	MOSTLY NOT TRUE$_2$	SOMEWHAT TRUE$_3$	MOSTLY TRUE$_4$	VERY TRUE$_5$
6.	I make sure that professionals understand my opinions about what services my child needs.	NOT TRUE AT ALL$_1$	MOSTLY NOT TRUE$_2$	SOMEWHAT TRUE$_3$	MOSTLY TRUE$_4$	VERY TRUE$_5$
7.	I know what to do when problems arise with my child.	NOT TRUE AT ALL$_1$	MOSTLY NOT TRUE$_2$	SOMEWHAT TRUE$_3$	MOSTLY TRUE$_4$	VERY TRUE$_5$
8.	I get in touch with my legislators when important bills or issues concerning children are pending.	NOT TRUE AT ALL$_1$	MOSTLY NOT TRUE$_2$	SOMEWHAT TRUE$_3$	MOSTLY TRUE$_4$	VERY TRUE$_5$
9.	I feel my family life is under control.	NOT TRUE AT ALL$_1$	MOSTLY NOT TRUE$_2$	SOMEWHAT TRUE$_3$	MOSTLY TRUE$_4$	VERY TRUE$_5$
10.	I understand how the service system for children is organized.	NOT TRUE AT ALL$_1$	MOSTLY NOT TRUE$_2$	SOMEWHAT TRUE$_3$	MOSTLY TRUE$_4$	VERY TRUE$_5$
11.	I am able to make good decisions about what services my child needs.	NOT TRUE AT ALL$_1$	MOSTLY NOT TRUE$_2$	SOMEWHAT TRUE$_3$	MOSTLY TRUE$_4$	VERY TRUE$_5$

12.	I am able to work with agencies and professionals to decide what services my child needs.	NOT TRUE AT ALL$_1$	MOSTLY NOT TRUE$_2$	SOMEWHAT TRUE$_3$	MOSTLY TRUE$_4$	VERY TRUE$_5$
13.	I make sure I stay in regular contact with professionals who are providing services to my child.	NOT TRUE AT ALL$_1$	MOSTLY NOT TRUE$_2$	SOMEWHAT TRUE$_3$	MOSTLY TRUE$_4$	VERY TRUE$_5$
14.	I have ideas about the ideal service system for children.	NOT TRUE AT ALL$_1$	MOSTLY NOT TRUE$_2$	SOMEWHAT TRUE$_3$	MOSTLY TRUE$_4$	VERY TRUE$_5$
15.	I help other families get the services they need.	NOT TRUE AT ALL$_1$	MOSTLY NOT TRUE$_2$	SOMEWHAT TRUE$_3$	MOSTLY TRUE$_4$	VERY TRUE$_5$
16.	I am able to get information to help me better understand my child.	NOT TRUE AT ALL$_1$	MOSTLY NOT TRUE$_2$	SOMEWHAT TRUE$_3$	MOSTLY TRUE$_4$	VERY TRUE$_5$
17.	I believe that other parents and I can have an influence on services for children.	NOT TRUE AT ALL$_1$	MOSTLY NOT TRUE$_2$	SOMEWHAT TRUE$_3$	MOSTLY TRUE$_4$	VERY TRUE$_5$
18.	My opinion is just as important as professionals' opinions in deciding what services my child needs.	NOT TRUE AT ALL$_1$	MOSTLY NOT TRUE$_2$	SOMEWHAT TRUE$_3$	MOSTLY TRUE$_4$	VERY TRUE$_5$
19.	I tell professionals what I think about services being provided to my child.	NOT TRUE AT ALL$_1$	MOSTLY NOT TRUE$_2$	SOMEWHAT TRUE$_3$	MOSTLY TRUE$_4$	VERY TRUE$_5$
20.	I tell people in agencies and government how services for children can be improved.	NOT TRUE AT ALL$_1$	MOSTLY NOT TRUE$_2$	SOMEWHAT TRUE$_3$	MOSTLY TRUE$_4$	VERY TRUE$_5$
21.	I believe I can solve problems with my child when they happen.	NOT TRUE AT ALL$_1$	MOSTLY NOT TRUE$_2$	SOMEWHAT TRUE$_3$	MOSTLY TRUE$_4$	VERY TRUE$_5$
22.	I know how to get agency administrators or legislators to listen to me.	NOT TRUE AT ALL$_1$	MOSTLY NOT TRUE$_2$	SOMEWHAT TRUE$_3$	MOSTLY TRUE$_4$	VERY TRUE$_5$
23.	I know what services my child needs.	NOT TRUE AT ALL$_1$	MOSTLY NOT TRUE$_2$	SOMEWHAT TRUE$_3$	MOSTLY TRUE$_4$	VERY TRUE$_5$
24.	I know what the rights of parents and children are under the special education laws.	NOT TRUE AT ALL$_1$	MOSTLY NOT TRUE$_2$	SOMEWHAT TRUE$_3$	MOSTLY TRUE$_4$	VERY TRUE$_5$

