

# Family Resilience and Domestic Violence: Panacea or Pragmatic Therapeutic Perspective?

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## Abstract

Theory, research, and practice have become increasingly informed by the principles of family resilience, harm reduction, and solution-focused intervention applications. These have a common emphasis on collaboration between counselors and clients, client and family competence, individual and systemic change, and coping well (versus cures and idealistic outcomes). The authors offer them together as a pragmatic intervention alternative for some, and for others, like themselves, an intervention of choice in cases of domestic violence.

It has been suggested that domestic violence is the most common yet least reported crime in this nation (DePanfilis & Brooks, 1989). Over two million United States women are abused each year by their husbands or partners and as many as four thousand women are killed during these batterings (U.S. Department of Justice, 1994). It has been estimated that one out of two women will experience violent interaction at some time in her life with a man who also "loves" her (Walker, 1994). The National Family Violence Survey of married and cohabiting American couples (Straus, 1990) reported that 16% of couples had experienced at least one act of violence during the previous year and that 6% of couples experienced "severe" violence (Barnett, Miller-Perrin, & Perrin, 1997). Compounding the seriousness of all these figures is that an overwhelming number of domestic assaults never becomes part of official records. Kaufman and Straus (1990) assessed this figure to be less than 7%. Furthermore, as a measure of domestic violence, self-report data tend to underestimate the amount and seriousness (Barnett et al.).

While there is continuing controversy with regard to male-to-female and female-to-male domestic violence (Bograd, 1990; Kurz, 1993; Schwartz & DeKeseredy, 1993), national victimization surveys reveal that over 90% of violent crimes committed by spouses are attacks on women by their husbands or exhusbands (Barnett et al., 1997). Given this, most traditional intervention programs addressing domestic violence conceptualize the problem in terms of a female victim and a male victimizer. In most intervention settings, particularly shelters for battered women, the separation of victim and victimizer is very strongly advocated as standard procedure.

## **Differential Diagnosis**

There are many reasons victims stay in traumatic family situations. These include frequency and severity of the abuse (the less infrequent and less severe, the more likely one will stay), childhood experiences (they may see abuse as natural if they were raised in an abusive family), economic dependence, fear, isolation, low self-esteem, or their beliefs about marriage. Yet consider the following case circumstances:

Marie and David have been married 6 years. They have three children ranging in age from 2 to 5 years. David has emotionally and physically abused Marie since early in their marriage. Three of these beatings have resulted in serious bruising requiring hospital emergency room visits. Marie has never been able to follow through with filing a formal complaint, as police have urged her to do. Following this most recent emergency room visit, Marie agreed to see the Mental Health Counselor at the hospital only to quell the urging of the emergency room physician who treated her. She was adamant about seeing herself as "stuck" in her present situation and gave many very real (for her) reasons. For example, when she did contact the local abuse shelter following a beating by her husband, she was told of the overcrowded conditions and how she and her three children would have to share one room with two other women who had two children each. She cried as she shared, "I just can't do that to my children."

As noted earlier, the most common intervention approach advocated in cases of domestic violence involves separation of victim and victimizer. Therapeutic intervention that follows is likewise gender specific. Men typically attend individual and group treatment to learn alternatives to behaving abusively. Concurrent group and individual treatment for women is also undertaken but often with greater emphasis on support than therapeutic change (Johansson & Tutty, 1998). Many (most) experts assert that conjoint treatment efforts occur only after gender-specific treatment has been completed and with assurances that the violence has ended (Philpot, 1991; Pressman, 1989).

Few professionals would disagree with the need for accurate diagnosis as the basis for any meaningful intervention plan. Diagnosis in psychological practice allows the practitioner to plan interventions tailored to the specific needs of clients. Differential diagnosis is the diagnostic process of distinguishing one form of psychological diagnostic category from another (Corey, Corey, & Callanan, 1993), thus allowing different forms of intervention to be aimed at differing elements of victims' experience. For women like Marie to be given an accurate diagnosis (i.e., differential diagnosis), the context she must function within needs to be fully considered as well as her position relative to the circumstances of that context. In cases such as Marie's where, for whatever reasons, she remains living with David, it is important to recognize that the risk for continuing violence and trauma still exists. Thus, it is

critical to structure intervention in such a manner as to find ways of reducing the potential harm associated with the violence and trauma if the choice is made to remain. Solution-focused intervention emanating from a foundation formed by the partnership of harm reduction and family resilience principles provides a pragmatic way of working with families such as Marie and David's.

