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dissertation entitled

PRODUCING SCRIPTS: AN ETHNOMETHODOLOGICAL STUDY OF INTIMATE PARTNER VIOLENCE CHILD WITNESS THERAPY

presented by

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has been accepted towards fulfillment
of the requirements for the

Ph.D. degree in Sociology

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August 19, 2008
Date

PRODUCING SCRIPTS: AN ETHNOMETHODOLOGICAL STUDY OF INTIMATE PARTNER VIOLENCE CHILD WITNESS THERAPY

By

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A DISSERTATION

Submitted to
Michigan State University
in partial fulfillment of the requirements
for the degree of

DOCTOR OF PHILOSOPHY

Department of Sociology

2008

ABSTRACT

PRODUCING SCRIPTS: AN ETHNOMETHODOLOGICAL STUDY OF INTIMATE PARTNER VIOLENCE CHILD WITNESS THERAPY

By

Stacie Marie Gibson

Child witnesses of intimate partner violence (IPV) have begun to receive explicit theoretical and therapeutic attention over the last decade. While research on these children is relatively sparse, there is some agreement in the literature that IPV child witnesses experience a number of childhood problems including aggressive behavior, anxiety, depression, anger, low-self esteem, temperament problems, and a tendency toward becoming abusers themselves. In response to these negative consequences, various therapeutic regimens that seek to rehabilitate these children have emerged. Subsequently, questions around the effectiveness of these therapeutic regimens have begun to surface.

The Community Coordinated Response Projects to Prevent Intimate Partner Violence collected data on the child therapy provided to 58 IPV child witnesses at a Michigan rural safe haven between January 2000 and September 2001 in an effort to explore the effectiveness of the traditional therapeutic environment on various outcomes for the children. This dissertation is a secondary analysis of the child therapy case notes collected through the original research project.

The dissertation uses ethnomethodology as a framework to examine how the traditional therapeutic environment is operationalized by one child therapist in the Community Coordinated Response Projects to Prevent Intimate Partner

Violence. The data analysis was conducted through content analysis of the therapy case notes using the ethnomethodological documentary method of interpretation. The central questions that frame this study focus on how the child therapist in the project accomplishes doing therapy. What claims does she make about the IPV child witnesses, and how does she arrive at these claims? What underlying assumptions does she appear to use in her assessments? How does indexicality inform the interpretations that the therapist makes? And, ultimately, what potential consequences for the IPV child witnesses result from a therapeutic process based on these particular definitions, assumptions, and interpretations?

The conclusions of the study suggest that the therapist approached her assessment and treatment of the children in her therapeutic care by employing a number of interpretive procedures. For purposes of analysis, those procedures are assembled into specific scripts including the *Traumatized IPV Child Witness* script, *Gendered* scripts, the *Healing IPV Child Witness* script, and the *Grateful IPV Child Witness* script. Each script documents certain characteristics, attributes, and activities that the therapist associates with particular IPV child witnesses in particular circumstances. The study also concludes that the therapist actively *produces* the scripts despite the likelihood that she experiences them as predetermined or predictable according to her personal and professional training, experience, and common sense knowledge.

ACKNOWLEDGEMENTS

I cannot begin to thank all of the people who have contributed to my ability to complete this unusually long journey as a graduate student at Michigan State University. I would, however, like to acknowledge a number of individuals who have played key roles in that process. First, I wish to thank my advisor, Dr. Thomas Conner, for his patience, his ethnomethodological imagination, and his commitment to the project. I would also like to thank my other committee members, especially Dr. Toby TenEyck, for his consistent support, encouragement, and belief in my abilities, without which I truly do not know how I would have persisted; Dr. Lori Post for her original research and her commitment to the welfare of the children in the project; and Dr. Steve Gold for always finding another relevant connection to be made.

I would also like to thank my family. My parents, siblings, and extended family have never wavered in their support and encouragement of my academic pursuits. I am eternally grateful to my partner, Dawn McCoy for her years of support, listening, understanding, and countless personal sacrifices she has made to allow me the space and time to work, think, and write. I owe gratitude to my two children, Cooper and Kennedy, for all of the small and large ways in which their young spirits have unknowingly provided me with the inspiration to continue through these last stages of project.

Finally, I would like to thank all of the other friends, family members, faculty, colleagues, and co-workers who have contributed to my academic life

over the years. I credit them with providing the courage, strength, kindness, perspective, and truth that I needed at the exact moments in time that I needed them.

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CHAPTER ONE

INTRODUCTION

Intimate partner violence (IPV) refers to physical, sexual, or psychological abuse by a current or former partner or spouse (CDC 2007). Children and adolescents who have seen or heard IPV, been used as a tool of the perpetrator, and/or experienced the aftermath of the violence are generally defined as having "witnessed" IPV (Edelson 1999). Child witnesses of IPV have begun to receive therapeutic attention over the last decade which has become explicitly theoretically driven (Edleson 1999; Groves, Zuckerman, Marans, & Cohen 1993; Rossman, Hughes, & Rosenberg 2000). Prior to this recent attention, the phenomenon of children witnessing IPV was typically addressed, if at all, as a tertiary issue related to either IPV or child abuse and neglect.

Like children who are victims of child abuse and neglect, child IPV witnesses have been shown to experience a number of childhood problems which can be loosely grouped into three main categories: behavioral and emotional, cognitive functioning and attitudes, and longer-term problems (Edelson 1999). Behavioral and emotional problems include aggressive and antisocial behavior, anxiety, depression, anger, low-self esteem, temperament problems, and diminished capacity to understand how others feel. Cognitive functioning and attitudes of IPV child witnesses are most notably impacted in their tendency to justify their own use of violence as a means of conflict resolution (Spaccarelli, Coatsworth, & Bowden 1995). Some studies have shown that these childhood problems can become longer-term and translate into

adulthood depression, low self-esteem, trauma-related symptoms, and low social adjustment (Silvern et al. 1995; Henning et al. 1996). There is also evidence that children exposed to IPV are more likely to become abusers themselves (Moffitt and Caspi 1998).

As a response to the host of detrimental responses that children can have as a result of witnessing IPV, various therapeutic regimens that seek to rehabilitate these children have emerged. A wide range of therapies exist and some will be examined in more detail below. However, in general, these therapies can be seen as making the basic assumption that IPV witnesses have manifested a degree of abnormal emotional and behavioral responses as a result of the stress or trauma that they experienced during the violence witnessing experience. The overall goal of child therapy then, is to help children learn to cope appropriately and to become "normalized" in their behaviors and emotional reactions.

Statement of Purpose

The most effective method for normalizing IPV children can be, and has been, debated (Groves 2002; Rossman, Hughes, & Rosenberg 2000). There are traditional clinical models, individual child counseling approaches, group therapy sessions for children, family therapy sessions, after-care programs, multi-disciplinary teams, play therapies, and various combinations of the above aimed at providing IPV witnesses with the most effective and developmentally appropriate menu of services. What has not been closely attended to in these

discussions however, is how the process of providing these therapies, and the fundamental assumptions that underlie them, contribute to a particular construction of identity for the IPV child witness that includes abnormal attributes. That is, the therapist in essence contributes to the child's sense of self, and purposefully so, during the course of treatment. The goal of normalizing the child is generated from the assumption that the child is somehow abnormal or has abnormal responses to his or her environment. As such, the specific assessments, activities, and interventions that the child is subject to in the name of normalization help to define and shape that child's self as abnormal in the first place.

This is not to say that IPV child witnesses do not suffer real and significant consequences as the result of their experiences. To the contrary, there is a wealth of clinical evidence that indicates that they do (Burgess, Harman, & Clements 1995; Rossman 1998; Mullender et al. 2002). What is being called into question is whether and how traditional therapeutic models are providing IPV witnesses with what they need in order to lead "normal" healthy lives. This study seeks to explore this question through an examination of the child therapy provided to 58 IPV child witnesses at a Michigan rural safe haven through the Community Coordinated Response Projects to Prevent Intimate Partner Violence. To develop this line of inquiry, a fundamental exercise in "sense-making" of the therapeutic process itself is required. The central questions that frame this study then, focus on how the child therapist in the project accomplishes doing therapy. What claims does she make about the IPV child

witnesses, and how does she arrive at these claims? What underlying assumptions does she appear to use in her assessments? How does indexicality inform the interpretations that the therapist makes? And, ultimately, what potential consequences for the IPV child witnesses result from a therapeutic process based on these particular definitions, assumptions, and interpretations?

Conceptual Framework

This study is decidedly an exercise in ethnomethodology. The conceptual framework that serves as the foundation for engaging in this exploratory secondary analysis is, at its core, rooted in the ethnomethodologic tradition. That said, it is worth noting that the ethnomethodologic "tradition" is itself somewhat fluid and difficult to package in any sort of neat way. Attempts to do so leave one with messy edges and loose, uncooperative ends that defy categorization. As such, we are better served by assembling a conceptual framework that accounts for a particular interpretation of ethnomethodology, as long as that interpretation can be shown to have valid tenants which allow for an instructive analysis to ensue.

The literature review will outline ethnomethodologic theory developed through the work of Harold Garfinkel. In addition, theory on various therapeutic models that shape child-therapy will provide an additional layer of context to the framework which will ultimately be employed to move through the analysis.

Research Data

The Data Set

This study involves an ethnomethodological secondary analysis of data collected as part of the Community Coordinated Response Projects to Prevent Intimate Partner Violence in a rural Michigan Safe Haven (see Post et al. 2003). The data were collected during phase II of the clinical trial portion of the project which included child therapy being offered to children and adolescents who were IPV witnesses. The goal of this aspect of the original project was to evaluate the effectiveness of the child therapy intervention provided to the IPV child witnesses by answering four questions:

> First, how does individual and family therapeutic counseling sessions with the Child Therapist improve the overall health outcomes of children and adolescents who witness and report intimate partner violence and trauma at home? Second, how effective were the short-term individualized therapeutic intervention(s) and selected arts of healing for the children and adolescents seen by the Child Therapist? Third, is group counseling as effective as individual counseling for children who have witnessed intimate partner violence or domestic violence, family violence, and trauma? Fourth and finally, how do the pre-school, elementary school-aged children, and adolescents living with various exposures of intimate partner violence or domestic violence, family violence, and trauma describe their 'real-world' and 'lived experiences'? (Post et al. 2003: 72)

Child therapy associated with this study took place at the rural safe haven between January 2000 and September 2001. During that time, 68 families (with 104 children) were referred to the same child therapist at the shelter and data are available on 58 children who had a least one therapy session with her. The child therapist recorded case notes after her therapy sessions with the children. The

notes were later transcribed by a research assistant. Each child was assigned a case number and that number was used to associate the child with the corresponding case notes. This collection of therapist case notes comprises the bulk of the data available from this study. Other background data elements extracted from the original study included researchers' summaries of group therapy notes completed by the therapist for a boys' group attended by some of the children, therapeutic workbooks and drawings completed by some of the children or completed by the therapist for the children during the course of their therapy, and demographic data compiled from shelter intake and referral forms.

In the original study, children's self-reports of well-being and clinical case notes from the child therapist were used to conduct an analysis of the effectiveness of the child therapy. The study concluded that the therapy seemed to be effective in improving children's well-being on a short-term basis and it provided them with an opportunity to discuss their concerns about their situation as well as their 'lived experiences'. The study conceded, however, that the short duration and other limitations of the study design and data sets prevented any conclusive substantiation of the effectiveness of the child therapy interventions.

The child therapist's case notes were obtained with permission from Lori A. Post, the Principal Investigator for the Community Coordinated Response Projects to Prevent Intimate Partner Violence, and comprised the bulk of the data set for this secondary analysis. In addition, other supporting demographic data, analyses, and conclusions that were compiled as part of the original research were utilized to provide additional context to the secondary analysis.

Data Adequacy and Limitations

As with any secondary analysis, this study is limited by the quality and parameters of the data collected for the primary investigation. A number of data limitations pertaining to this component of the original study were noted by the primary researchers including; the lack of use of validated instruments; the absence of a control site; the use of self-reporting from a self-selected sample of women and children experiencing crisis; and a small, predominately white group of participants, (Post et al. 2003). In addition, the therapist did not work from a specific grounded theory or adhere to a specified study design. Finally, case notes were not always adequately numbered so that they could be tracked back to the corresponding child in therapy. These limitations made it difficult for the primary researchers to track children's progress over time or to assess the real efficacy of the child therapy sessions in any meaningful way. Another layer of complication exists in that the completed intake forms, parental interview forms, and biological information forms cited in the original study could not be located or were otherwise unavailable for the secondary analysis.

There is also a significant challenge posed by the questionable quality of the case notes. The notes are written in a stream of consciousness style. In many instances, the speaker is not identified and it is difficult to discern if the case notes are referring to what the child actually said during the session or what the therapist concluded based on the discussions that took place. Some sessions included multiple family members and it is unclear who the therapist

addressed and whose responses and reactions are recorded in the case notes. In other entries, individuals are identified in the notes as having said or done something without any description of the individuals' relationship to the child. There is often no sense of whether the therapist is referring to a sibling, parent, guardian, teacher, or other helping professional who happened to interact with the child that day. There is also an overall lack of context in the case notes. Connections are not always made with previous sessions and the case notes exhibit little follow-up on issues that the children presented with from one session to the next.

The combination of these limitations admittedly make it very difficult to conduct any investigation into the therapy's effectiveness in improving the well-being of child IPV witnesses. However, the data did offer a very interesting ethnomethodological opportunity to look at the manner in which the therapy was provided and the possible consequences for the child's conception of self. The musings of the therapist, if that is all we can say they are, reflect the information and details that she believed were pertinent to the course of therapy. This had something to say about her perception of the children, their degree of "abnormalness", their progress toward becoming more "normal", and her role as their therapist.

While the original data set poses significant challenges to arriving at empirical findings through a traditional secondary analysis, this is an ethnomethodological analysis and there is a wealth of information teeming with evidence of interactions, assumptions, interpretations, negotiations, and

reflections representing a data set well-suited to meaningful analysis through ethnomethodological inquiry.

CHAPTER TWO

THEORY & LITERATURE

This study will use ethnomethodology as a framework to examine how the traditional therapeutic environment is operationalized by one child therapist in the Community Coordinated Response Projects to Prevent Intimate Partner Violence. The work of Harold Garfinkel and other ethnomethodological scholars will be employed to establish the analytical and methodological framework. I will also provide a brief review of literature related to psychotherapeutic theory and culture to give some insight into the therapeutic environment being analyzed in this study.

Ethnomethodology as Theory

A student of Talcott Parsons, Harold Garfnkel is credited with founding ethnomethodology in the 1950s and 1960s (Heritage 1984; Francis & Hester 2004; Hilbert 1992). In his classic work, *Studies in Ethnomethodology,* Garfinkel describes ethnomethodology as, "the investigation of rational properties of indexical expressions and other practical actions as contingent ongoing accomplishments of organized artful practices of everyday life," (Garfinkel 1967: 11). Ethnomethodology often escapes neat sociological definition precisely because it is a "method" or a means of "investigation" rather than a theory proper. Others have described the ethnomethodological approach as follows:

> Its concerns are with the 'observability' of ordinary social life, and its principal method of investigation is that of observation.

> Its focus is upon the methods by which observable social activities are produced. It seeks to investigate how social activities are accomplished by members of society...Its key assumption is that the production of observable social activities involves the local or situated use of member's methods for doing such activities. (Francis & Hester 2004: 20)

Because of its focus on everyday interaction, ethnomethodology is often associated with the symbolic interaction tradition, and/or similar perspectives such as social constructionism and phenomenology. While some basic similarities do exist, ethnomethodology departs from these traditions in important ways. Social rules and norms provide a foundation for symbolic interactionist traditions. For the social interactionist, shared meanings, or typifications, are internalized by individuals through a process of socialization. These become the common rules that members of a particular group use to conduct their day to day lives. Reality, then, is not objective, but socially constructed through the everyday interaction between members of a particular group.