25.	I feel that my knowledge and experience as a parent can be used to improve services for children and families.	NOT TRUE AT ALL$_1$	MOSTLY NOT TRUE$_2$	SOMEWHAT TRUE$_3$	MOSTLY TRUE$_4$	VERY TRUE$_5$
26.	When I need help with problems in my family, I am able to ask for help from others.	NOT TRUE AT ALL$_1$	MOSTLY NOT TRUE$_2$	SOMEWHAT TRUE$_3$	MOSTLY TRUE$_4$	VERY TRUE$_5$
27.	I make efforts to learn new ways to help my child grow and develop.	NOT TRUE AT ALL$_1$	MOSTLY NOT TRUE$_2$	SOMEWHAT TRUE$_3$	MOSTLY TRUE$_4$	VERY TRUE$_5$
28.	When necessary, I take the initiative in looking for services for my child and family.	NOT TRUE AT ALL$_1$	MOSTLY NOT TRUE$_2$	SOMEWHAT TRUE$_3$	MOSTLY TRUE$_4$	VERY TRUE$_5$
29.	When dealing with my child, I focus on the good things as well as the problems.	NOT TRUE AT ALL$_1$	MOSTLY NOT TRUE$_2$	SOMEWHAT TRUE$_3$	MOSTLY TRUE$_4$	VERY TRUE$_5$
30.	I have a good understanding of the service system that my child is involved in.	NOT TRUE AT ALL$_1$	MOSTLY NOT TRUE$_2$	SOMEWHAT TRUE$_3$	MOSTLY TRUE$_4$	VERY TRUE$_5$
31.	When faced with a problem involving my child, I decide what to do and then do it.	NOT TRUE AT ALL$_1$	MOSTLY NOT TRUE$_2$	SOMEWHAT TRUE$_3$	MOSTLY TRUE$_4$	VERY TRUE$_5$
32.	Professionals should ask me what services I want for my child.	NOT TRUE AT ALL$_1$	MOSTLY NOT TRUE$_2$	SOMEWHAT TRUE$_3$	MOSTLY TRUE$_4$	VERY TRUE$_5$
33.	I have a good understanding of my child's disorder.	NOT TRUE AT ALL$_1$	MOSTLY NOT TRUE$_2$	SOMEWHAT TRUE$_3$	MOSTLY TRUE$_4$	VERY TRUE$_5$
34.	I feel I am a good parent.	NOT TRUE AT ALL$_1$	MOSTLY NOT TRUE$_2$	SOMEWHAT TRUE$_3$	MOSTLY TRUE$_4$	VERY TRUE$_5$

Research and Training Center on Family Support and Children's Mental Health.
Regional Research Institute for Human Services, Portland State University, PO Box 751, Portland, OR 97207-0751.

Scoring Procedure for the Family Empowerment Scale

The current scoring procedure for the Family Empowerment Scale is based on a simple, unweighted summation of the items within three construct areas: Family, Service System, and Community/Political. These areas are described in the original article (Koren, DeChillo, and Friesen, 1992). In particular, refer to the figure on page 311.

The items within each area are as follows:

Family: 2, 4, 7, 9, 16, 21, 26, 27, 29, 31, 33, 34
Service System: 1, 5, 6, 11, 12, 13, 18, 19, 23, 28, 30, 32
Community/Political: 3, 8, 10, 14, 15, 17, 20, 22, 24, 25

To obtain a score for each area, sum the item responses where *NOT AT ALL* is scored as 1, *MOSTLY NOT TRUE* is scored as 2, *SOMEWHAT TRUE* is scored as 3, *MOSTLY TRUE* is scored as 4, and *VERY TRUE* is scored as 5. The items are all scored in the same direction, i.e., no item scales are reversed, and a higher score indicates relatively more empowerment in each respective area.

For further information, please contact Paul Koren at (503) 725-4162 or Barbara Friesen at (503) 725-4166.