### **Harm Reduction**

Harm reduction is originally a European term that is also referred to as "risk reduction" in American literature (Marlatt, Larimer, Baer, & Quigley, 1993; Marlatt, Somers, & Tapert, 1993). Harm-reduction interventions were originally developed in Great Britain during the late 1980s. Several factors led to this development, primary among them being the increase in the numbers of intravenous drug users in the region. The threat of HIV infection was becoming an increasing reality. Current approaches being employed to address this threat appeared to be adding to the problem rather than controlling it. It was becoming increasingly obvious that programs and policies such as the *War on Drugs* implemented in the United States were ineffective. What was needed was a more pragmatic approach, which viewed the consequences of contracting HIV more seriously than the consequences associated with IV drug use. From this philosophical position, the *Merseyside Model of Harm Reduction* was developed, working at the individual, community, and law enforcement levels to minimize or reduce the harm associated with IV drug use in an effort to reduce the rate of HIV infection (O'Hare, 1992).

The Merseyside Model was developed with the realization that IV drug use is a relapsing condition, and in order to prevent more serious consequences (such as HIV infection), interventions can be implemented to reduce the risk of harm from such behaviors. The model is organized on three levels; low, medium, and high-threshold. The low-threshold level involves intervention aimed at providing education and outreach in an attempt to make contact with the target population, as well as create minimal change in behaviors and attitudes (Brette, 1991; Marlatt & Tapert, 1993). The middle-threshold level offers interventions aimed at "treatment-in-place" such as outpatient clinics, while the high-threshold level involves a larger environmental intervention such as "residential treatment" (Brette). The aim of the model is to diagnose differentially affected individuals as to their willingness to enter treatment and then to offer intervention at a place wherein it will produce positive changes in behaviors.

In this regard, Strang (1992) offered the following assertion:

It is likely that more individual and public good will be accrued by a modest reduction in intake of the majority rather than by a major reduction of intake by

*the minority . . . in essence, a policy of harm reduction requires an approach of pragmatism rather than purism—an acceptance that it may sometimes be better to go for a probable silver than a possible gold. (p. 146)*

According to Marlatt, Somers, and Tapert (1993), harm reduction is “the application of methods designed to reduce the harm (and risk of harm) associated with ongoing or active [risk] behaviors” (p. 147). The goal is for individuals who are engaging in risk behaviors to begin to take steps toward reducing the risks of such behaviors, with abstinence (i.e., “total and voluntary forbearance”) being the ideal, ultimate goal (Marlatt & Tapert, 1993). Abstinence is not the *only* goal, as any movement or steps toward reducing harm is seen as progress (Marlatt, Somers, & Tapert).

Harm reduction has been generalized from the field of addictions to include other risk conditions (Marlatt, 1994). Interventions focus on reducing the frequency or intensity of risk behaviors, thereby reducing the risk of harm (Marlatt, Somers, & Tapert, 1993). For example, Kishline (1994) developed an alternative approach to traditional abstinence-based twelve-step programs called Moderation Management (MM). This approach is very consistent with the philosophies of harm reduction, stressing a nonabsolutistic approach to intervention. MM stresses differential diagnosis with “treatment matching,” matching a specific treatment to the assessed level of individuals’ readiness to enter treatment. Rather than assert a goal of abstinence and total renunciation of the risk behavior to all, levels of intervention from moderation to abstinence are provided depending upon individuals’ unique needs and requirements. Persons are provided information, support, assessment, skills training, decision-making strategies, individual, group, and family therapy, as well as residential treatment as appropriate.