Ethnomethodolgy also holds that reality is not an objective or external fact. However, it does not place the construction of reality squarely on the shoulders of a pre-existing set of shared meanings, common knowledge, rules, norms, or typifications.

> Ethnomethodolgy goes further. The structures of 'objective reality' are characterized as being far more fragile and malleable. For the ethnomethodologist there is no shared set of understanding and meaning which members attach to the world around them...What members do share are methods for making sense. Schutz's [phenomenological] common stock of knowledge is reconceptualized as a shared set of interpretive procedures, sense making activities that are invoked and employed continually in interaction. These procedures allow members to produce practical accounts of specific individuals

> engaged in specific activities in the context of particular situations. (Keel 1999: 3)

Garfinkel's work pays particular attention to this distinction. Ethnomethodology treats common understanding as a procedure or an operation rather than something that assimilates an external rule. Consider this excerpt from *Studies in Ethnomethodology:*

> 'Shared agreement' refers to various social methods for accomplishing the member's recognition that something was said-according-to-a-rule and not the demonstrable matching of substantive matters. The appropriate image of common understanding is therefore an operation rather than a common intersection of overlapping sets...In short, a common understanding, entailing as it does an 'inner' temporal course of interpretive work, necessarily has an operational structure. For the analyst to disregard its operational structure, is to use common sense knowledge of the society in exactly the ways that members use it when they must decide what persons are really doing or really 'talking about,' i.e., to use common sense knowledge as both a topic and a resource of inquiry. An alternative would be to assign exclusive priority to the study of the methods of concerted actions and methods of common understanding. Not *a* method of understanding, but immensely various methods of understanding are the professional sociologist's proper and hitherto unstudied and critical phenomena. (Garfinkel 1967: 31)

For Garfinkel, the notion that there exists a common set of rules that members of a particular society simultaneously construct and employ in order to understand each other is abandoned in favor of ethenomethodology. Ethnomethodology, then, is the work of studying how sense-making is achieved to accomplish practical actions in everyday life.

To accomplish this, he describes five 'policies' that guide ethnomethodological inquiries. I will briefly describe them below.

1) The first policy Garfinkel puts forth pertains to the scope of activities or occasions that can be studied in ethnomethodological research. Quite simply put, the scope is infinite. "No inquiries can be excluded no matter where or when they occur, no matter how vast or trivial their scope, organization , cost, duration, consequences, whatever their successes, whatever their repute, their practitioners, their claims, their philosophies or philosophers," (Garfinkel 1967: 32). Because ethnomethodology is concerned with everyday practical actions, all the stuff of everyday life is appropriate research material.
2) The second policy necessitates a recognition that rational activities are continuous procedures engaged in by members rather than a simple exercise of invoking some pre-existing rule. We cannot assume a definition of rational action exists for the members, and therefore neither can we assume so for the researcher. We must recognize that, "[m]embers to an organized arrangement are continually engaged in having to decide, recognize, persuade, or make evident the rational...," (Garfinkel, 1967: 32).
3) Upon acceptance of the second policy, the third policy becomes a matter of course. That is, we cannot assume that activities are efficient, planned, typical, consistent, or uniform. As such, it does not make sense to attempt to describe rules that exist outside of the activity itself as somehow guiding the activity. Instead, ethnomethodology focuses on the *production* of rules and rational action by members within a setting rather

than the *employment* of external rules by members to guide their actions. Rules can be understood to be used by members as part of the social order rather than as an explanation of it.

4) The fourth policy, "is recommended that any social setting be viewed as self-organizing with respect to the intelligible character of its own appearances as either representations of or as evidences-of-a-social-order," (Garfinkel 1967: 33). Every setting is uniquely organized through its member' methods to make its own activities accountable.
5) Finally, Garfinkel suggests that in every possible inquiry there will be evident the apparent rational properties of the sense-making activities (proverbs, passing remarks, fables, expressions, etc.) of the members. The production of rational properties of indexical expressions and actions by members is experienced by those members as practical and organized conduct.

This last policy is key to the ethnomethodological perspective. Garfinkel suggests that there are underlying and, indeed, 'unrecognizable' features to everyday life. Members recognize their sense-making activity as common sense, practical, and organized. However, ethnomethodology seeks to recognize that same activity as something more – namely, as ongoing, continually produced, contingent, 'artful' practices.

Indexicality

As we have seen above, the concept of indexicality is central to ethnomethodological inquiry and, as such, it warrants some additional treatment here. According to Hilbert (1992) ethnomethodologists use the term 'indexical' to refer to a property of expressions that suggests that their meaning is imprecise and varies depending upon context. We can only understand an expression or a collection of words within the particular context or situation in which they were used. Garfinkel (1967; 1974) has noted that traditional sociological analysis has been uncomfortable with indexical expressions and found them rather inadequate for understanding an objective reality. As a consequence, social scientists have sought to develop a standardized descriptive vocabulary by substituting 'objective' expressions for 'indexical' expressions with a goal of accomplishing a scientifically sound and literal description of the social world. However, this is where ethnomethodology makes an important departure from other forms of analysis. Garfinkel suggests that all expressions are indexical and therefore, an objective decontextualized sociological vocabulary is impossible and basically useless.

Garfinkel takes this argument a step further and suggests that most sociological researchers end up recognizing that whatever objective approach they are trying to employ is somehow inadequate due to the indexical nature of the situation, but they will try to pass the research off as meaningful nonetheless. "In every actual case without exception, conditions will be cited that a competent investigator will be required to recognize, such that in *that*

particular case the terms of the demonstration [that objective concepts are in use] can be relaxed and nevertheless the demonstration be counted as an adequate one," (Garfinkel 1967: 6).

Given that we are stuck with indexical expressions and only indexical expressions, Garfinkel takes them on head on as the unit of analysis in ethnomethodological investigations. Instead of trying to generalize or uncover some underlying social rule set to apply to everyday indexical expressions, ethnomethodological work focuses on understanding each expression within its context. Why is something being said at this particular time, in this particular way, by this particular person, in this particular situation? How is the action of what is being said linked to the situation in which it was said? "Thus, the point is not to construct theories of the relationship between, for example, culture and behavior or social rules and their application, but to investigate the cultural methods and resources persons actually and observably employ in getting done whatever it is that they are doing," (Francis & Hester 2004: 31).

Culture of Traditional Psychotherapy

This study is social-psychological in nature and does not in any way attempt to provide an in-depth analysis of the history and theory behind the various approaches to child therapy. However, I feel that some cursory discussion of theory and practice of the traditional therapeutic approach is warranted as it lends context to the behaviors, reflections, and impressions of the child therapist and her interactions with the child IPV witnesses. In general, the

literature on child therapies for IPV witnesses tends to support approaches that are multifaceted, involve several family members, and are developmentally appropriate (Rossman, Hughes, & Rosenberg 2000). Because a good deal of child IPV witness therapy takes place in women's shelters, a comprehensive approach to treating IPV witnesses is often not possible due to limited resources available to the shelter and the limited amount of time families typically will reside in, or be associated with, the shelter. As a result, IPV witness therapy in practice may be as much a reflection of what is possible as it is a response to therapeutic models that have been shown to be effective. To further complicate matters, empirical testing of IPV witness therapy is scarcely conducted due to the relative newness of the field coupled with the lack of shelter resources and short duration of family stay as noted above (Rossman, Hughes, & Rosenberg 2000).

Despite the lack of comprehensive or conclusive research in this area there are, nonetheless, a number of therapists doing clinical work with IPV witnesses and these therapists do that work within whatever particular theoretical framework their training and experience has afforded them. There are several theories that support the work of child therapists seeking to assist IPV child witnesses. Most are couched in a culture of traditional therapy. Harry Stack Sullivan (1933; 1934; 1937; 1938; 1940; 1947; 1951) is largely credited with formulating the foundations of modern psychiatry and the psychiatric interview. Sullivan's conceptions about psychotherapy are based largely on his understanding of the self. Like symbolic interactionists, Sullivan understands the self to be reflective and dependent upon interactions with others. Sullivan pays

particular attention to the development of the self through childhood. His conclusions are particularly germane to this study of IPV child witnesses.

> The self may be said to be made up of reflected appraisals. If these were chiefly derogatory, as in the case of an unwanted child who was never loved, of a child who has fallen into the hands of foster parents who have no real interest in him as a child; as I say, if the self dynamism is made up of experience which is chiefly derogatory, then the self dynamism will itself be chiefly derogatory. It will facilitate hostile, disparaging appraisals of other people and it will entertain disparaging and hostile appraisals of itself. (Sullivan 1940: 10)

The basic premise of this conception is that children who grow up in difficult circumstances where they do not feel safe, secure, and loved, will be challenged with low self-esteem and inappropriately negative conceptions of others. Sullivan's assessment of the mental state of individuals who experience these issues is equally as telling.

> Needless to say, limitations and peculiarities of the self may interfere with the pursuit of biologically necessary satisfactions. When this happens, the person is to that extent mentally ill. Similarly, they may interfere with security, and to that extent also the person is mentally ill. (Sullivan 1940: 10)

This points to a culture of therapy that has emerged from a position that understands children with difficult backgrounds as necessarily afflicted with low self-esteem and by definition, mentally ill.

The child therapist involved in the Rural Michigan Community Coordinated Response Projects to Prevent Intimate Partner Violence cites the widely employed work of Carl Rogers (1959; 1961) and the "client-centered" or "person-

centered" approach as fundamental to her theoretical base. Building on humanistic theory and Maslow's Hierarchy of Needs, Rogers' approach suggests that because the client or individual has an innate drive for self-actualization, it is the client rather than the therapist who has the capacity to affect positive personal change. In order to facilitate that process then, the therapist must exhibit three attributes; congruence or genuineness, unconditional positive regard for the client, and accurate empathetic understanding for the client. The goal of client-centered therapy is to have the clients develop self-trust, relinquish defenses, and achieve insight in order to take on personal responsibility for making positive changes that will result in a greater sense of personal happiness.

In addition to the client-centered approach, the child therapist in the Rural Michigan Community Coordinated Response Projects to Prevent Intimate Partner Violence indicates that she is guided by principles of feminist therapy. This is a consistent theme with many therapies typically provided in response to family violence (Rossman, Hughes, & Rosenberg 2000). With feminist theory as a foundation, feminist therapy is rooted in the understanding that male-dominated cultures devalue women and children and that the experience of living in such a culture has an adverse effect on not only their life chances, but on their mental health as well. The therapeutic environment then, is strength-based and very focused on addressing the dynamics of power.

> Feminist therapy attempts to create an egalitarian therapy relationship, in which, although the inequality of power between therapist and client is acknowledged, intentional efforts are made by the therapist to empower the client and to define her or him as an authority equal in value to the therapist. Clients are encouraged to discover the manner in which their authority in their lives has

> been taken from them and, using the therapeutic relationship as one model setting, begin to reclaim that authority and to speak in their own voice. (Brown 2000: 2)

Validating repressed feelings of anger, self-doubt, and self-hatred are common features of feminist therapy as is the focus on relearning sex-role socialization and the building of women's strengths.

It is within this traditional theoretical matrix that child IPV witnesses are frequently treated. Whether the child receives individual therapy, group therapy, or some combination thereof, the basic premise of the therapeutic environment is one that has at its base a notion of the child repairing a damaged "self" through a positive and trusting relationship with his or her therapist. While there is some agreement that a therapeutic regimen is somewhat beneficial for IPV child witnesses (Moore & Pepler 1998; Rossman, Hughes, & Rosenberg 2000), there remains a dearth of empirical studies that provide conclusive evidence of the degree and nature of the benefit. This further begs investigation into the consequences to the self that may be experienced by children in the traditional therapeutic environment.

It is important to consider the dynamics of power at work in the traditional therapeutic environment as well. The typical provider-client relationship is socially constructed in such a way that the therapist has a degree of social authority over her patients (Turner 1995; 1996). The therapist's status as a professional, or at least as a paraprofessional, affords her some measure of power over her clients. Professions are constructed in such a way that ensures that members have this power.

> The specialized knowledge of the professional creates the basis for prestige and social distance between the expert and the client, since the client by definition is excluded from the esoteric knowledge of the professional association. We might suggest that the professions have to have a hermeneutic basis; that is, there has to be the development of interpretation which provides the barrier against external regularization through the routinization of its base in knowledge. (Turner 1995: 133)

While the professional prestige of a therapist is certainly less significant than that of a physician or a psychologist, the interpretive nature of the work and the occupational specialization of therapy within a quasi-medical context results in a power imbalance between therapists and clients in the therapeutic setting nonetheless. In the case of IPV child witness therapy, this unequal distribution of power is further exaggerated by the fact that the provider is an adult and the client is a child. These dynamics must be accounted for in the examination of how the therapist's relationship with the child IPV witness contributes to the child's concept of self.

CHAPTER THREE

METHODOLOGY

For this secondary analysis, ethnomethodological content analysis of the child therapist's case notes and the other available documents from the child therapy project was conducted. The full set of case notes representing the therapist's work with the children from January 2000 to September 2001 was used to conduct the analysis. To the extent that demographic data could be extracted from the data set, basic relationships between the recorded content of therapy sessions and the children's gender, age, ethnicity, cultural background, and familial structure were examined to provide context for the rest of the analysis.

Ethnomethodology in Practice

Documentary Method

The basic principles and concepts of ethnomethodology have been established above. The fundamental questions that ethnomethodology seeks to explore have been outlined and the central tenants of that exploration have been explicated. What has not yet been attended to is how one actually 'does' ethnomethodology. Garfinkel employs Mannheim's (1952) 'documentary method of interpretation' to assist us here.

> The method consists of treating an actual appearance as 'the document of', as 'pointing to' as 'standing on behalf of' a presupposed underlying pattern. Not only is the underlying pattern derived from its individual documentary evidences, but

> the individual documentary evidences, in their turn, are interpreted on the basis of 'what is known' about the underlying pattern. Each is used to elaborate the other. (Garfinkel 1967: 78)

As we have shown, ethnomethodologists understand 'underlying patterns' as essentially nonexistent and without core meaning due to indexicality. However, we have also shown that members experience such patterns as common-sense knowledge that might be understood as something akin to folklore. Individuals expect or anticipate that their expressions will be meaningful to each other in the context of a whole. Schutz provides us with a key understanding about this intersubjectivity. Essentially, Schutz asserts that two individuals will never have the exact same experience, but this does not matter because each individual will invariably assume and operate as if their experiences are, practically, the same.

> I take it for granted – and assume my fellow man does the same – that if I change places with him so that his 'here' becomes mine, I shall be the same distance from things and see them with the same typicality as he actually does; moreover, the same things would be in my reach which are actually in his... 'We' assume that both of us have selected and interpreted the actually or potentially common objects and their features in an identical manner or at least an 'empirically identical' manner, i.e. one sufficient for all practical purposes. (Schutz 1962: 11-12)

Individuals achieve intersubjectivity, then, by functioning in a perceived common world. As such, they do not utter every detail of what they are trying to communicate to one another. They use expressions and vague references in their interactions and yet they seek to maintain a common understanding by what they experience as the use of common-sense.