APPENDIX D

Semi-structured Interview Questions

1. How do you feel your trauma experiences may affect how you live your daily life?
2. How might your trauma experiences affect your participation in FIT (family intervention team) services?
3. In what ways do your trauma experiences affect your ability to trust or feel safe in therapy sessions with your FIT therapist?
4. How did the community respond (court, police, etc.) to your trauma?
5. How has the community responded to your child(ren)'s behavioral and emotional needs?
6. How has community response been the same in each situation?
7. How has community response been different to each situation?
8. Who did you turn to for help or comfort when you experienced abuse?
9. Who do you turn to now when you need help coping with your child(ren)'s behaviors?
10. How come these people are the same (or different)?
11. (Define survival skills). What survival skills do you notice that you have?
12. How do your survival skills help you work with your therapist and participate in FIT?
13. How do your survival skills help you to know what your family needs and set goals?

14. What do you need to feel safe, connected and respected in your relationship with your FIT therapist?
15. What are your strengths?
16. What expectations do you have for yourself and how do you accomplish them?
17. How do you feel about yourself in connection with other people?
18. Where are you in your recovery from your trauma experiences?
19. What are the things related to your trauma experiences that you still need to work through or deal with?
20. What do you think the role of FIT should be in helping you through this?
21. How will your continuing to recover from trauma help you and other members of your family?
22. (Define family empowerment) What do you need from FIT to help increase your family empowerment?
23. What do you need from FIT to help you become a better parent?
24. What is your role in helping your family achieve its' goals?
25. How have you worked together with FIT to help your family?
26. What has gotten better for you and your family as a result of your partnering with FIT to improve things?
27. What changes have you and/or your family made that you are most proud of?

APPENDIX E

Informed Consent Form

MATERNAL HISTORIES OF ABUSE SURVIVAL AND INTENSIVE FAMILY-BASED SERVICES INTERVENTION: A QUALITATIVE ANALYSIS OF FAMILY EMPOWERMENT INQUIRY

PURPOSE: You have been identified as a mother who is participating in FIT services with her family. You have also been identified as someone who has survived sexual and/or physical abuse.

We estimate that about 90% of FIT moms have lived through abuse. You are being invited to participate in a research project designed to study the relationship between surviving abuse and developing family empowerment for families involved in FIT services.

Family Empowerment is a process by which families gain knowledge, skills and resources that help them to move towards having more positive control of their lives and improving the quality of their family life. It is the main value and goal for FIT services. This project will ask about your experiences with FIT and in the community. This project will ask you questions about being a mom who has survived abuse. Our purpose for this study is to learn more about your experiences so that we can be more helpful to FIT families who have had similar life experiences.

PROCEDURE: Your participation will entail one meeting with the researcher which should take approximately two hours. The procedures followed are: 1) You will be asked to complete three brief paper and pencil tasks. 2) You will then be asked to participate in an interview with the researcher. 3) You will be provided with information about Family Empowerment and abuse survival. 4) At the end of the interview, you will receive a $10 gift card to Meijer's in appreciation for your participation.

The purpose of this project is to help FIT better serve its families. Your participation in this research project is completely voluntary. You will continue to receive FIT services as you usually do whether or not you choose to participate in this research. You can refuse to answer any questions that you do not wish to answer. The interview will be audio-taped. You can refuse to be taped or request at any time that audio-taping be stopped. You can withdraw your participation at any time without penalty.

RISKS AND BENEFITS: You may feel tired during or after the evaluation. Some psychological discomfort may be experienced from revealing personal information or thinking about things that are related to your abuse experiences. Keep in mind that you may take a break at any time and you can refuse to answer any questions that make you uncomfortable. After the interview, should you feel overwhelmed or stressed, please contact the researcher, the FIT team (616) 761-3151, or the 24 hour crisis line at Ionia County Community Mental Health (888) 527-1790.
You may benefit from your participation in this project by adding your experiences to this research. The goal of this research is to help the Family Intervention Team better serve consumers like yourself. It is also to add to knowledge to practice and procedures in the family-based services field.

CONFIDENTIALITY: All information that refers to you, or can be identified with you will remain confidential to the maximum extent permitted by law. If you choose to sign this consent form, you are also giving consent to have the interview audiotaped, so that the researchers have complete and correct information from the interview. You may request at any time to have the taping stopped and you can refuse to be taped at all. All data, including audio-tapes, will be kept for three years and then destroyed. Michigan State University may review your research records.

Other than this form, all questionnaires and data will be identified only with a code number. A list linking your name to the code will be kept in a locked file for the duration of the study. Once all the data are collected and analyzed, the list linking the names to the code numbers will be destroyed.