Des Jarlais (1995) summarized harm reduction as composed of five underlying concepts:

1. Risk behaviors are inevitable in any society. Interventions cannot be based on a utopian belief that such behaviors will be eliminated.
2. Risk behaviors will inevitably produce important social and individual harm. Interventions cannot be based on a utopian belief that all individuals engaging in such behaviors will do so safely.
3. Individuals who engage in risk behaviors are an integral part of the larger community. Protecting the community as a whole therefore requires protecting these individuals, and this protection requires integrating them within the community rather than attempting to isolate them from it.
4. Risk behaviors lead to individual and social harms through many different mechanisms, so a wide range of interventions is needed

to address these harms. These interventions include providing health care, reducing the numbers of individuals who are likely to engage in such behaviors; and, particularly, enabling such individuals to switch to safer forms of these behaviors.

5. Interventions must be pragmatic. They must be assessed on their actual consequences, not on whether they symbolically send the right, the wrong, or mixed messages. (pp. 10–11)

Harm reduction is “a pragmatic approach to the social and individual problems associated with [risks] . . . if [risks] cannot be eliminated in the near term (or even in the long term), then at least some of the problems . . . can then be reduced” (Des Jarlais, Friedman, Choopanya, Vanichseni, & Ward, 1992). Harm reduction is broad based in that it includes and integrates various techniques and approaches aimed at reducing harm (Marlatt, Somers, & Tapert, 1993). Harm reduction is also normalizing in that it recognizes the difficulty of completely eliminating or abstaining from the problem behavior in the immediate present, yet encourages incremental steps toward the ideal of abstinence (Marlatt, Somers, & Tapert).

### **Family Resilience**

Until recently, the vast majority of interest in resilience has focused on the strengths found in “individuals” who have mastered adversity. Resilience has typically been viewed in terms of personality traits and coping strategies that enable a child or adult to overcome harrowing life experiences, particularly those found within their “dysfunctional families.” One popular representation of this perspective is, for example, *The Resilient Self: How Survivors of Troubled Families Rise Above Adversity* (Wolin & Wolin, 1993). Chapter one “The Challenge of the Troubled Family” heralds the book’s beginning with the final chapter being “A Survivor: One Who Prevails.”

The concept of family resilience expands the view surrounding individual resilience to a contextual one that incorporates the latter within a wider family system perspective. This contextual view considers how families confront and manage disruptive experiences, buffer stress, effectively reorganize, and then move forward with life. It recognizes that the family interactions inherent in these processes influence immediate and long-term adaptation for both family members as individuals, and for the family as a unit. Family resilience shifts perspective from seeing families as only “damaged” to viewing them as perhaps damaged, but also challenged and able to address adaptively most challenges. Family resilience further shifts the tendency to perceive family health or normality as residing in mythologized, problem-free families to seeking understanding how families can and do survive and regenerate even

in the midst of overwhelming stress and crises. Finally family resilience affirms families' capacities for self-repair through identifying and amplifying family transactional processes that make it possible for families to emerge following adversity functioning more adaptively, not in spite of, but rather strengthened through their experience (Walsh, 1996).

Recent research findings supporting resilience as a framework for prevention and intervention programs and policies have asserted that resilience offers an "appealing" perspective that "emphasizes the promotion of positive outcomes while not ignoring risk-focused strategies" (Masten, 2001, p. F2). Likewise, it offers a balanced perspective relative to the many dichotomies within the mental health fields (i.e., deficit/pathology vs. collaboration/competence; victim vs. victimizer; individual vs. family). Of particular relevance to domestic violence and more particularly the case circumstances of Marie's decision to remain in physical residence with David offered above, this contemporary resilience framework encompasses several major assertions:

1. Theories that underlie interventions and explain the development of "problems" equally consider behaviors that lead individuals to "cope well" as well as those that contribute to serious problems.
2. Intervention goals are defined both in promotional terms (e.g., promoting competence) and remedial terms (e.g., reducing or preventing pathology and problems).
3. Assessments to guide and evaluate interventions include considerations of competence, strengths, and assets as well as symptoms, deficits, and risks.
4. Intervention strategies include building strengths, increasing resources, and mobilizing positive processes as well as reducing deficits and treating symptoms.
5. Intervention programs incorporate both development and risk reduction.