Rather than recognizing sense-making procedures of members as a common body of knowledge that resides in pre-existing empirical social

structures, ethnomethodologists view each concrete use of an expression as 'documentation' of both the production/assembly and the presupposition of a body of social structures on the member's part. An ethnomethodological researcher cannot make interpretations based on presuppositions, but must temper any interpretation of an expression with the context of the situation, what may have been said prior to the expression, and what may be said after the expression was uttered. Just as social structures emerge in every social setting, so too must the interpretations made by the researcher. The same word or expression can, and Garfinkel would argue invariably does, have different meanings when used in different context. It is the ethnomethodological researcher's task (just as it is the members' task) to consider the various alternate meanings and arrive at some adequate description of the expression within the particular social situation. An important feature of the documentary method of interpretation then, is its temporality. According to Mannheim, "documentary interpretation has the peculiarity that it must be performed anew each period, and that any single interpretation is profoundly influenced by the location within the historical stream from which the interpreter attempts to reconstruct the spirit of the past epoch," (Mannheim 1952: 36).

While the documentary method of interpretation is not a popular methodology in sociological analysis, there have been a handful of ethnomethodological studies that have used the documentary method successfully. The most well-known are detailed in Garfinkel's (1986) *Ethnomethodological Studies of Work.* In this collection of organizational

studies, Garfinkel, true to his first policy, demonstrates that the scope of inquiries and practical actions that lend themselves to ethnomethodologic study is ubiquitous. A range of studies focusing on everything from truck wheel accidents, to Kung Fu instruction, to designing a notational system for transcribing lectures, to the occult science of alchemy are profiled. Despite the vast range of topics and data sets, the procedures and conclusions of the researchers are unmistakably ethnomethodologic. For example, in an inquiry of accident data related to truck wheel accidents, Baccus (1986) notes the indexicality of service personnel's assessments of the types of improper behavior that could contribute to an accident. "These improprieties are contextual assessments. That is, seeing actions as improper in some fashion, either as shortcutting or as illegitimate action, is seeable only within a context of looking. The context is made up of existing schema of the account of what the enterprise – here truck tire servicing – is about and of what it consists," (Baccus 1986: 38). Using the documentary method, Baccus goes on to explicate how these real-world assessments both evidence and produce an underlying pattern or "common-sense" body of knowledge for the service personnel.

In a slightly more recent, and arguably more exotic, ethnomethodologic study, David Zeitlyn (1990) uses the documentary method of interpretation to inform his analysis of Mambila spider divination. Zeitlyn's study focuses on the Mambila society of Cameroon. The Mambila practice spider divination which involves a process of enticing a spider out of its hole in the ground forcing it to disturb leaves placed near the mouth of the hole. The pattern the spider creates

in the leaves is then interpreted by a diviner as one of two possible answers to a question posed by the person who has come to seek advice. Often multiple questions about a particular problem are asked and multiple spiders may be consulted during the process. Zeitlyn analyzes divination sessions as situated dialogue and pays particular attention to how contradictory answers are understood to provide additional information. He suggests that when apparent contradictions in the answers arise, the diviners redefine the contradictions as opportunities to pursue other lines of questioning. Negotiating contradictions in this way serves to protect the validity and integrity of the divination practice itself. If the answer to one question contradicts the answer to a previous question, the contradictory answer is interpreted as begging a new question and suggesting the question that produced the contradictory answer was not the appropriate line of inquiry. He concludes, "Garfinkel's methods may be used to reveal the way in which diviners construct the dialogue. In essence: contradictions were understood as question-rejection moves. They give pause for thought, and lead to changes in tack," (Zeitlyn 1990: 663). Zeitlyn's study is an excellent example of how even ancient practices that have been ritualistically repeated numerous times are new productions each and every time they are performed. Each production 'documents' a certain presupposed common body of knowledge (the validity of the divination practice) at the same time it contributes to it.

Expansion Analysis

This secondary analysis employs procedures related to the documentary method of interpretation (Mannheim 1952, Garfinkel 1967) as described above. In order to understand the various methods individuals use to accomplish shared meaning, Garfinkel recommends a meticulous exercise whereby records of situated dialogues are expanded to include the 'unspoken' or taken for granted information within a particular context. Garfinkel relays an example of this exercise that he engaged in with his students.

> Students were asked to report common conversations by writing on the left side of a sheet what the parties actually said and on the right side what they and their partners understood that they were talking about. A student reported the following colloquy between himself and his wife.

HUSBAND: Dana succeeded in putting a penny in a parking meter without being picked up.	This afternoon as I was brining Dana, our four-year-old son, home from the nursery school, he succeeded in reaching high enough to put a penny in the parking meter when we parked in a parking meter zone, whereas before he has always had to be picked up to reach that high.
WIFE: Did you take him to the record store?	Since he put a penny in a meter that means you stopped while he was with you. I know that you stopped at the record store either on the way to get him or on the way back. Was it on the way back, so that he was with you or did you stop there on the way to get him and somewhere else on the way back?....

(Garfinkel 1967: 38)

Garfinkel goes on to discuss how the colloquy demonstrates that the couple understood many things that were not explicitly mentioned, and that understanding was possible both because of what was said and what was left unsaid. The understanding relied on temporality and biography. The couple often had to rely on their historical knowledge and also wait for future expressions to be made in order to accomplish meaning. Further, the couple could achieve a common understanding by treating each other's actual expressions as 'documents' of an underlying pattern. "The underlying pattern was not only derived from a course of individual documentary evidences but the individual documentary evidences in their turn were interpreted on the basis of 'what was known' and anticipatorily knowable about the underlying patterns. Each was used to elaborate the other," (Garfinkel 1967: 40).

By treating the therapist's case notes as a situated dialogue, the data in this study was analyzed through the same meticulous methodology. Excerpts from actual case notes were placed on the left side of the page. On the right side of the page, what was actually recorded in the case notes was expanded to include an interpretation of the 'taken for granted' information that was not recorded. Like Garfinkel suggests above, the interpretations needed to rely on what was previously documented in the record as well as what was subsequently documented in the record. Admittedly, there was ultimately a degree of 'leap-taking' in the interpretation, especially since the analysis was physically and temporally removed from the actual event of the therapist note-taking. However, that uncertainty was mitigated by the existence of an extraordinary volume of

notes available for analysis. Further, the therapeutic literature provided a sense of the therapeutic approach, or underlying assumptions experienced as common sense knowledge likely employed by the therapist as she engaged with the child IPV witnesses for therapy sessions. While current delivery mechanisms for child therapy may vary, according to Groves (1999), certain therapeutic goals for children who have witnessed domestic violence are well-established and commonly accepted.

> A first goal of therapeutic intervention is promoting open discussion of the children's experiences...the process of retelling or reenacting a traumatic event in the safety of a therapeutic relationship is in itself a healing experience, and a first step toward integrating the experience into their understanding of themselves. Second, therapists seek to help children understand and cope with their emotional responses to the violence, while promoting their acquisition of positive behavior patterns...Third, mental health interventions seek to reduce the symptoms the children are experiencing in response to the violence...Finally, therapists work to help the family create a safe, stable, and nurturing environment for the child, because children cannot begin to recover from the effects of exposure to violence so long as the exposure continues. (Groves 1999: 125-126)

With the background of the therapeutic literature that likely occupied the therapist's common sense knowledge and an expansive record in the data set, there was increased opportunity for 'underlying patterns' to be documented with significant frequency and a high degree of efficacy through the expansion analysis process. This provided more substantial evidence of how sense-making was accomplished in this context and left less up to interpretative leaps.

In true enthnomethodologic fashion, the use of expansion analysis necessitates an acknowledgement that there is a purposeful layer of

interpretation (rather than an objective relaying of empirical facts) occurring by the researcher. Ethnomethodologic research employs the same process that it seeks to understand – the sense-making process. In doing so, it requires the researcher to be explicit about the interpretive procedures being used to conduct the analysis. For this study, the secondary analysis was physically and temporally removed from the actual occurrence of the provision of therapy. The analysis was primarily conducted on the written case notes that were dictated by the therapist. As such, the task of expanding each case note required interpretation based upon not only what was written, but also upon what was known by the researcher about the therapist, the therapeutic environment, and the commonly held tenants of providing child therapy.

The following excerpt from the case notes has been arranged in such a way to illustrate the multi-layered interpretive process involved in conducting the expansion analysis. The first column represents an exact quote from the data set, the second column is the expansion analysis, and the third column has been added to provide insight into how the expansion analysis was arrived at by the researcher. It is explicit about the procedures, or common sense knowledge, employed by the researcher in the task of conducting the analysis. Again, just as Garfinkel suggests, the ethnomethodological researcher goes about sense-making (analyzing) in the same manner as do his or her research subjects. Unique to ethnomethodology is the deliberate-ness of this interpretive process and the acknowledgement that it is not (and, in fact, cannot be) a purely objective exercise.

Therapist Case Notes:	**Expansion Analysis:**	**Researcher Extrapolation:** (for illustration purposes)
Gave Owen affirmations poster. Say it everyday.	During the therapy session today, the therapist seems to have recognized that Owen has low self-esteem due to his IPV witnessing experience. The therapeutic course of action she took was to present him with a poster that had a positive, self-affirming message on it. The therapist instructed Owen to repeat the saying to himself everyday apparently with the intent that it would become second nature and he would begin believing it, thereby increasing his self-esteem.	With the background knowledge that the therapist produced the case notes as a result of providing therapy to IPV child witnesses as part of a larger project, it is understood that the therapist recorded these particular notes subsequent to a therapy session with Owen (rather than a casual conversation with him) and Owen is understood to be a child IPV witness. Further, with the knowledge that the therapeutic literature consistently identifies children who have witnessed intimate partner violence as having low-self esteem, it is understood that the therapist, having been formally trained (presumably formal training credentials were required in order to be employed by the shelter in the study) and likely exposed to the therapeutic literature, would recognize Owen as having low self-esteem. The therapeutic literature also suggests that a goal of therapy is to help children deal with negative emotional responses and develop positive ones. Again, given that the therapist would likely be familiar with this commonly held tenant of the literature, it is understood that she would prescribe interventions to accomplish the goal of increasing Owen's self esteem. With the benefit of having read a large volume of the therapist's case notes and seeing reference to affirmations posters in other contexts, it is understood that

		these posters (by nature of being called 'affirmations posters') and by how they are referenced in these other contexts, contain positive messages and are intended to help the child recipient of the poster to increase self-esteem by repeating the phrase on the poster every day. According to therapeutic literature and self-help lore in the general culture, the repetition of verbalizing positive sayings helps the individual engaging in the verbalization to internalize the sentiment in the saying and feel more positive about themselves and/or their own abilities. As such, the affirmations poster given to Owen by the therapist is understood to be a therapeutic intervention intended to increase his self-esteem.

As this illustration demonstrates, the expansion analysis is neither an objective regurgitation of fact nor a randomly subjective collection of presuppositions. Instead, the researcher arrives at the analysis through interpretive procedures that take into account the indexicality of the situation. That is, the researcher draws on background knowledge of the context in which the therapy was provided, what is known about the therapeutic literature and the therapist's likely exposure to it, what is present in previous and subsequent case note entries, and general features of the culture in which the original therapy took place.

Ethnomethodologic Principles

On a practical level, the content analysis adheres to Fancis and Hester's (2004) four ethnomethodologic principles.

1. The demonstrable relevance of sociological descriptions
2. The consequentiality of members' orientations and understandings
3. The situatedness of talk and action
4. The inspectability of data

The first principle of demonstrable relevance of sociological descriptions suggests that whatever is observable in the data is relevant to the members' understandings and thus, relevant to the analysis. If the therapist organized her case notes in a particular way, wrote something down, or neglected to write something down, then the organization, inclusions and the omissions are all relevant to the analysis. They tell us something about her orientation and her sense-making of the interactions. Care needs to be taken not to pre-define or over-categorize the data, but rather to let the themes emerge from the data as the analysis progresses.

The second principle suggests that the consequentiality of members' orientations and understandings is important. This simply means that the researcher must show how a member's orientation or understanding is involved in the production of the social activity. It forces attention to the details of the data and spells out how a social actor took his or her orientation into account when producing a particular action.

The third principle, situatedness of talk and action, relates to how members make sense within a particular context. In what situation are the

actions taking place? What knowledge are the actors drawing on to make sense of the situation? How are the actors orienting themselves to their particular knowledge about the situation and how does that orientation and knowledge factor in the production of a resulting action? In every situation, meaning is locally produced. In a particular therapy session, the therapist and the child are drawing on the unique accumulation of history and reservoir of knowledge and experience that each of them possesses at that point in time.

Finally, the inspectability of data principle suggests that the analyst must ensure that the data can be inspected by the reader. Direct quotes from case notes are necessary to relay an ethnomethodological conclusion. Generalizations and statistical indices from data that has been cleansed and codified can provide background or supplemental points of reference, but this type of information does not contain the elements of specificity germane to ethnomethodology.

Membership Categorization Analysis

The expansion and interpretation of the case record as described above, was informed by elements of Membership Categorization Analysis (MCA), (see Sacks 1967; 1972; 1974; 1992). MCA is an activity involved in 'doing' ethnomethodolgy. More specifically, MCA is a sense-making process engaged in by both everyday individuals and professional sociologists alike.

> The focus of MCA (Membership Categorization Analysis) is on the use of membership categories, membership categorization devices and category predicates by members, conceptualized as lay and professional social analysts, in accomplishing (the sociology of)

> 'naturally occurring ordinary activities'. MCA directs attention to the locally used, invoked and organized 'presumed common-sense knowledge of social structures' which members are oriented to in the conduct of their everyday affairs, including professional sociological inquiry itself. (Hester & Elgin 1997: 3)

MCA gives lexicon to a twofold process; one by which individuals use to make sense of their everyday lives and a subsequent process by which sociologists use to analyze (make sense of) that very sense-making process. The MCA activity engaged in by the individual in his or her everyday life and that of the researcher performing an analysis is essentially the same. However, the ordinary individual experiences the activity as the employment of common-sense knowledge whereas the researcher experiences it as deliberate analysis.

Sacks (1972; 1992), suggests that the MCA activity can be understood according to a number of organizational procedures and rules. The most basic of these is the 'membership category'. Individuals belong to various membership categories in their everyday lives such as male, female, sister, brother, mother, father, teacher, therapist, construction worker, artist, runner, etc. Each individual belongs to multiple membership categories simultaneously. I am at once a female, a mother, a daughter, a sister, an aunt, a student, a partner, a supervisor, an employee, a football fan, etc. However, in accordance with the 'situatedness of talk and action' principle, we must account for the fact that individuals are uniquely oriented in each interaction and as such certain membership categories will be operationally relevant in certain situations whereas others will not. When I am at work assigning a task to an employee, my membership categories of daughter, aunt, and football fan are not necessarily

relevant with respect to that particular activity, whereas my membership categories of supervisor, employee of the Department, and female are quite likely to be operationally relevant. One challenge for the ethnomethodological researcher is to avoid simply presuming that certain membership categories are relevant for individuals in a particular situation. As much as possible, the researcher must allow the relevant categories to emerge from careful examination of the data. As Garfinkel would argue, the detail of the situated dialogue contains the documentary evidence to establish the membership categories relevant to the actors in the particular circumstance being studied.

Once relevant membership categories are established for an individual, a good deal of information about that individual can be inferred. "[W]hen we know what category applies to a person, then we know something about them. We can predict what kinds of attributes they may have, what their obligations and entitlements are and, perhaps most importantly...what kinds of activities they properly and typically engage in, and hence how they may act in the here and now," (Francis & Hester 2004: 39). Again, this process of inferring is done by ordinary individuals as they engage others in their everyday lives and it is done by researchers as they analyze those everyday interactions.

According to Sacks (1972), membership categories are organized into collections that are recognizable as part of our common-sense knowledge. We expect certain membership categories to co-exist in certain collections such as a family, a baseball team, or a first-grade class. Some categories within these collections are understood to go together as 'standardized relational pairs'. A

parent can always be understood to be paired with a child. Similarly, doctor-patient, therapist-client, husband-wife, teacher-student, and the like occupy our common-sense knowledge as standardized relational pairs. We typically expect one category to imply the other and to exist in a specific relationship to that other category. A mother is understood not only to have a child, but also to have specific obligations, possess specific rights, perform specific activities, and take on specific attributes in relation to the child.