WHO TO CONTACT FOR ANSWERS: If there are any questions you have at any time about this research project or your participation in it, please contact one of the investigators:

Kathleen Jager, M.S.	OR	Marsha Carolan, Ph.D.
5827 N. Orleans Rd. Orleans, MI 48865 (616) 761-3151		13 B Human Ecology East Lansing, MI 48824 (517) 432-3327

If you have questions or concerns regarding your rights as a study participant, or are dissatisfied at any time with any aspect of this study, you may contact (anonymously, if you wish) Ashir Kumar, M.D., Chair of the University Committee on Research Involving Human Subjects (UCRIHS) by phone: (517) 355-2180, fax: (517) 432-4503, e-mail: ucrihs@msu.edu, or regular mail: 202 Olds Hall, Michigan State University, East Lansing, MI 48824.

PARTICIPATION IS VOLUNTARY: Your participation in this study is voluntary. If you wish, you may decline to participate, simply by telling the project investigator or your FIT therapist. If you decide to participate in this study, and later decide that you do not wish to continue, you may at any time withdraw your consent and stop participation. Your decision not to participate, or to participate and later withdraw from the study will not in any way result in a penalty to you, or a loss of benefits to which you are otherwise entitled.

I voluntarily agree to participate in this study.

PARTICIPANT	DATE
WITNESS	DATE

APPENDIX F

Transcriber Confidentiality Agreement

MATERNAL HISTORIES OF ABUSE SURVIVAL AND INTENSIVE FAMILY-BASED SERVICES INTERVENTION: A QUALITATIVE ANALYSIS OF FAMILY EMPOWERMENT INQUIRY

TRANSCRIBER CONFIDENTIALITY AGREEMENT

I, _____, the undersigned transcriber, agree to keep in my confidence the information that I am transcribing. I will not discuss with anyone other than the researcher any of the information that I am transcribing from the audio-tapes. I will not make or keep copies of any of the audio-taped information for personal use of dissemination. I will uphold the confidentiality of the research participants to the fullest extent of the law.

I agree to keep the confidentiality of this research project.

_____ _____
TRANSCRIBER DATE

_____ _____
WITNESS DATE

APPENDIX G

Letter to Families

Family Intervention Team
Ionia County Community Mental Health
5827 N. Orleans Rd.
Orleans, MI 48865

Dear
You have been identified as a mom who is participating in FIT services with her family. This letter is to let you know that the Family Intervention Team (FIT) is involved in a research project to help strengthen their services to families in the community.

You may be eligible to participate in this project if you are:

- **A mom of a family currently participating in FIT**

And

- **A survivor of physical and/or sexual abuse**

And

- **Consider yourself the primary parent of your child who is identified for FIT services.**

We estimate that about 90% of FIT moms have survived abuse. The research project is designed to study the relationship between surviving abuse and developing family empowerment for families involved in FIT services.

Family Empowerment is a process by which families gain knowledge, skills and resources that help them to move towards having more positive control of their lives and improving the quality of their family life. It is the main value and goal for FIT services. If you are eligible and decide you would like to participate, this project will ask about your experiences with FIT and in the community. This project will also ask you questions about being a mom who has survived abuse. Our purpose for this study is to learn more about your experiences so that we can be more helpful to our FIT families who have had similar life experiences. Participants will receive a $10 Meijer's gift card in appreciation for their time. Participation in the study should take approximately 2 hours.

Your participation in this project is completely voluntary. If you think you may be eligible, and you would like to participate, please contact:

Kathleen Jager
Ionia County Community Mental Health
5827 N. Orleans Rd.
Orleans, MI 48865
(616) 761-3151, ext. 1135

Thank you,
The Family Intervention Team

APPENDIX H

STUDY FLYER

FIT MOMS, SURVIVAL, AND GAINING FAMILY EMPOWERMENT

The Family Intervention Team (FIT) is involved in a research project to study the relationship between abuse survival and developing family empowerment for moms of FIT families.

The purpose of the study is to help strengthen FIT services to families in the community.

You may be eligible to participate if you are:

- **A mom of a current FIT family, AND**
- **A survivor of physical and/or sexual abuse, AND**
- **Consider yourself the primary parent of the child who is identified for FIT services.**

If you are interested in participating, please contact project investigator:

Kathleen Jager, M.S.

Family Intervention Team, ICCMH, 5827 N. Orleans Rd., Orleans, MI 48865. Phone: (616) 761-3151.

*project participants will receive a $10 gift card to Meijer's Supermarket.

APPENDIX I

Interview Hand-Out

Family Empowerment:

A process by which families access knowledge, skills and resources that help them gain positive control of their lives and improve the quality of their family lifestyles.

Survival skills:

Learned behaviors that were needed for survival in an abusive relationship. These skills are generally acquired through childhood trauma experiences, and they usually continue into adulthood (e.g. hypervigilance, dissociation, compartmentalizing).