### **Solution-Focused Intervention**

The partnership of harm reduction and family resilience principles provides a firm philosophical foundation for working with families wherein domestic violence is present. Solution-focused intervention (Berg, 1994; De Shazer, 1985, 1988, 1991; Huber & Backlund, 1991; O'Hanlon & Weiner-Davis, 1989) is perhaps one of the most vividly described clinical applications emphasizing collaboration and client competence without downplaying or dismissing resistance, failed attempted solutions, and deficits. Solution-focused interventions mirror and complement both harm reduction and family resilience principles:

[Solution-focused interventions] are more efficient, pragmatic, empowering, and effective. They assume that clients desire change, that change is a constant, evolving process, and that resistance is more about misguided therapist behaviors than client stubbornness. Further, symptomatic behavior is not viewed as mysterious or insidious, but as predominantly a response to natural challenges of dealing with daily life and developmental stressors. (Christensen, Todahl, & Barrett, 1999, p. 14).

Solution-focused interventions complement harm reduction and family resilience in assuming that families and their individual members have attempted to address adversity they encounter in the best manner they know of. They have too frequently been unsuccessful in these efforts and, for varied reasons, do not recognize alternatives readily available to them. They thus become “stuck” in a repetitive recreation of unsuccessful solution interactions. As Fisch, Weakland, and Segal (1982) wrote in this regard:

Our experience has indicated over and over—ironic as it may seem—that something in people’s “solutions,” the very ways they are trying to alter a problem, contributes most to the problem’s maintenance or exacerbation. . . . From very early in life, we all learn culturally standard solutions for culturally defined problems. These standard solutions often work, but sometimes they do not. Since they have been learned largely at an unconscious or an implicit level, to question or alter such solutions is very difficult. When people are in stressful situations, as they are when struggling with problems, their behavior usually becomes *more* constricted and rigid. Contrary to the widespread view that people are illogical, we propose that people are *too* logical; that is, they act logically in terms of basic, unquestioned premises, and when undesired results occur, they employ further logical operations to explain away the discrepancy, rather than revising the premises. (pp. 13, 287)

At any given moment, mental health professionals have the opportunity to highlight their clients’ failure or their clients’ assets. It is a choice between emphasizing and promoting resilience or further perpetuation of discouraging processes. It is clearly a mistake to assume that clients, even those with chronic histories of abusive interactions like David and Marie, are void of the skills necessary to avert destructive behaviors. To do so is to employ narrow definitions and descriptors of their actions and dismiss their capabilities and competence.

The cornerstone of solution-focused intervention is its vigilant solicitation of exceptions to problematic interactions. It is assumed that a search for exceptions to abusive, violent, or otherwise destructive behaviors will uncover problem-averting behaviors that clients have employed in the past, even if on only one occasion. This assumption is very consistent with the philosophies of harm reduction and family resilience, but it adds unique, specific strategies for putting these philosophical principles into action. Symptomatic behaviors are not dismissed but rather seen as manifestations of

frustrated and failed attempts to deal with daily life. Of critical importance, however, is that they are viewed as only one part of a larger picture. Family members' efforts have not *always* failed; at least on occasion, their efforts have proven successful (or less unsuccessful). The subsequent premise becomes then relatively simple. Because an exception to the problematic interactions occurred at least once, it can occur again when similar conditions recur. Focusing on exceptions exemplifying more successful solutions directs clients to behaviors they have employed to deal effectively with problematic circumstances at least once and, by implication, could so duplicate their own previously exercised skills (Huber & Backlund, 1991). It is to these moments, small successes and exceptions to the problematic interactions, that solution-focused interventions devote their attention. As Burke (1997) asserted:

An active belief in clients' competencies is so essential that it alone can encourage "spontaneous" change . . . a genuine conviction in the client's native capacities can be relayed without minimizing emotional pain. . . . These assumptions bank on the idea that individuals are often better able to modify their own reality than they realize and encourage clients to investigate positive solutions. (p. 2)

### **Pragmatic Therapeutic Intervention: "The Safety Plan"**

The most important aspect of any program aimed at addressing issues of domestic violence is to assist family members make plans for their safety (Dutton-Douglas, 1991). Walker (1994) highlighted this critical intervention component from a traditional victim-victimizer perspective:

In the event that the woman is in immediate danger, it is imperative to find a safe place she can go where she won't be tracked down or stalked by the batterer—such as a shelter for battered women or the home of family or friends. If she is in danger, but not at immediate risk of serious injury or death, a crisis safety plan needs to be developed. (p. 18)