According to Sacks, individuals use collections of categories such as standardized relational pairs to assist in the organization of their thinking and talking about their everyday lives. Sacks also identifies several 'rules of application' that guide the use of categories. Francis and Hester (2004) describe the most fundamental of these rules as follows.

> [T]he 'consistency rule', refers to how, if one uses a category from a particular collection, to describe a first member of the population of persons, then one may use a further category from the same collection to refer to an additional member of that population. It is from the consistency rule that the 'hearer's maxim' is drawn as a corollary. This states that if a hearer can hear two consecutively (not necessarily immediately adjacent) categories as going or belonging together then: hear them that way. In other words, don't doubt that they are related if that is how you hear them, unless you have good reason for doing so. (Francis & Hester 2004: 41)

The hearer's maxim pays particular attention to how individuals describe their experiences as well as how they make sense of the descriptions of experiences that they encounter in their everyday lives. When I encounter a description involving a 'player' and a 'coach', I immediately recognize them, or hear them, as belonging together in the collection of 'team' but also in a standardized 'player

and coach' relational pair. Without any evidence to the contrary, I recognize the coach and the player as members of the same team. Further, I am going to understand (hear) that the coach is the coach of the player that was referenced earlier and not the coach of another player. They belong to a standardized relational pair.

Categories can also be understood to be associated with 'category bound predicates' or characteristics which, "can conventionally be imputed on the basis of a given membership category," (Watson 1978: 106). Various predicates including; activities, attributes, rights, obligations, attributes, tendencies, and skills are specifically associated with membership in a certain category. So, for example, delivering a lecture is a category-bound activity of professors and filling a cavity is a category bound activity of dentists. Similarly, acting out in school might be understood as a category-bound activity of male IPV child witnesses. Category bound predicates provide us with methods for sense-making and as such, comprise elements of our common-sense understanding of our everyday lives.

Just as individuals can be understood to go together in standardized relational pairs, so too can activities be understood to go together as 'category-paired actions'. When we hear a description that includes an individual falling off a ladder and breaking her leg, and then hear a subsequent description that the individual went to the hospital, we understand that description to mean that she went to the hospital *because* she broke her leg and not for some other reason.

Breaking one's leg and going to the hospital are category-paired actions and, without any evidence to the contrary, we will hear them as related actions.

Through Membership Categorization Analysis, individuals are able to make sense of their everyday lives through drawing on various processes and rules of application to fill in what is left unsaid in day-to-day interactions. These processes and rules occupy each individual's body of common-sense knowledge. Similarly, the ethnomethodological researcher is able to analyze data through a more explicit, but parallel exercise in sense-making. And it is through this explicit attention to the rules of application employed by the child therapist, as evidenced and documented in the data, that the analysis for this study was conducted.

CHAPTER FOUR

DATA ANALYSIS: PRODUCING SCRIPTS

Ethnomethodology suggests that expressions are always indexical. Ethnomethodological data analysis must understand meaning as produced anew in each and every situation. However, ethnomethodology also suggests that individuals employ certain rules and procedures (common sense knowledge) to produce this meaning and make sense of their everyday lives. What follows is an analysis of how the child therapist in this study made sense of the child IPV witnesses that received therapy during the Community Coordinate Response Projects to Intimate Partner Violence. The data analysis will be presented through a series of scripts. Each script represents the aggregate of procedures and rules that the child therapist apparently used to make sense of certain children in her professional care during the course of the project.

The characterization of these procedures and rules as scripts suggests that they might be fixed or standardized in some way. The therapist draws on her body of common sense knowledge related to child therapy to form her personal and professional opinions about each child's emotional and psychological responses to their IPV witnessing experiences. In doing so, the therapist is indeed experiencing her common sense knowledge as a sort of script – an underlying pattern that includes a predictable series of actions and reactions. Indeed, one could argue that the therapist has a certain amount of investment in understanding the scripts, or at least the story lines within the

scripts, to be predetermined objective realities in order to validate her common stock of knowledge and legitimize her professional standing as a therapist in this particular environment. However, rather than being fixed or predetermined, the data suggest that each script is actually *produced* during the course of the therapist's interactions with each child. The children's responses serve as documentary evidence to support the therapist's production of a script based on an underlying pattern/story line in the first place, and at the same time, they serve to reinforce the validity of the script once it is produced.

Stated another way, the scripts represent the intersection of the abstracted institutional system of providing therapy and the actual occurrence of providing therapy to the IPV child witnesses in the original project. The work of Dorothy Smith (1987) and David Sudnow (1965; 1967) suggests that sociologists have often struggled with accomplishing generalizations from the study of particular or local "cases". However, Smith maintains that if we use methodologies that approach the local, or the everyday world, as problematic, we discover the generalizations in the underlying patterns. The generalizations are, in fact, actively adjusted and organized into the local productions of meaning. This is explicitly apparent in institutional systems, including the therapeutic environment.

> Professional and bureaucratic procedures and terminologies are part of an abstracted system. Abstracted systems are set up to be independent of the particular, the individual, the idiosyncratic and the local....In actual operation...the abstracted forms must be fitted to the actual local situations in which they function and which they control. In practice, the abstracted system has to be tied to the local and particular. Psychiatric agencies develop ways of working which fit situations and people which are not standardized, don't

> present standardized problems and are not already shaped up into the forms under which they can be recognized in the terms which make them actionable. What actually happens, what people actually do and experience, the real situations they function in, how they get to the agencies—none of these things is neatly shaped up. There is a process of practical interchange between and inexhaustibly messy and different and indefinite real world and the bureaucratic and professional system which controls and acts upon it. The professional is trained to produce out of this the order which he believes he discovers in it. (Smith 1975: 97)

In a similar fashion, the therapist's employment and production of scripts can be understood to represent the process of 'shaping up' or 'fitting' the actual local situations into actionable forms.

Membership Categorization Analysis draws this script production process out more explicitly. The therapist's case notes, once expanded, reflect the membership categorization, standardized relational pairs, category-bound predicates, category-paired actions and the like she employs to make sense of her interactions with the children. These rules of application can be loosely assembled into scripts for purposes of analysis. So, for example, the 'traumatized IPV child witness' script contains the components of the therapist's common-sense knowledge that are employed to understand child IPV witnesses as possessing certain category-bound predicates that can be associated with a child who is traumatized. This script is employed by the therapist to reflect her understanding of the children, but the script then also informs her assessment and treatment of the children. The children are approached by the therapist 'as if' they behave, act, and react according to the script, when in fact, they may not. The intersection of the script, which attempts to understand the children

according to certain rules, and the contextual indexicality of each interaction with the children produces meaning anew. This meaning is understood according to, and as evidence of, the therapist's common sense knowledge of IPV child witnesses.

The therapist's common sense knowledge of IPV child witnesses is informed by the therapeutic literature. Indeed, the scripts she both employs and constructs with the children in her care appear to follow what is, in a sense, prescribed by the literature. As described above, the literature suggests that IPV child witnesses suffer emotional, behavioral, and cognitive functioning difficulties such as low self-esteem, anger, and a tendency toward becoming abusers themselves due to their violence witnessing experiences. In addition, the literature identifies that, "children may harbor rage, feelings of guilt, and a sense of responsibility for the violence. Children who witness traumatic events, such as incidents of domestic violence, may feel helpless and see the world as unpredictable, hostile, and threatening," (Groves 1999: 123). We see evidence of all of these features in the therapist's construction of scripts for the children that emerge from the data.

The 'Traumatized IPV Child Witness' Script

One script that emerges from the analysis of the therapist's case notes is that of the *Traumatized IPV Child Witness*. That is, the therapist appears to draw on a particular set of procedures (common sense knowledge) in the course of providing therapy to the children that understands these children as experiencing

trauma as a result of their having witnessed IPV. According to this script, the children not only experience trauma, but they continue to be traumatized by the experience and are emotionally compromised in some way as a result. Consider the following case note excerpt and corresponding expansion analysis from the therapist's session with Emily. This is Emily's second session with the therapist- her first full session after an initial intake was conducted.

Therapist Case Notes:	**Expansion Analysis:**
Got new house. She is excited.	The child, Emily, returned to therapy for her session this week. It became known to the therapist that Emily was going to be moving into a new home. The therapist discussed with Emily (or observed) how she felt about moving out of the shelter and into a new home. The therapist interpreted Emily's responses and behaviors to mean that she was pleased to be moving into a new home.
Drew – praised drawing.	During the therapy session, Emily drew a picture. The therapist provided her with positive feedback about her drawing, likely in an attempt to contribute to positive self-esteem.
Listened to Spinoza "You are All You Need To Be."	A therapeutic technique that the therapist employed during the session was to listen to a juvenile tape that contains a positive message. The particular tape is called "You are All you Need to Be."
We talked about the message and that Stymie the Skunk is mean (on the tape).	There is a character on the tape named Stymie. Stymie is a skunk and his character exhibits unkind behavior. The character is apparently meant to provide an age-appropriate way for children to be able to process feelings about people they know in real life who are unkind. Recognizing that Emily has feelings about someone who is unkind in her own life, the therapist seems to use the characters on the tape to initiate a discussion about

	that type of behavior.
I told her when people say or do mean things to others it is because they have problems not because there is something wrong with the person they are being mean to.	The therapist understands children to be likely to feel that they have done something wrong when they are in an abusive household. Apparently recognizing that, as an IPV witness, Emily may have the perception that she had done something wrong, the therapist explained to her in general terms that when people behave in an unkind way toward someone, it is not because the person did something wrong or deserved to be treated in an unkind way.

This excerpt reflects the general orientation that the therapist takes toward Emily as a traumatized IPV child witness. With apparently no prompting behavior from Emily, the therapist elects to show her a therapeutic tape about processing feelings around the "mean" behavior of others. This suggests that the therapist assumes that Emily is struggling with the issue and needs therapeutic intervention to deal with it.

We see further evidence of this orientation as the session continues.

Therapist Case Notes:	**Expansion Analysis:**
She said a boy knocked her down. She told the teacher. The teacher made him apologize. She felt better.	During the therapy session, Emily relayed an incident that occurred while she was at school. Another child who is male and attends the same school, pushed her and she fell down as a result of the boy pushing her. After the incident, Emily told a teacher who works at the same school where the incident occurred, very likely, it was her own teacher. The teacher that she told required the boy who pushed her down to apologize to her for pushing her down. After the boy was made to apologize for pushing her down, Emily indicated that her negative feelings

	about the incident were at least partially ameliorated.
I asked what she does when she feels mad or sad – go play in my room.	Recognizing that IPV child witnesses have difficulty expressing their feelings and that IPV children frequently feel anger and sadness as a result of the IPV witnessing experience, the therapist asked Emily how she reacts when she has the feeling of anger or the feeling of sadness. Her response was that she goes to her bedroom to play when she has feelings of anger or sadness.
Sometimes kids are mad at mom. Is she? Yes, It's okay to be mad.	Recognizing that IPV children often feel anger toward their mothers, the therapist explained to Emily who she knows to be an IPV witness, that if she were to feel anger toward her mother, that would be a normal reaction given her situation. Then, she asked her if she felt anger toward her mother and she responded in the affirmative. The therapist appears concerned that Emily may feel negative feelings toward herself for being angry with her mother, because normally, children recognize that they should only feel positive feelings toward their parents. In response to this concern, the therapist attempted to diffuse any self-directed negative feelings she may have about her anger by telling her that it is appropriate for her to feel angry toward her mother.
How does she feel? Guilty. She has a right to feel mad.	The therapist asked Emily how she felt about being angry toward her mother and she responded that she felt guilty about those feelings. The therapist then explained to Emily again that her anger is a normal, appropriate response to her situation and that she should not feel guilty about it.
Mom is trying to make things better.	The therapist explained to Emily that her mother is trying to improve the situation and cease putting the child in a position where she will be exposed to IPV. Since the therapist likely assesses

	that being exposed to IPV is what is making the child angry toward her mother, she concludes that Emily's anger will be diminished as her mother is able to keep her from being exposed to IPV.
When she comes here, we will help her not feel mad anymore.	Emily is concerned about being angry with her mother. To help alleviate her concerns, the therapist explained to her that the therapy sessions will assist her with not feeling that anger any longer and this is framed as a positive outcome for the child.
What are some things she could do?	The therapist asked Emily what strategies she might use to address and process her angry feelings.

After discussing the pushing incident that took place at school, the therapist asks Emily if she is angry at her mother by first "normalizing" the feeling of anger toward mothers – "Sometimes kids are mad at mom. Is she?" Emily's response in the affirmative serves to reinforce the validity of the therapist's procedures. While the question itself is framed from the therapist's common-sense knowledge that IPV child witnesses are often angry toward their mothers, Emily's affirmative response becomes new documentary evidence of that common-sense knowledge. As Garfinkel suggests, each elaborates the other.

The therapist further attempts to normalize Emily's anger toward her mother by telling her it is okay to be mad and she has a right to feel mad. This is tempered by the therapist's subsequent remark to Emily that coming to therapy will help her to not feel mad anymore. With attention to the situatedness of this expression, it appears that the therapist is really saying that it is normal for IPV child witnesses to experience anger toward their mothers given the trauma they

have been through, however, it is not a normal state of being for emotionally healthy children to experience anger toward their mothers, and, at a minimum, it is not desirable. Therefore, the goal of therapy becomes to assist Emily with not feeling this anger any longer. The therapist begins to administer treatment toward this goal by introducing a therapeutic tool that describes healthy ways to express anger.

Therapist Case Notes:	**Expansion Analysis:**
Reviewed "25 Healthy Ways to Express Anger."	Apparently recognizing that Emily did not possess healthy ways to process anger, the therapist reviewed a therapeutic tool entitled "25 Healthy Ways to Express Anger" with her. This tool is intended to provide the child with healthy ways to express her anger.
She enjoyed my "angry dance."	One of the healthy ways to express anger that is identified in the therapeutic tool is to dance in a forceful, energetic way. The therapist demonstrated this technique to her and assessed by observing her body language and/or listening to her reaction that she was pleased by watching the demonstration of this technique.
I told her I will give this to mom so she can help Emily and her sibs get out their anger in healthy ways (which I did).	The therapist explained to Emily that she would give the tool entitled "25 Healthy Ways to Express Anger" to her mother. The reason she communicated for giving it to her mother was because she would then be able to review it and explore positive ways to express anger with the child and her siblings. It is known to the therapist that Emily and her siblings are all IPV child witnesses and she assesses they all can benefit from treatment because they all have anger and they do not possess healthy ways to express their anger. By giving this tool to the children's mother, she will be able to administer appropriate treatment to give them more normal

	ways to express anger. (Sometime after telling Emily that she would give the tool to her mother, she actually did give the tool to her mother.)

The introduction of the therapeutic tool again suggests that Emily needs assistance with healthy ways to express anger. Note Emily's earlier self-report that she goes to her room to play when angry or sad is not explored as a potential healthy response. The fact that different techniques are introduced and Emily's current technique is not explored suggests that the therapist does not believe Emily's response is a healthy one.

Taken in whole, the therapist's interactions with Emily document her common sense understanding of Emily as a "typical" IPV child witness in that she feels guilt about the child IPV witnessing experience, she feels anger toward her mother, she feels guilt about being angry toward her mother, has low self-esteem, and she does not possess healthy ways to express her anger. Stated another way, Emily's therapy session documents the therapist's understanding of category-bound characteristics of child IPV witnesses as angry, guilty and lacking appropriate tools to express their anger.

Further evidence of the therapist's common sense knowledge of IPV child witnesses as traumatized emerges in the following brief excerpt from her session with Max.

Therapist Case Notes:	**Expansion Analysis:**
Feelings check – denied having any feelings but happy.	When Max came into the therapy session today, the therapist inquired as to how he was feeling. This is a therapeutic tool aimed at assessing the emotional state of the child. Max

	indicated that the only feeling he could identify having was one of happiness. The therapist inquired about other feelings that IPV child witnesses generally have (and she seemed confident that he was also experiencing these feelings) but he denied having any of these other feelings.
I acted surprised when he hadn't been sad, mad, or shy.	When Max veered off script and denied having feelings of being sad, mad or shy, the therapist used verbal and non-verbal behavior to indicate to Max her surprise that he hadn't felt any of those other feelings. This was apparently intended to challenge Max on his denial of those feelings and to let him know that the therapist expected him to have those other feelings.
He smiled and said he might have been shy.	Upon recognizing her reaction of surprise, Max understood that the therapist had expected him to have feelings of being mad, sad, or shy. This recognition prompted him to admit that he may have been feeling shy. Max smiled during the admission which reinforces the therapist's assessment that he was embarrassed to admit feeling shy. Max did not admit to feeling mad or sad.

In this excerpt, the therapist challenges Max's assertion that he is not feeling angry, sad, or shy by acting surprised. By challenging Max in this way, the therapist again evidences her common sense knowledge that IPV child witnesses are sad, angry, and shy. She is, in essence, attempting to pull Max back on script. Max's response, however, only provides the therapist with limited reinforcement of her common sense knowledge as he will only somewhat reluctantly admit to being shy. The therapist must account for this as she produces meaning from the interaction. It is possible that she attributes Max's

reluctance to admit anger or sadness to his shyness. Alternatively, she may determine that Max is in a deep denial about these feelings and will eventually admit to having them. However this information is incorporated into the meaning that is produced, the therapist clearly indicates that she believes Max does indeed have feelings of anger and sadness about the IPV. At this point, it does not appear that she needs Max's admission to corroborate her script. However, Max's non-admission does give her new information and is something she has to account for one way or another as she deciphers meaning from the interaction.

This feature of the script is challenged in a similar way during a session with Kendall.

Therapist Case Notes:	**Expansion Analysis:**
Kendall completed several pages in her workbook today.	During the therapy session today, Kendall completed several exercises contained in her therapeutic workbook.
She wouldn't complete statement about feeling sad or bad. She said she never feels that way.	When Kendall was presented with an exercise in the workbook that asked her to complete statements about feeling sad or bad, Kendall did not complete them. When the therapist inquired as to why she did not complete the statements, she indicted that she does not ever feel sad or bad.
I said everyone feels that way sometimes and gave her examples, but she still denied ever having hose feelings.	Knowing that IPV child witness in particular have negative emotions resulting in feeling sad or bad, and that it is important for them to admit those feelings in order to heal from their IPV witnessing experience, it appears that the therapist attempted to get Kendall to admit her feelings by relaying to her that she knows that everyone feels negative feelings sometimes and she offered some examples of what might cause a person to feel sad or bad. Despite the explanation and examples, Kendall continued to deny feeling sad or bad.

She drew a picture of herself and her cat as her favorite memory.	One of the exercises in the workbook asked Kendall to draw a picture of her favorite memory. Kendall drew a picture depicting herself with her cat as her favorite memory.
She chose the little princess as the theme for her story. She said the princess has no family and she is sad about that.	In the story that Kendall made up for the exercise, she chose a princess theme and indicated that the princess did not have a family. Kendall was able to identify feeling sad about the princess not having a family.
PLAN: To continue exploring issues around family separation.	It is likely the therapist's assessment that Kendall has negative feelings related to the IPV witnessing experience and the subsequent family separation resulting in her father moving out of the home. The therapist appears to believe that Kendall is unwilling to express these negative feelings and that is not emotionally healthy for her. In response to this belief, the therapist indicates that she will attempt to provide Kendall with additional therapeutic interventions aimed at getting her to identify with the negative feelings in future sessions.

Again we see the child's resistance to admitting negative feelings challenged by the therapist. This points to an underlying assumption on the part of the therapist that the IPV child witnesses in her therapeutic care are experiencing negative feelings as a result of the trauma of IPV and, at least in Kendall's case, the aftermath of the IPV that led to family separation. It is clear that when the children do not respond according to the therapist's perceived script for them, she makes an effort to pull them into the script. When those efforts fail, she is able to create new meaning out of the interaction that allows her to maintain the validity of the script and the underlying story line. In much the same way as the diviner does in the Mambila spider readings, she is able to take contrary

responses and redirect or negotiate them in such a way as to avoid invalidating her common sense knowledge. In this case, rather than coming to the conclusion that Kendall is not traumatized by the IPV witnessing experience and does not have negative feelings related to it, the therapist appears to attribute Kendall's lack of negative feelings as a deeper denial that needs more therapeutic intervention to be overcome.

Similar meaning is achieved when Ethan denies angry or sad feelings during one of his sessions.

Therapist Case Notes:	**Expansion Analysis:**
Feelings check – happy.	During the therapy session today, Ethan indicated that he was happy when the therapist administered the therapeutic technique aimed at assessing his emotional state.
Denied any sad or mad feelings.	When the therapist inquired as to whether Ethan had feelings of sadness or anger, he indicated that he did not. The therapist appears to assess that he does have feelings of sadness and anger and he is unwilling to admit those feelings.
I read him "When I Get Angry" and "Let's Talk about Feeling Sad."	The therapist appears to believe it is beneficial for IPV child witnesses to admit their negative feelings. In an attempt to get Ethan to admit feeling anger and sadness, the therapist read two therapeutic books to him that are aimed at getting children to discuss negative feelings, "When I Get Angry" and "Let's Talk about Feeling Sad."
Ethan listened for a time but said that talking about feelings was "garbage talk", I said everyone has feelings and it's okay.	While the therapist was reading the books, Ethan appeared to be listening for a period of time, but before the therapist finished reading, Ethan said to therapist that he thought talking about feelings was "garbage talk". The therapist assessed this comment as Ethan believing that it was not

	acceptable to have certain feelings so she told him that everyone has feelings and it is acceptable
PLAN: Meet with mom about feeling issues.	Given Ethan's refusal to follow the prescribed script, the therapist looks to another person—a parental figure—to re-engage the proper script, in a sense challenging any cognitive dissonance raised by the interaction with Ethan.

Again, the case notes reveal that the therapist's expectation according to her common sense knowledge is that Ethan feels sad and angry. When Ethan does not initially follow the script, the therapist assesses his reluctance not as contradicting the script, but as Ethan having "feeling issues" that prevent him from recognizing that he does indeed fit the script. In essence, the denial of negative feelings becomes another feature the traumatized IPV child witness script.

We get additional insight into the therapist's common sense understanding of IPV child witnesses as traumatized when she conducts an intake session with, Jan, the mother of two children who are entering therapy.

Therapist Case Notes:	**Expansion Analysis:**
Jan outlined abusive relationship with Rob and answered interview questions.	Jan, the mother of the children that are entering child therapy met with the therapist and told her about her relationship with Rob and how that relationship had been abusive. She also answered standard interview questions that the therapist typically asks mothers at an initial meeting.
I let her tell her story which took about an hour.	Jan's description of the abusive relationship that she had with Rob took about 1 hour, which is unusually long.
She apologized for talking so much.	Jan recognized that her description was unusually long and she apologized to

	the therapist for taking a long time to describe the situation with Rob.
Sam has underlying behavioral problems that have been ongoing throughout his life.	Jan told the therapist that her son, Sam, has experienced behavioral problems. These problems have occurred throughout Sam's life and are not just recent.
He appears to be depressed and Jan would be open to meds for him as she herself has recently begun taking antidepressants and anti-anxiety meds and sees that they are working.	Jan reported to the therapist that her son, Sam, appears to be suffering from depression. Jan indicated that due to the depression she believes her son is suffering from, she would be willing to consider putting her child on prescription medication that is intended to treat depression. Jan is comfortable with using medication to treat depression because she has recently started to take both antidepressants and anti-anxiety prescription medication and it has been her experience that the medications are having a positive impact on her feelings of depression and anxiety.
Sam's reaction with the bat is a normal reaction to the trauma he witnessed. (Jan understands that.)	Jan and the therapist talked about a situation that involved Sam taking some inappropriate action with a baseball bat. Jan was concerned that Sam's behavior was abnormal. The therapist explained to Jan that Sam took that action because he was experiencing trauma as a result of the abuse that he witnessed in the home. The therapist also explained that it is normal for children to behave abnormally when they are witness to abuse in the home. Jan indicated to the therapist that she understood the therapist's explanation and agreed that Sam's behavior with the bat, though abnormal for a well-adjusted child, was a normal response for a child who had experienced the trauma of witnessing IPV. The parental agreement serves as a sort-of third-party validation of the traumatized IPV child witness script.

Parents appear committed to their children – questions remain, however.	The therapist's perception from the session with Jan is that both she and Sam's father are invested in their children's well-being. Something about the interview had the therapist concerned about how effective the parents are going to be at improving their children's situation and/or their behavioral problems.
PLAN: To see Jan next week to complete intake. Then set up a first appointment for Sam at that time.	The course of therapeutic treatment that the therapist intends to pursue with this family is to schedule another meeting with Jan in one week. At that meeting they will continue to discuss the intake questions and answers that they were unable to complete today. They will complete those questions and answers next week. It is also the therapist's intent during the appointment next week to talk to Jan about when she can schedule the first therapy session with her son, Sam.

Without having met Sam, the therapist is able to make some evaluative remarks about the behavior his mother has reported by drawing on her common sense knowledge that IPV child witnesses are traumatized. The therapist tells Jan that whatever action he took with the bat is *normal* for a child who has witnessed IPV. Again, the abnormal behavior is normalized for an IPV child witness. This suggests that the therapist expects IPV children to behave in this abnormal way, or at least she is not alarmed by the abnormal behavior when it is an IPV child witness who is engaging in it. According to the therapist, it is all part of the script that she simultaneously employs and produces. It is also of note that the therapist documents that Sam has had behavioral problems throughout his life.

Nonetheless, the incident with the bat is attributed to the trauma of his having witnessed IPV.

Through careful attention to the underlying patterns in the data, the elements of the therapist's *Traumatized IPV Child Witness* script emerges. This script approaches IPV child witnesses as having a certain set of category bound characteristics resulting specifically from the trauma of witnessing IPV. These characteristics include; harboring feelings of anger, sadness, and shyness, experiencing anger specifically toward their mothers, feeling guilt about the IPV itself, and the resulting anger toward their mothers, denying negative feelings or having difficulty expressing negative feelings in healthy ways, possessing low self-esteem, and having aggressive, abnormal behaviors. Again, the therapist at once employs this script and develops or produces it as she engages in therapy with the children and/or the children's parents.

Throughout this process, there is evidence that the therapist's common sense knowledge outlines a particular plot or story line within each script for the IPV child witnesses. A script is employed and produced during the course of the therapy to fit a particular story line that is, in essence, known to the therapist in advance. The work of producing the script reinforces the story line and validates the therapeutic literature, professional experience, and academic training that make up the therapist's common sense knowledge. And like the case of the Mambila spider divination, the production of the script both documents and contributes to a particular presupposed body of common knowledge.

Gendered Scripts

Weaved within the *Traumatized IPV Child Witness Script* are gendered scripts. That is, the case notes suggest that the therapist understands female IPV child witnesses to have specific category-bound attributes and characteristics that are distinct from those of male IPV child witnesses. This emerges and is evidenced by the different therapeutic assessments that are made of boys and girls and the different therapeutic treatments that are offered to them.

In a session with Emily, the therapist records the following therapeutic intervention.

Therapist Case Notes:	**Expansion Analysis:**
Getting along with sister, not with brother. He hates me. Mom makes him go in time out.	In the therapy session today, Emily indicated that she gets along well with her sister, but she does not get along well with her brother. Emily indicates that she feels that her brother hates her. She also indicated that when he is misbehaving, their mother requires him to go to a time out where he is isolated from others for a period of time as a form of discipline.
Had her draw picture of her new house and family.	A therapeutic tool that the therapist employed during the session today was to have Emily draw a picture of her family in their new house.
Gave her "Girls Only" daily book. Had Jenna come in and she will read it to Emily each day. She made a promise. Emily gave permission before I asked Jenna.	The therapist presented Emily with a therapeutic tool, a book that is written for girls and has something that is to be read each day likely with the intent to help increase self-esteem. The therapist asked Emily if she would like her to ask her sister to read the book to her every day and she agreed. The therapist asked the child's sister to come into the therapy session and proceeded to ask her if she would read the book to the child each day, she

	agreed and made a promise to read it to her sister each day.

It is significant that the therapist makes a point to identify the therapeutic workbook as being for girls. This pattern emerges in subsequent sessions as well.

Therapist Case Notes:	**Expansion Analysis:**
Feeling happy. Watched "I Like Being Me."	At the session today, the child indicated that she was experiencing feelings of happiness. The child and the therapist viewed a therapeutic positive self-esteem video titled, "I Like Being Me." The therapist apparently assesses that the child is in need of increasing her self-esteem and the video is intended to assist her with that need.
Did nine pages in her workbook (Girls).	During the session, the child completed nine pages of activities in her therapeutic workbook. The workbook that the child worked in is a workbook designed specifically for girls. There is a different workbook available for boys. The therapist appears to understand boys and girls to respond differently to the experience of witnessing IPV and have different therapeutic needs and therefore need different workbooks.
Talked about saying no to adults (she had marked that kid's shouldn't say no to adults.)	In one of the workbook exercises, the child had made mark in the book indicating that it was her understanding that children should not say, 'no' to adults. Recognizing that the child's perception about this as incorrect, the therapist spoke with her further about it to try to teach her otherwise.

We also see this specific gender identification with regard to the therapeutic workbook in the case notes from sessions with boys.

Therapist Case Notes:	Expansion Analysis:
Ethan came in and we did a feelings check. He said he is happy today.	Ethan is a child that is seen in therapy. Upon Ethan's arrival at the therapy session, the therapist administered a therapeutic technique aimed at assessing his emotional state. Ethan reported feeling happy today.
He listened to Spinoza "You Are All You Need To Be". I reinforced the message, "You are a fine person even if someone says mean things to you. Everyone is good just because they are."	Ethan listened to an audio tape titled, "You Are All You Need to Be" during the session today. The tape had a character named, Spinoza. The message that the tape communicates to the listener is, "You are a fine person even if someone says mean things to you. Everyone is good just because they are." The therapist reviewed this message with Ethan and likely attempted to state it in different ways so that it would make a deeper impression on him.
He began to complete a workbook with help from the counselor. "My Own Thoughts and Feelings (for boys)"	One of the therapeutic tools that the therapist uses with children who are IPV witnesses is a therapeutic workbook called "My Own Thoughts and Feelings" There are two versions of this workbook, one for girls and one for boys. Since Ethan is a boy, the therapist gave him the version for a boy understanding that girls and boys need different workbooks because they process feelings differently and have different reactions to experiences of IPV.

The identification of gendered therapeutic tools for girls and boys suggests that there are different scripts for girls and boys. Certain therapeutic interventions and assessments recorded in the case notes give us further clues into the specific characteristics that are featured in the girls' script and in the boys' script. For girls, we are more likely to see an encouragement to express angry feelings,

which would suggest that the therapist understands girls to repress anger related to their IPV witnessing experiences.