Walker went on to list an eight-step model for developing such as safety plan:

1. Assess several battering incidents.
2. Gather details of abuse, such as what the batterer said and how; the presence of drug or alcohol use and its impact; and his body posture.
3. Determine where the battering starts.
4. Request the woman develop a floor plan.
5. Determine what the woman needs to do to escape.
6. Locate a safe place she can go



7. Discuss what she should tell him, re: time-out, conditions for returning.
8. Rehearse the exit several times.

A safety plan like that proposed by Walker above requires insight and forethought, not to mention the ultimate ability to carry out such a plan in what might be extremely stressful if not potentially dangerous circumstances. Mental health professionals working with many domestic violence cases routinely encounter and reencounter the same individuals repeatedly behaving in a violent manner as well as their partners being the recipients of this violence. The phenomenon of opening, closing, and reopening case files, often over a period of years and even across generations, is not unheard of (Christensen et al., 1999). All too many families embroiled in domestic violence are only vaguely aware of the intrapersonal as well as interpersonal nature of their responses to and during these violent episodes. As is reflected in comments such as “and then we started doing what we always do,” family members are typically aware that a pattern exists. They are obviously not confident of their ability to interrupt the pattern when it has started, or avoid it, or when necessary, escape it before harm occurs.

Traditional intervention models such as Walker’s (1994) are superbly structured to identify (a) when victims are most at risk [Steps 1–3]; (b) the individual and contextual warning signs signaling the potential onset of a violent episode [Steps 1–3]; and (c) the skills needed to avoid, interrupt, and escape these situations as appropriate [Steps 4–8]. With regard to this third set of steps, however, there is the assumption that these skills will need to be “developed” followed by “planning and rehearsing” relative to their implementation. The implication is that *new skills* are necessary to meet the challenge of breaking free from the current pattern of abuse. To ask that new skills be learned and then implemented under very stressful and even potentially dangerous circumstances might be highly difficult for an objective outsider not embroiled within these circumstances. Ironically, “Sarah,” the central case study figure of Walker’s Survivor Therapy training module, had significant difficulty rehearsing as well as implementing the plan she and Dr. Walker had developed: “Asked if she’d rehearsed her new safety plan, she sheepishly shook her head ‘no’” (Walker, p. 43). Perhaps a more pragmatic (practical) approach might be better considered in such circumstances.

While an assertion that new skills need to be developed is not in and of itself incorrect, a family resilience perspective posits this as an assumption that follows from assessment focused primarily on pathology and destructive behaviors: David battered Marie; each of them must learn to act differently. Family resilience presupposes an expanded assessment lens: David battered Marie on this occasion; David or Marie was able to interrupt a potentially violent interaction on this *other* occasion. Family resilience considers

behaviors that contributed to these serious problems, of course, but also and to a greater extent those that led to “coping well” with the assertion that such times are inherent in any continuing family interaction. Further, the family resilience perspective expands the view surrounding the victim and victimizer as individuals needing skill development to a contextual one that incorporates the latter within a wider family system perspective: “Both David and Marie *together* were able to interrupt a potentially violent interaction on this other occasion.” In this manner, “skill development” addressing this high-risk interaction is targeted and relevant, and it emanates from the family members’ own history; they have already successfully employed these skills and thus are more readily able to reemploy them. Thus, a safety plan from a family resilience perspective is routed in detailed descriptions of *both* abusive circumstances *and* circumstances wherein a potentially abusive interaction was avoided or interrupted.

To return to Walker’s (1994) eight-step model for developing a safety plan, the following adaptation reflects the more pragmatic position offered by the principles of family resilience and harm reduction as a foundation for solution-focused intervention:

1. Assess at least one battering incident *and* at least one incident where the circumstances were similar in that there was the potential for battering to occur but something was done to interrupt or avoid this pattern and lead to a more peaceful, safe outcome.
2. Gather details of both the battering incident *and* the incident where the circumstances were similar but had a more peaceful outcome: What he said and how and what she said and how; the presence of drug or alcohol use and its impact; his and her body posture, and so on.
3. Determine where the battering started *and* where the interaction that led to the avoidance or interruption of the potential battering started during each of the two sets of circumstances described above.
4. Request that the partners *together* develop a floor plan *within the session*.
5. Determine what both he and she did differently to interrupt or avoid the outcome they experienced by *comparing* the details of their interaction during the battering incident with the similar and potentially battering circumstances they experienced during their other reported interaction that led to the more peaceful, safer outcome.
6. Reconsider the “safe places” that *both* he and she were able to go during the time they reported interrupting or avoiding a potentially battering outcome.