Therapist Case Notes:	**Expansion Analysis:**
Laura asked to play with playdoh so we did. I encouraged her to squeeze and "pound" it to get out feelings.	During the therapy session today, Laura requested to play with some play dough that the therapist keeps in her office. She agreed to let her play with the play dough. Apparently recognizing that Laura has negative feelings and a difficulty expressing those feelings due to the trauma of being an IPV witness, the therapist took the opportunity to encourage her to play rough with the play dough so that she could expend physical energy acting out the negative feelings. This physical expression of negative feelings is likely understood to help the child to become more aware of her repressed negative feelings and deal with them in a healthy way. It is also understood that failure to express negative feelings manifests in unhealthy ways for IPV child witnesses.
She seemed to enjoy doing this.	Laura took the therapist's suggestion to play rough with the play dough and the therapist could tell from observing her that it was a positive experience for her and that it was having the desired therapeutic effect of helping her to express negative feelings that she would otherwise have been unable to express.

Similarly, Hannah is encouraged to punch a punching bag to release anger during one of her therapy sessions.

Therapist Case Notes:	**Expansion Analysis:**
Hannah used remote controlled car.	During the therapy session today, Hannah played with a remote control car that is in the office.

Hugged Sasha and petted her. Was happy to be with Sasha.	Hannah showed affection by hugging and petting Sasha, the dog that is frequently present during therapy sessions with the children. Hannah's verbal and/or nonverbal communication indicated that she was pleased to be interacting with Sasha.
Been fine not too many mads, sads, or loneliness.	During the therapy session, Hannah communicated that she had not recently experienced significant amounts of anger, sadness or loneliness.
Punched punching bag with boxing glove (getting out mads).	The therapist administered a therapeutic exercise with Hannah to assist her in releasing feelings of anger. This exercise involved Hannah putting on a boxing glove and punching a punching bag. The exercise appears to have been conducted because it is the therapist's assessment that Hannah has feelings of anger that are repressed and need to be released and that physical aggression conducted in a controlled, safe environment will assist her with achieving the release of anger.
Began My Thoughts and Feelings for Girls.	The therapist provided Hannah with a therapeutic workbook designed specifically for girls and their unique reactions and needs resulting from experiencing trauma. The therapist provided Hannah with this workbook because it is likely her assessment that she has experienced trauma as a result of the IPV witnessing experience. Hannah began to complete some of the workbook during the therapy session.

It is particularly interesting that Hannah reports not having many feelings of anger just prior to being encouraged to punching the punching bag to "get mads out". This represents an attempt to maintain the script and suggests that the therapist is understanding Hannah to have feelings of anger despite her self-report that she did not. Further, it suggests that the therapist believes it is in the best

interest of Hannah to acknowledge the anger, and to release it through physical aggression toward an inanimate object.

For boys, we see parallel evidence in the case notes that the therapist understands them to have feelings of anger around the IPV witnessing experience. As discussed above, her common sense knowledge also frames boys as lacking methods for healthy or appropriate expressions of anger. However, rather than efforts to just release the anger as we see with girls, the therapeutic efforts directed toward boys appear to be generated from a script that casts boys as a potential physical danger to self and others. Consider the following session with Owen.

Therapist Case Notes:	**Expansion Analysis:**
Gave Owen affirmations poster. Say it everyday.	During the therapy session today, the therapist seems to have recognized that Owen has low self-esteem due to his IPV witnessing experience. The therapeutic course of action she took was to present him with a poster that had a positive, self-affirming message on it. The therapist instructed Owen to repeat the saying to himself everyday apparently with the intent that it would become second nature and he would begin believing it, thereby increasing his self-esteem.
Watched "Lean Mean Machine".	An additional therapeutic tool that the therapist employed was to have Owen watch a video entitled "Lean Mean Machine." This video has a message about being "mean" and is intended to positively impact Owen in some way.
Talked about ways to process anger that won't hurt self and others.	The therapist apparently understood Owen to inappropriately express anger as a result of his IPV witnessing experience. She also understands him to be in danger of physically or mentally hurting himself or other people because

	of his abnormal expressions of anger. The therapist discussed with him some ways to process anger that are healthier and more appropriate. If he complies with the suggestions, the danger posed to himself and others is understood to be diminished.
He admitted that sometimes he slams doors and yells.	During the discussion, Owen disclosed to the therapist that one of the ways that he negatively expresses anger during the course of his everyday life is by physically slamming doors and verbally yelling at other people. His disclosure confirms the therapeutic observation that the child is engaging in inappropriate behaviors brought on by his IPV witnessing experience.
We will look at ways to get out angry feelings.	In future therapy sessions, the therapist will continue to engage in therapeutic discussions and activities aimed at getting Owen to move from abnormal expressions of anger to more normal and appropriate expressions of anger. Once Owen is able to address these anger-related feelings appropriately, it is apparently understood that he and other people will be at less risk of becoming physically or mentally injured by his expressions of them.

Owen's admission that he slams doors and yells serves as documentary evidence of the therapist's common sense knowledge about his potential for self or other-directed violence. In this situated dialogue, the therapist is able to achieve particular meaning about Owen. At the same time, her common-sense knowledge about IPV child witnesses is validated, and more specifically her common-sense knowledge about *male* IPV child witnesses and their reactions to IPV is elaborated. This all contributes to the script she produces for male IPV child witnesses. For the therapist, the script may be understood as relatively

fixed, but as we see from the excerpt above, the script is only the underlying pattern, the meaning itself is produced throughout the course of each individual interaction.

The therapist receives additional validation for this script in a session with an older male IPV child witness, Kevin.

Therapist Case Notes:	**Expansion Analysis:**
Talked about feelings and how we all have them and we need to express them or they come out in bad ways like kicking a chair across the room.	At the session today, Kevin and the therapist talked about feelings. Recognizing that Kevin has had difficulty expressing his feelings appropriately as a result of his IPV witnessing experience, the therapist told him that everybody has feelings and that they all need to express feelings in a positive way or they will manifest in a negative way. The therapist referenced a recent incident where Kevin kicked a chair across the room as an example of his feelings being expressed negatively and inappropriately.
Kevin acknowledged that his response to the younger kids at group was out of proportion to the incident.	Kevin had kicked the chair across the room during a group therapy session at some point prior to this individual session. He kicked the chair in response to something that the younger children in the group had said or done. He indicated during the individual therapy session that his response of kicking the chair was not appropriate and was an overreaction to what the other children had said or done that made him upset.
I acknowledged that it is hard for boys (and everyone else) to talk about their feelings.	Apparently sensing that Kevin needed to be reassured that his abnormal reaction and inability to express feelings was normal for children, especially boys, who had witnessed IPV, the therapist indicated to him that boys in particular have difficulty expressing their feelings. Given that Kevin is a boy, the

	therapist intended for him to identify with the statement.
He agreed.	Kevin made some verbal or nonverbal communication indicating his agreement with the statement.
I told him about ways to express feelings and not hurt self or others.	Because of the incident with kicking the chair and his IPV witnessing experience, it is apparently the therapist's assessment that Kevin is in danger of hurting himself or others. In order to address this danger, she explained to Kevin some appropriate ways to express feelings that would be alternatives to him acting violently and hurting himself or other people.
I agreed to create unsent letters to Mike, Harold, Mom and others he has strong feeling toward.	One of the therapeutic interventions the therapist suggested as a way to appropriately express feelings and avoid violence, was to write letters explaining negative feelings to the target of the feelings and then not send the letters. The therapist agreed to assist Kevin with this exercise of writing letters to the people he indicated he was having negative feelings toward. Three of the people he identified having negative feelings toward were Mike, Harold, and Kevin's mother.
I showed him affirmations for self-esteem and I assisted him in creating an affirmations tape for himself.	It is apparently the therapist's assessment that Kevin is experiencing low self esteem as a result of his IPV witnessing experience. The therapeutic intervention she used to assist with increasing his self esteem was to show him affirmation statements that are intended to improve self esteem. She then assisted him with recording affirmations onto a cassette tape so that he could continue to listen to the affirmation statements outside of the therapy sessions.
I gave him a cassette player to use it.	In order to listen to the cassette tape with affirmation statements that Kevin and the therapist created during the therapy session, Kevin would need to have a cassette player. She gave Kevin

	a cassette player to ensure that he would be able to listen to the tape outside of the therapy sessions.

This excerpt from Kevin's session appears to coincide with research cited above that suggests that children who experience violence as children are more likely to perpetuate violence as they become adults. This research is undoubtedly known to the therapist and has become part of her common sense knowledge about IPV child witnesses and she likely has investment in its validity. As such, it becomes part of her script for Kevin as she engages in the therapy session with him. Meaning is produced around that script as she interacts with Kevin and he affirms her assessments regarding his difficulty expressing feelings (especially as a male) and his subsequent inappropriate violent behavior.

The gendered scripts produced and employed by the therapist can be said to cast female IPV child witnesses and male IPV child witnesses as experiencing different reactions to their witnessing experiences and as needing different therapeutic regimens in response to those reactions. Girls are understood as repressing anger and in need of physical aggression to release it. Boys, on the other hand, are cast as expressing their anger but doing so in ways that represent physical harm to themselves or others.

One final feature of the gendered scripts was not as explicitly evidenced in the data, but the allusions to it are interesting and worth noting. There are two references to children feeling physically ill in the case notes. In both instances, the children noted as feeling ill were female. In the case of Annie, her report of illness appears to be treated as psychosomatic in nature by the therapist.

Therapist Case Notes:	Expansion Analysis:
Things are okay. Grandma took us to see dad at treatment. He likes treatment.	During the therapy session today, the child in treatment, Annie, indicated that things are not going either particularly well or particularly poorly. Annie's grandmother took her to see her father in a treatment center. While there, her father indicated to her that he liked the treatment he was participating in.
When Annie talked with him, he wanted her to tell me something. He wants Annie to be in a stable home. She felt sick to stomach. We did deep breathing affirmations. She didn't want to say what he told her to say.	While Annie was visiting her father, he told her to tell her therapist something. One thing he told her to tell the therapist was that he wanted her to have a stable home. Annie was uncomfortable with something else that her father told her to tell the therapist. She was so uncomfortable that it made her feel physically ill with a sick stomach. Recognizing this as a psychosomatic symptom, the therapist helped the child by treating with therapeutic breathing that they did together.
I told her no one (adults) should be putting that on her. Tell dad to call someone himself (or mom if she does this) or he can call me and I'll explain to him why he shouldn't put her in the middle.	The therapist explained to Annie that adults should not expect her to relay their messages for them. She also explained to her that if her father or her mother wanted to say something to another adult, then they should say it themselves rather than having her do it for them. The therapist told Annie that she could tell her father to call her directly if she wanted the therapist to explain to him why it is inappropriate for him to have her deliver his messages for him.

In the other reference to a child experiencing physical illness, there is not necessarily a direct link made to a psychosomatic cause, however, there is reference to the possibility of something worrying the child.

Therapist Case Notes:	Expansion Analysis:
Mom and Tina came in.	Tina and her mother arrived for the therapy session together today. Both Tina and her mother were present during the session.
Tina was not feeling well. Looked tired and pale.	It was communicated to the therapist, or she observed that Tina was not feeling well. It was the therapist's assessment that Tina appeared to be tired and her skin was pale. This visual assessment appears to have confirmed for the therapist that Tina was not feeling well.
We talked about her weekend and the fun she had at grandma's.	Tina, her mother and the therapist discussed the events that took place over the weekend. It was communicated to the therapist that Tina spent time at her grandmother's house and that she had an enjoyable time while visiting there.
Then I asked her what her worries were?	The therapist apparently assessed that Tina was worried about something and so asked her what was worrying her.
Mom probed in different areas – mom and dad, the kitties, school, etc.	Tina's mother also began inquiring about specific areas that she thought might be worrying Tina including the relationship between her mother and father, some kittens, something at school, and other areas of Tina's life.
Tina denied having any worries.	Tina indicated that she was not worried about anything.

In this excerpt, the therapist appears to acknowledge physical illness through her observation of Tina's tiredness and paleness. The case notes then reference a question on what might be worrying Tina, which could suggest that the therapist felt there might be an underlying psychosomatic cause. However, the case notes lack sufficient detail to determine if that is indeed the script that the therapist was working from. Again, while there were only two references to females experiencing physical illness, and only one of those references could be said to

explicitly point to psychosomatic causes, it is an interesting allusion and one that could be explored as a possible feature of a female IPV child witness script in a future inquiry.

The 'Healing IPV Child Witness' Script

As described above, one feature of the *Traumatized IPV Child Witness* script is that it understands the child witnesses to have a difficulty expressing feelings, especially negative feelings. Another script that emerges from the data is that of the *Healing IPV Child Witness.* In this script, children receiving therapy are compliant with the therapeutic regimen being administered to them by the therapist. They willingly participate in therapeutic exercises and present little if any challenges to the therapist's assessments of their emotional well-being.

You will recall Ethan who was initially resistant to admitting his negative feelings and later given the workbook specifically for boys in earlier sessions. In a subsequent session, Ethan is able to sail through the exercise pages and therapeutic activities with ease.

Therapist Case Notes:	**Expansion Analysis:**
Ethan identified himself as "happy" during the feelings check.	At the therapy session today, Ethan indicated that he was feeling happy when the therapist administered a therapeutic technique to assess his emotional state.
He identified many activities he can do by himself and identified as having had every feeling listed at some time or another.	At some point during the therapy session today, Ethan completed an exercise that asked him to list the activities he is able to do by himself. Ethan was able to list several activities in response to this. He was also asked to indicate if he had experience a number of feelings by identifying them

	from a list on a worksheet. Ethan indicated that he had experienced every feeling that was listed on the worksheet.
He also easily completed the page that asks for examples of time the child has felt scared, happy, mad, sad, bad, good.	During the therapy session, Ethan completed a page in his workbook that asked him to give examples of instances where he has felt various emotions including scared, happy, mad, sad, bad, and good. Ethan completed the workbook page with no obvious reluctance or difficulty.
He chose making Disney pictures on the computer as his "fun" activity and made several posters of Mickey and Minnie at the beach, etc. He had a snack and chose several small toys for his prize.	Ethan was offered one of several fun activities to complete during the therapy session. He chose to make posters on the computer from the choices he was offered. The posters he made included pictures of the Disney characters, Mickey and Minnie. At least one of the posters depicted Mickey and Minnie at the beach.
ASSESSMENT: Ethan identifies his feelings easily	Based on Ethan's success in completing exercises in the therapeutic workbook, it is the therapist's assessment that Ethan does not have difficulty in identifying the feelings that he experiences. This is apparently viewed as positive because it is understood that most IPV child witnesses do have difficulty identifying their feelings and Ethan has demonstrated this difficulty in the past.
PLAN: to continue with feelings, self-esteem building and social skills.	Despite Ethan identifying feelings easily, it is the therapist's plan to continue to explore his ability to express and process feelings in future therapy sessions. Since IPV witnesses tend to have low self-esteem, and poor social skills, the therapist apparently plans to use therapeutic techniques to assist Ethan with developing positive self-esteem and social skills in future therapy sessions.

Ethan appears to comply with the therapist's assignment of tasks. The only challenge he really presents to her common sense understanding of IPV child witnesses is that he now does not deny negative feelings, whereas we had seen that feature become incorporated into the *Traumatized IPV Child Witness* script above. While it is not explicit in the case notes, there is a positive tone that suggests that the therapist believes this willingness to identify feelings, both negative and positive, represents progress for Ethan and is a desired outcome and indeed a goal of therapy for IPV child witnesses. It is interesting however, that while Ethan clearly accomplishes the goal of identifying negative feelings, the therapist's plan continues to contain additional therapeutic work on feelings for Ethan. This is perhaps an indication of how steadfastly the therapist holds a fundamental understanding of IPV child witnesses as emotionally traumatized. Again, the scripts are produced in such a way as to validate the "pre-determined" efficacy and necessity of the therapeutic environment according to all of its foundations. Nowhere in the case notes is it evident at which point any IPV child witness would not benefit from more work on feelings. There is no sense of what a 'healed' IPV child witness might look like. However, we do see glimpses of what a child headed down the correct path – a *healing* child might look like in excerpts such as Ethan's above.

We see further evidence of a healing child in the therapist's case notes from her sessions with Carter. During intake with Carter's mother, she had indicated that Carter was frequently getting in trouble at school for hitting and spitting on other children. After several sessions where the therapist

administered videos and workbook exercises to Carter, suggested a reward system to his mother, and discussed appropriate reactions to anger, the case notes reflect the therapist's assessment that Carter is making positive progress.

Therapist Case Notes:	**Expansion Analysis:**
Feelings check – happy.	During the therapy session today, Carter indicated that he was happy when the therapist administered the therapeutic technique aimed at assessing his emotional state.
Showed Carter how to use the "bop" bag to express anger.	The therapist demonstrated to Carter how to physically punch a bag designed for punching and explained to him that punching the bag was intended to express anger in a healthy way. It is apparently the therapist's assessment that despite reporting feeling happy, Carter is still needs to learn healthy ways to express anger due to his IPV witnessing experience and the inappropriate expressions of anger he has exhibited in the past.
He used it for several minutes	Carter proceeded to punch the bag for several minutes after the therapist demonstrated how to use it.
He listened to Spinoza "Do You Wonder?" while we completed several pages in his workbook on mistakes, happiest times, changing things.	Carter listened to a therapeutic tape with a character named, Spinoza. The title of the tape was "Do You Wonder?" At the same time the tape was playing and Carter was listening to it, the therapist assisted him with completing pages in his therapeutic workbook. The topic of the exercises in the workbook were related to the child's experience and understanding of making mistakes, his happiest times, and his experience and/or expectations of going through changing times.
He used stickers to decorate the pages when he was finished.	Upon completion of the workbook pages, Carter placed stickers on the pages in a decorative manner.
ASSESSMENT: Carter is willing to look at feelings, thoughts, etc. He is able to tell me what he should do	Apparently based, at least in part, on Carter's successful completion of exercises in the therapy session today,

when he is mad. (Walk away, tell a grownup, etc.)	it is the therapist's assessment that he is progressing in a positive manner because he is willing to openly identify his feelings and thoughts. He is also able to verbally express to the therapist how he should react when he is mad. He correctly indicated to the therapist that he should walk away or tell an adult when he is feeling mad.

Here we see an apparent validation that the therapy is having a positive benefit as Carter is making progress, presumably as a result of the interventions that have been provided to him. We see evidence of a healing child in Carter as he willingly participates in therapeutic exercises and, as with Ethan, he is able to identify his feelings to the therapist. Further, Carter is able to recite healthy responses to anger which is cited as additional evidence that he is making progress toward healing from his IPV witnessing experience. The *Healing IPV Child Witness* script attaches certain category bound characteristics to children that can be considered to be healing from their IPV witnessing experience. Those characteristics include; the ability to identify negative feelings as well as positive feelings, a willingness to engage in therapeutic exercises, the ability to recite healthy ways to express anger, and a need for additional therapeutic intervention to continue the healing process.

The 'Grateful IPV Child Witness' Script

A final script that emerges from the data is that of an IPV child witness who is grateful to be removed from the situation where the violence was occurring. This script is layered with a bit more ambiguity and tenuousness. To

this point, the various scripts described have established IPV child witnesses as experiencing a multitude of negative emotions, behaviors, and reactions to violence witnessing. Those scripts have also recognized the IPV child witnesses as having a number of the same difficulties related to the aftermath of IPV that often results in the children having to leave their homes, having to live separately from siblings and other family members, leaving pets, friends, and personal belongings behind, going to another school, and sometimes being forced to live in a crowded shelter environment with other families. But this recognition that leaving the violent situation is difficult for the children is tempered by an underlying common sense understanding that, at a basic level, the children are glad that the IPV is no longer occurring, or at a minimum, it is no longer occurring in their presence.

We see evidence of this grateful IPV child witness script throughout the therapist's case notes. The following excerpt is from Emily's initial session with the therapist.

Therapist Case Notes:	**Expansion Analysis:**
I gave her affirmations poster and asked her to say it everyday. She said the shelter is hectic, but not fighting so she likes it.	In the therapy session today, the therapist gave Emily a poster with a positive message on it. The therapist appears to understand the child as needing to internalize the positive message to mitigate her low self-esteem. The therapist asked Emily to read the message aloud every day to help her internalize it. Emily spoke about what it is like to be in the shelter. She indicated that she feels like it is hectic, but the negative feelings associated with the chaos are outweighed by her relief that there is no fighting. Her previous living situation

	exposed her to fighting which is less preferable than the chaos of living in the shelter.

We see similar evidence of this 'gratefulness' with Bradley's intake session during an assessment of sorts that is being conducted by the therapist.

Therapist Case Notes:	**Expansion Analysis:**
Glad to be at [Shelter] and out of situation. Likes: Gym, science, recess, writing workshop. Dislikes: Advanced math, social studies, homework.	During the therapy session today, Bradley relayed to the therapist that he is pleased to be living at the shelter. The reason he is pleased to be living at the shelter is because he was previously living in an environment where he either witnessed or experienced violence in the home. He did not like witnessing/experiencing the violence. Living at the shelter means that he and his mother are presumably no longer living with the person who perpetrated the violence, so the violence has ceased. Bradley is glad that the violence is no longer occurring. The therapist proceeded to assess Bradley's likes and dislikes related to school. He indicated that the things he enjoys in school are gym, science, recess, and writing workshop. The things he reported disliking about school are advanced math, social studies and homework.

In another intake session, Nathan discusses his reaction to the IPV that occurred at his home prior to coming to the shelter.

Therapist Case Notes:	**Expansion Analysis:**
About mom and dad's fighting...me and my brother hide. I hide where I can see. I feel scared for mom, mad at dad for hitting mom, sad because there is fighting and mom gets hurt.	The therapist engaged Nathan in a discussion about the IPV that had been occurring at his previous home between his mother and his father. Nathan indicated that, during the incidents of violence, he and his brother would hide.

	He further indicated that he would hide somewhere in the home where he believed he was out of sight of his mother and father, but where he could still see them, and he would still witness the violence as it occurred. Nathan relayed to the therapist that he felt fear for his mother during the violence and he felt anger toward his father for perpetrating the violence against his mother. He also relayed feelings of sadness because the violence was occurring and because his mother would be physically injured by his father during the incidents of violence.
Misses dad somewhat but doesn't miss the abuse. Is glad to be at [Shelter] with mom.	The therapist inquired (or Nathan volunteered) as to how Nathan was feeling now that he no longer lived in the violent situation since he and his mother had moved into the shelter and his father was no longer living with them and could not perpetrate violence against his mother. Nathan indicated that he missed his father, but the therapist appears to have interpreted Nathan's verbal and/or nonverbal responses to mean that those feelings of missing dad were not very strong. Nathan indicated that he did not miss being in a situation where his father was perpetrating violence against his mother and that the feelings of relief about being out of the situation outweighed the feelings of missing living with his father. Nathan further indicated to the therapist that he was pleased to be living at the shelter with his mother, presumably in the absence of his father.

As evidenced in the excerpts above, a fundamental characteristic of the grateful IPV child witness script is that it casts the child as disliking the violent situation they had been living in and preferring even less- than-ideal living situations (e.g.

hectic shelters, away from other family members who are missed) to those that include IPV. The importance of this feature of the script is underscored when a child fails to fully comply with it. Consider the following excerpt from a session with Carrie.

Carrie had been dealing with a very difficult situation where her step-sister was sexually abused by her stepfather, George. Once her step-sister came forward, Child Protective Services became involved and Carrie and her mother moved into a small apartment while the step-siblings moved in with a relative. During this particular session, Carrie was relaying to the therapist the disappointments of her new living situation which included missing her friends and step-sisters and having to share a room with her mother.

Therapist Case Notes:	**Expansion Analysis:**
We discussed her prior fears. She said she is not afraid anymore.	During the therapy session, the therapist talked to Carrie about what made her fearful in her prior living situation. Carrie indicated that she is no longer fearful, presumably because her living situation had changed and she no longer lives with George who is alleged to have perpetrated sexual abuse on Carrie's step-sister.
She is disappointed because she believes George is using her old bedroom to sleep.	Carrie indicated to the therapist that she thinks that now that she no longer lives in the previous home with George, George has begun sleeping in the bedroom that used to be hers when she lived there. The therapist interpreted Carrie's feeling about this assumption as one of disappointment.
Reframed- she has a new bedroom and he can't come in there.	Apparently sensing that Carrie was not fully convinced that her current situation (away from the abuser) was necessarily better than her previous situation where the abuser was present but she had, among other things, a bedroom that she

	liked, the therapist attempted to reframe Carrie's perception of her current living situation. In order to do this, the therapist reminded Carrie that her current bedroom was a new bedroom and that one positive feature of it was that it was a place that George did not have access to. This was understood to be a positive benefit because Carrie had expressed some fear of George coming into her bedroom when she was in her previous living situation.

Here, we see the therapist attempting to assist Carrie with following the 'Grateful IPV Child Witness' script. Carrie expresses some negative feelings (however mild) toward her new living situation and some nostalgic positive feelings toward the people and things she had in the previous living situation despite the presence of the alleged abuser whom she admittedly feared. The therapist, likely believing that there is therapeutic benefit for children when they adhere to the script, is explicit in the case notes about her deliberate work to maintain it and even notes that she "reframed" Carrie's concerns. She goes on to identify reasons why Carrie should be grateful for her new living situation despite the fact that it has meant she has had to leave certain people and things behind.

The 'Grateful IPV Child Witness' script features category-bound characteristics that include IPV child witnesses feeling relieved to be out of the situation where IPV was occurring. Further, the script acknowledges and allows for negative feelings about leaving the previous living situation related to missing friends, family, and belongings. Ultimately, however, the script requires that the child prefer, or at least see the benefit of, leaving the violent living situation.

Indeed, it strikes our "common sense" that it should be the most basic desire for a child living in a violent household to want to move to a non-violent living situation. It is almost unthinkable that a child would prefer to stay in the situation if given a choice, and even if they might prefer to stay, both the therapeutic literature and the cultural notions about IPV suggest that it would not be in the child's best interest. The grateful IPV child witness script is really at the heart of the current IPV child witness therapeutic culture, and certainly employed by the therapist in this study. First and foremost, the IPV living situation is understood as less preferable than almost any other non-violent living situation. The remaining scripts that aim to assess, treat, and heal the IPV child witness are predicated on the understanding that the child should be glad to leave, or at least eventually be grateful that they had been forced to leave.

CHAPTER FIVE

CONCLUSIONS

This dissertation has explored the process of providing therapy to IPV child witnesses in a rural safe haven through the Community Coordinated Response Projects to Prevent Intimate Partner Violence. The analysis used an ethnomethodological approach to understand the sense-making procedures used by the child therapist as she engaged in the therapeutic process with 58 IPV child witnesses. What follows is a summary of the theoretical tenants of the study, the methodology used in the analysis, key findings, and implications for future thinking about the theory and practice of IPV child witness therapy.

Study Overview

This study drew on ethnomethodological theory as informed by social construction and symbolic interaction to understand how meaning was produced by the child therapist in one particular therapeutic setting. Ethnomethodology served as both the theoretical underpinning of the study as well as the method of analysis. At its core, ethnomethodology understands meaning as at once *employed* and *produced* in social interaction. As such, the study approached the case note data set not as a record of the pre-packaged meanings utilized by the therapist during her therapeutic interventions with the children, but as evidence of the various underlying assumptions that the therapist experienced as common sense knowledge as she both employed and produced meaning anew through the course of her interactions with the children in her care.

The data for the study consisted of case notes on therapy sessions with 58 IPV child witnesses. The case notes were recorded by one child therapist during the Community Coordinated Response Projects to Prevent Intimate Partner Violence. A secondary analysis of the case notes employed an ethnomethodological methodology whereby the case notes were expanded to reflect the unrecorded, taken for granted information that comprised underlying patterns. The underlying patterns that emerged from the data were arranged into a series of scripts for purposes of analysis. Each script represented the culmination of interpretive procedures (common sense knowledge) used by the therapist as she assesses and treats each child. In addition, the analysis pays particular attention to how the therapist actively produces these scripts despite the likelihood that she experiences them as predetermined, or predictable based on her personal and professional training, experience, and common sense knowledge.

Discussion of Findings

The data analysis revealed that the therapist employed a number of procedures as she approached the IPV witnesses in her therapeutic care. The procedures were organized into sets of category bound attributes, characteristics, and activities loosely grouped together as scripts. The scripts included the *Traumatized IPV Child Witness* script, *Gendered Scripts* for male and female IPV child witnesses, the *Healing IPV Child Witness* script, and the *Grateful IPV Child Witness* script.

The *Traumatized IPV Child Witness* script understands the IPV child witnesses as angry, sad, and guilt-ridden. Further it understands those feelings to have manifest in such a way to cause the children to have low self-esteem, exhibit aggression, deny negative emotions, and have difficulty expressing feelings in appropriate, healthy ways. Threaded through this script is also the understanding that the children are experiencing these abnormalities and difficulties primarily as a result of having witnessed IPV.

Gendered Scripts assigns particular characteristics to IPV child witnesses that are category bound based on the child's gender. For female IPV child witnesses, issues of concern are a reluctance to express anger and a need to act out physical aggression in order to access and resolve repressed negative emotions. Another potential, though less well-evidenced, characteristic of female IPV child witnesses is the tendency to exhibit symptoms of physical illness that are psychosomatic in nature. Male IPV child witnesses, on the other hand, are understood in the script to express anger, but do so in ways that are inappropriately aggressive. As such, male IPV child witnesses are thought to present physical danger to themselves and others without appropriate therapeutic intervention.

The *Healing IPV Child Witness* script is reserved for children who are actively engaged in the therapeutic regimen. They are cast as making positive progress, able to identify feelings and name appropriate ways to express them, and can be understood to be recovering or healing from their traumatic IPV witnessing experience. An interesting feature of this script, however, is that it

appears to fall short of identifying a point at which an IPV child witness would be completely healed. Indeed, this script suggests that IPV child witnesses can always benefit from additional therapeutic intervention despite any amount of positive progress toward healing that might have been made by an individual child.

Finally, the *Grateful IPV Child Witness* script centers around an understanding that IPV child witnesses are grateful to be removed from the environment where the IPV was occurring. The script recognizes that this gratitude may not be immediate given the host of difficulties and challenges that can surround the uprooting of the child from his or her previous living situation. However, it does suggest that the child, if not initially relieved, will eventually come to realize that the benefits of being separated from the individual perpetrating the IPV far outweigh the disruptions that that separation may have caused. Indeed, part of the therapeutic regimen appears to be aimed specifically at helping reluctant IPV child witnesses to come to that very realization.

Together, the four scripts identified through the ethnomethodologic expansion analysis of the data provide evidence of the common sense knowledge employed by the therapist as she engaged in therapy with the child IPV witnesses in this study. While these scripts do not likely exhaust the breadth or full scope of that common sense knowledge, they do assemble a well-documented comprehensive assessment of the therapeutic environment in which the children were treated.