7. Discuss what both he and she told each other that was *different* during the time they reported interrupting or avoiding a potentially battering outcome.
8. Rehearse within the session what had *already* been successful for both him and her during the time they reported interrupting or avoiding a potentially battering outcome.

### **David and Marie**

David and Marie reported the details of their most recent battering interaction with remorse and trepidation as to the recurring nature of similar occasions during their relationship history. The mental health counselor was very clear in communicating about David's abusive actions as utterly contemptible. The counselor also, however, reflected David's apparent remorse and regret with similar intensity. David was particularly surprised by the collaborative nature of the inquiry as he had defensively expected to continue to be placed in a punished, pathologized position. The couple was then asked about a time in the not-too-distant past where circumstances were similar to the most recent battering incident but somehow concluded with a more peaceful, safer outcome for them both.

As the details of these latter circumstances were shared, the counselor made particular note of both Marie's and David's competencies in interrupting what might have been a similarly abusive situation. Of particular note was David's thoughts during this situation about the impact his loud voice and threatening posture toward Marie was having on their two children who were present. He related glancing toward the children and being stunned by the horrified looks on their faces. He immediately stopped his threats toward Marie and apologized to her and the children. During this time, Marie reported her decision to "stand up to David for the children's sake" and not cower to his threats as she had done during the most recent battering incident they had earlier described as well as other times when the children were present. She reported not wanting to upset them nor have them see David's fury toward her but this time decided "they need to see what their father is really like." When David began apologizing, Marie reported feeling stronger and asserting to him that he needed to leave the house for a couple of hours to think about what he was doing, which he did.

David and Marie were asked to consider the differences between these two occasions. The thoughts, feelings, and actions accompanying David's recognition of his threatening speech and actions' effect on the children and Marie's out-of-character assertiveness were highlighted as the basic elements

of a safety plan that had worked for them both. The counselor punctuated how neither wanted to continue the high-risk pattern that they were encountering and reencountering and the good feelings of safety both experienced during the safer occasion they had just relived during the session. They were then asked to consider a time during the upcoming week where the potential for a battering incident might occur and enact in session how they might use what they had already used to contribute to that safer outcome for them both.

### **Pragmatic Alternative and Intervention of Choice**

For most of the history of mental health practice, and particularly recent decades relative to the “right way” to intervene in cases of domestic violence, the primary emphasis has been placed on pathology and dysfunction. It has been assumed that certain diagnoses are the norm for both victimizer (e.g., Intermittent Explosive Disorder) and victim (e.g., Posttraumatic Stress Disorder). These diagnoses are then used to instruct intervention efforts by presupposing prescribed, corresponding remedial processes. Within this practice perspective, individuals and families have generally been viewed as service recipients rather than capable, active partners in the change process. Indeed, the mental health profession has been increasingly criticized as aloof, assuming an objective professional expertise and emphasizing client deficits and pathology (Minuchin & Nichols, 1993). Those clients who do not accept professionals’ expert diagnoses and corresponding therapeutic recommendations are consequently labeled “resistant” and their potential contribution to the change process even further minimized (Berg, 1994; Christensen et al., 1999).

Families where domestic violence is experienced tend to anticipate that they will be criticized by mental health professionals, the “victimizer” directly so and the “victim” indirectly. They may be embarrassed or guilty, often wanting to hide their actions and inactions from others. Some feel wrongly accused while others feel discriminated against. Many hold the belief that what occurs in the privacy of their own home is their business alone. More recently, theory, research, and practice have become increasingly informed by the principles of family resilience, harm reduction, and solution-focused intervention applications. These have a common emphasis on collaboration between counselors and clients, client and family competence, individual and systemic change, and coping well (versus cures and idealistic outcomes). Together as presented herein, they are offered as a pragmatic intervention alternative. For us, they are the intervention of choice in cases of domestic violence.

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