Theoretical and Practical Implications

This study offers an opportunity to look at the traditional therapeutic environment for child IPV witnesses and pose some important questions about the central tenants of that environment. The data analysis revealed a therapeutic regimen that approaches child IPV witnesses with a certain repertoire of common sense knowledge. Without attempting to make an empirical conclusion regarding the validity of that repertoire, the analysis contributes to thinking in this area first and foremost by acknowledging that there are sense-making procedures being employed in the therapeutic environment. This acknowledgement challenges the notion that IPV child witnesses in fact present with a certain host of empirically known abnormal characteristics as a result of being traumatized by the IPV witnessing experience. Instead, we can understand the therapeutic environment to approach these children 'as if' they possess these characteristics even in instances where their interactions with the therapist might not necessarily support such a conclusion. Instead, contradictory actions are incorporated into the common-sense understanding of these children in a way that creates meaning anew in order to fit the 'as if' approach. By making this observation, the analysis contributes to the body of IPV child witness literature from a theoretical standpoint.

From a practical standpoint, the analysis begins the conversation about the consequences of providing traditional therapy to IPV child witnesses. While this study was not designed to tell us everything about child IPV witness therapy, it does tell us something about it. Through this study, the manner in which

therapy is accomplished has been shown to be a *productive exercise*, rather than a purely interpretive exercise on the part of the therapist. This is a jumping off point for further inquiries into how this type of therapeutic environment impacts outcomes for the children receiving the interventions. From there, inquiries into the efficacy of alternative approaches are certainly warranted.

Finally, while not a primary goal of the project, this study makes a methodological contribution in that it was conducted as a true ethnomethodological analysis. As such, it provides an example of using ethnomethodology to investigate how, as Dorothy Smith (1987) suggests, institutions serve to generalize local experience. In this case, the institution of child therapy generalizes the local experience of certain children who have witnessed IPV into particular scripts. We must look at what is lost in that process of generalization when we actively/productively 'fit' a child's individual experience into a script. As a methodological contribution then, this study provides a framework for future institutional inquiries to be conducted in a similar fashion.

APPENDICES

APPENDIX A

"EMILY'S" CASE NOTES

March 2, 2000
Mother, Linda, rescheduled intake 3 times. After leaving "Shelter", she did not continue therapy services.

October 11, 2000
I gave her an affirmations poster and asked her to say it everyday. She said the shelter is hectic, but not fighting so she likes it. Emily drew pictures with very prolific captions and messages. We talked about them. She had written to her mother "You are very kind to us. You work hard for us and we still don't forgive you." She told me she isn't mad at mom but some others are. I explained that sometimes it takes people time to get over being mad. She likes school and the shelter and is looking forward to a safe new home. She likes to ride bikes but doesn't have one of her own. I will ask Jane to keep an eye out for one for her. I thanked her for coming to see me and told her I will see her next week.
I told Linda I will see all three of them each Wednesday.

October 18, 2000
Got new house. She is excited. Drew – praised drawing. Listened to Spinoza "You are All You Need To Be". We talked about the message and that Stymie the Skunk is mean (on the tape). I told her when people say or do mean things to others it is because they have problems not because there is something wrong with the person they are being mean to. She said a boy knocked her down. She told the teacher. The teacher made him apologize. She felt better. I asked what she does when she feels mad or sad – go play in my room. Sometimes kids are made at mom. Is she? Yes, It's okay to be mad. How does she feel? Guilty. She has a right to feel mad. Mom is trying to make things better. When she comes here we will help her not feel mad anymore. What are some things she could do? Reviewed "25 Healthy Ways to Express Anger". She enjoyed my "angry dance". I told her I will give this to mom so she can help Emily and her sibs get out their anger in healthy ways (which I did).

November 1, 2000
Good. Like new school, making friends. New house is good. Getting along with sister, not with brother. He hates me. Mom makes him go in time out. Had her draw a picture of her new house and family. Gave her "Girls Only" daily book. Had Veronica come in and she will read it to Emily each day. She made a promise. Emily gave permission before I asked Veronica. Misses dad. That's

understandable. Doesn't miss Tom. That's understandable too. He was mean. School is good. Went there before. Misses dad, doesn't miss Tom. Liked video. Will play Amazon Trail next time. Likes jungle. May come to group after Christmas.

November 15, 2000
Everything is good. Mom wanted her to tell me something but she can't remember. Asked to watch movie. Visit with dad was good. We watched "Letter on Light Blue Stationary" (self-esteem). "You Are Very Special and You Are One of a Kind". We sang along with the video (she began on her own). I drew her a picture that said "Emily is special" and gave it to her to put up in her room. I told her she was special and she agreed. Veronica said she will help Emily read her daily book this week also. I asked if Emily could remember what she wanted to tell me but she couldn't.

November 29, 2000
Feeling happy. Watched "I Like Being Me".
Did nine pages in her workbook (Girls). Talked about saying no to adults (she had marked that kids shouldn't say no to adults). I explained good, uncomfortable and bad touch. That it is okay to say no to things that hurt or make her feel uncomfortable. We did a lot of work on self-esteem and being proud of oneself. She chose a doll.
The other two children were gone to friend's tonight.
Gave her paper for drawing.

December 6, 2000
Feeling good. Wanted to watch a movie "From Mad to Worse". Drew pictures. Discussed feelings – she gets mad at Mike, sad about dad. Happy she has a different bed. I drew a picture of her that said Emily is a good person. She took it home to hang on her wall. Discussed ways to handle sibs being mean. Helped her pick out something to take home. She also picked out something for Amanda.

December 13, 2000
Emily – everything is good. She asked to watch a video and chose "From Mad to Worse". Did questions and answers. Emily drew during the movie. We talked about ways to handle anger and using "I" messages. She is happy to be going to grandma's for Christmas.

January 10, 2001

Asked to watch movie that Mike watched. She agreed to complete a worksheet "Some Ways You Can Help Yourself Feel Happy". Afterward I have her supplies to draw while she watched the movie. I made affirmations poster for her while she worked. I instructed her to put them up on the wall and say them every day.

END "EMILY'S" CASE NOTES

APPENDIX B

"SAM'S" CASE NOTES

February 11, 2000

Jan outlined abusive relationship with Rob and answered interview questions. I let her tell her story which took about an hour. She apologized for taking so much. I explained that I wanted to hear what she had to say. She agreed to come back to finish the assessment. She would like to provide transportation to appointments for Sam to let him know she supports the counseling. As far as Tuesday group, she and her ex-husband are taking Sam to the "Recreation Center" on Tuesday nights to work out. They and his brother are encouraging him to get in shape so kids will see that he is strong and leave him alone at school. He is enjoying the attention from them. Sam, has underlying behavioral problems that have been ongoing throughout his life. He appears to be depressed and Jan would be open to meds for him as she herself has recently begun taking antidepressants and anti-anxiety meds and sees that they are working. Sam's reaction with the bat is a normal reaction to the trauma he witnessed. (Jan understands that.) Parents appear committed to their children – questions remain, however.
PLAN: To see Jan next week to complete intake. Then set up a first appointment for Sam at that time.

February 16, 2000

Met with Jan regarding her son, Sam. Completed parent interview and biographical information form. Asked her for feedback, questions, concerns, etc. Sam responds to positive reinforcement best. Jan hopes he will learn better social skills in therapy.

ASSESSMENT: Sam would be a good candidate of our therapy program. They have not discussed the abuse in detail.
PLAN: Jan will call on 2/17/00 after she gets her work schedule, to make Sam's first appointment.

February 21, 2000

Client had not called on 2/17/00. Called Jan and left message on her phone to call for an appointment.

February 23, 2000

Sam was reluctant at first. Jan stayed for session. He didn't answer when I asked him to tell mom why he wanted to come. I had mom tell him what she wanted to see for him. (Happy, not reacting to taunts, feeling safe - kids taunting at school,. Told us he usually ignores it but it increases until he reacts. Got

more frequent after he told the football coach this fall when one of this teammates kept kicking sand in his face. The player and his friends have been "ripping on him" continuously since then. He asked what precedes the attacks) he said nothing, that they pick on other kids too. He used avoidance tactics such as staying in the classroom to ask the teacher a question until the next class begins or running out the door first to get away. I asked him to tell me about Rob and the attack. He recounted the incident and mother brought up the bat. I told him it is understandable that he is not feeling safe. Mom tried to make him say he is now feeling safe. But he wouldn't (he mentioned that Rob still calls there. I asked mom if she could have Rob not contact her anymore so that Sam could feel safe. Both Jan and Sam said Rob keeps getting the phone number. I acknowledged Sam has been through an awful lot and to give himself credit for what he has accomplished. I gave him an affirmations poster that I made for him and a joke book. He said he would like to come back next week. Jan will have to call me to set the appointment. I asked about ways he has tried to make friends. No real answer. I asked if he could make friends with kids from the middle school in "Riverton" through clubs, etc. or the Recreation Center in "Prestonville" (they attend the Recreation Center in "Two Oaks" right now). Both Jan and Sam said that any efforts to make things better for him at school will only make things worse. Discussed high school and several "guys" he knows and likes there so that next year he will be in the same school with them. Sam thanked me for the poster and book. We made small talk about baseball which really drew Sam out.
Jan said she would call with a day/time that would be good next week.

<u>February 25, 2000</u>
Jan's voice sounded husky. She sounded "flat". She apologized for not calling and made an appointment for Sam for 4:00 p.m. on Wednesday. I said it sounded like she had a cold. She started to cry and said it's probably from yelling at Rob. He has been calling her the last few weeks and verbally manipulating her and now she feels that the PPO is not in effect. (She had answered her cell phone and in a moment of weakness – talked to him). I asked if she was safe. She said yes. I reminded her that the PPO is against him, not her. Even if she let him violate it in the past, it is still in effect. She has a 1:00 p.m. appointment with Darcy to see what she can do to stop him from calling. I asked if I could do anything to help her – she said if I could call Darcy to tell her that Jan is running a little late.

<u>March 1, 2000</u>
Called Jan. She confirmed that she is bringing in Sam today at 4:00 p.m.
Sam and his mother, Jan came in and both seemed exhausted and down. (Both slouched down on couch, kept jackets on, said things were bad). (Jan had been here earlier in the afternoon with counselor from Shelter regarding PPO problems – Sam may not know about this). Sam had an especially upsetting teasing

incident the day before. A group of his football teammates insulted him and pelted him with snowballs while they were waiting for someone to come and unlock the training building. No one could unlock it and Sam finally walked to the Gas Station to phone mom to come and get him. Questioned what may have happened in the incident. Sam said nothing. Jan said she went to the principal last year when the teasing escalated to poking and pinching. The next day the kids called Sam a squealer and the abuse intensified. Sam claims that teachers usually don't step in even when they see it occurring. He does not want intervention with the school as he fears it will get worse. Looked at ways he can cope (ignore it, reframe to keep from reacting, use affirmations to self while they are teasing him, seek out friend at Recreation Center in "Prestonville"). Jan will look into activities at the Recreation Center in "Prestonville". Sam could meet new boys his age to at least have friends for weekend activities. Asked Sam to fill out a worksheet "Feeling Good About Myself" and bring it to next appointment. Will try to meet with Sam alone for part of appointment.

March 10, 2000

No one there to assist me (that has worked with her). Had them check crisis sheets. Called on 3rd CPS report made by _____ on _[date]_____. Rob was drinking _[date]_____ at ___[time]__ a.m. talked to counselor about abuse, depression and surprised she is in this situation as a professional. Upset about police coming to her house as the incident had been put in PPO already.

March 8, 2000 (note: dates out of order in original case notes)

Rob had hearing, basically got a slap on the wrist. Last called on 3/8/00.

March 10, 2000

Sam came in by himself and Jan (his mother) joined us the last 20 minutes. Sam brought the feelings worksheet. He mentioned that he hadn't filled in some blanks. Things have been about the same at school. They checked the board for activities at the Recreation Center. There are none that would work for him. Began completing intake form. Sam began to discuss his fears for his mother because he heard Rob's voice in the night several times this week. He suggested he would come to his mother's aid if Rob assaulted her. Explained that the best way to help her would be to call 911 and get himself to safety. Explored other options – call dad and stay with him, asked Sam if I could have mom come in and share the safety plan and his fears with her. At first Jan was very angry and threatened to stop all services at the Shelter if I was going to threaten with a CPS report. I told her in a calm voice that I was not threatening her with anything, that I was helping Sam with a safety plan and to voice his fears, which I feel are justified. I had Sam tell her how he feels. Jan agreed not to contact Rob or let him come over this weekend. She said she is trying very hard not to have contact with him but is afraid if she stops speaking to him he will

take revenge on her in some way. Discussed Shelter support services, encouraged the use of affirmations for both her and Sam and gave them each an affirmations poster.
OTHER: Made an appointment to see Sam next week.

March 16, 2000
OTHER: Referral to "Children's Activity Group".

March 16, 2000
Family did not come to 4:00 p.m. appointment. Jan had been here earlier and met with Helen. Helen said that Jan indicated they were coming to see me.
PLAN: Will call Jan on Friday to see if they want to reschedule.

March 17, 2000
Jan wants Sam to come here. Apologized for missing appointment. Things are bad for Sam – has tried to spend more one-on-one time with him. Wonders if she is rewarding his behavior – His acting out may be his way of letting her know something is wrong. Gave referral to Children's Activity Group. Jan took the number and said she will call as soon as she gets off the phone. She said she realizes he needs to have at lest one friend. She and her daughter will be taking Sam somewhere tonight as his older brother is having his friends over and they have already said they don't want Sam to hang around and "bug" them.

March 24, 2000
Asked if Sam needed safety plan or felt unsafe – has not (he appeared more relaxed and less unhappy). Jan mentioned Children's Activity Group to him. He is non-committal. Asked about his weekend (Jan mentioned several things that he did when he said he had done nothing.) I offered ideas – a party for his softball team, a babysitting class through a Social Service Agency, a party for his confirmation class at church. I asked him to go up to kids three times this week who have reached out to him in the past and make small talk. I gave him a chapter from "Building Self Esteem in Teens" to read and begin using the affirmations. Gave him baseball cards, a case of jelly bean gum (suggested he bring some to school for kids that haven't been mean).
PLAN: Mom agreed to take him and any friend bowling. She also would be willing to let him have a pizza party at their home or drive him to classes.
OTHER: Offered Jan safety plan – has forms. Knows what she needs to do.

March 31, 2000

Sam was upbeat, Jan seemed down (bags under eyes, not smiling). Jan moved a box of toys off the couch to sit next to Sam (rather than one of them sit in the chair). We made small talk for a while. I inquired about Children's Activity Group, bowling outing. They had not take action on either but Jan said Sam wants to take the babysitting class through the Social Service Agency and she will call on that. I asked Sam if he made an effort to speak to anyone. He said he didn't. He also hadn't read through the affirmation until today. Both Jan and Sam mentioned baseball coming up and how busy he will be and Jan and I offered encouragement the high school will be better as he knows some older boys there that don't tease him. I mentioned that the last few weeks Sam has been more upbeat, that things were rough a few weeks ago. What is different? Sam explained happily "My mom is not seeing Rob anymore. She hasn't seen him in a few weeks." Jan said "Yes everyone is really happy about it. Of course I'm grieving and depressed but I'll get over it". I reminded her that the Shelter is there for support and assistance with PPO violations. She said that won't be a problem. Toward the end of the session I asked if she wanted to set up another appointment for Sam. She and Sam exchanged a few words regarding baseball season and being busy. Jan said she would call me regarding a future appointment. I made a point of telling Sam I am glad he is feeling better and that I have enjoyed meeting with him (in case he doesn't come back.)

April 25, 2000

I contacted Shelter regarding whether they are still serving Jan. They are not. They have heard she went back with her abusive boyfriend. I got permission from Karen to write a letter to Sam telling him that he could call the crisis line anytime he needs to talk to someone about his feelings. I also invited him back to therapy at any time. I included a copy of his safety plan.

END "SAM'S" CASE NOTES

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