A Feminist Look at A Solution Focused and Narrative Approach to Treatment of Child Sexual Assault Victims and Their Families

By Mareena Yusishen

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A FEMINIST LOOK AT A SOLUTION FOCUSED AND NARRATIVE APPROACH TO TREATMENT OF CHILD SEXUAL ASSAULT VICTIMS AND THEIR FAMILIES

BY

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A Thesis/Practicum submitted to the Faculty of Graduate Studies of The University of Manitoba in partial fulfillment of the requirements of the degree

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MASTER OF SOCIAL WORK

PRACTICUM REPORT (Revised)

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Abstract

The sexual assault of a child can have devastating consequences for both the child and his or her family. It is therefore imperative that effective treatment strategies be devised and utilized in order to assist families in working through this trauma and to facilitate a process of recovery whereby the sexual assault is not interfering with their ability to live satisfactory lives.

In this practicum this writer worked with five families using a combination of solution focused and narrative intervention strategies under the umbrella of a feminist perspective. This process allowed these families to focus on their strengths and abilities in overcoming the effects of the assault while also gaining an understanding of the context a sexual assault from a societal as well as individual perspective.

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CHAPTER I

INTRODUCTION

The reported and substantiated incidence of child sexual assault has continued to grow in the last decade and shows no sign of decreasing in the future. Recognition of the damaging effects to children, their families and society in general has also become more accepted (Marshal, Laws, & Barbaree, 1990). It is therefore important that effective treatment strategies be devised and utilized in order to combat child sexual assault and its devastating effects.

Prevalence

Overall, the research on the prevalence of childhood sexual assault indicates that significant numbers of women and men are reporting being sexually assaulted as children and that this number continues to rise. Finkelhor et al. (1990) and Fromouth and Burkhart (1989) estimated that fifteen to thirty-three percent of females and from thirteen to sixteen percent of males are sexually assaulted during childhood. Briere (1992) concurs with this estimate for males but estimates the range from twenty to thirty percent for females. The National Centre for Child Abuse and Neglect (1988) has noted in its research an increase in reported child sexual assault from 42,900 in 1980 to 138,000 in 1986. Gil (1996) suggests that child sexual assault has steadily been increasing in North America with more than 2.5 million cases being reported in 1994. In Manitoba the Child Protection Centre at the Health Sciences Centre in

Winnipeg has noted increases from 95 sexual assault cases in 1982 to 453 sexual assault cases in 1990.

Although the research indicates a range regarding prevalence, it certainly acknowledges that the occurrence of child sexual assault is a wide-spread problem. One of the reasons for the differences in incidence and prevalence rates of child sexual assault can be attributed to the varying definitions used by the researchers. For the purpose of this report, this writer has adopted the definition of child sexual assault used by Gil and Cavanagh (1993). They state that "sexual assault includes only situations in which children are being used for someone else's sexual gratification, ranging from hands-on abuse, such as fondling, oral sex, or intercourse, to exposure to disturbing sexual material" (Gil & Cavanagh, 1993, p.101).

Another possible reason for the discrepancies in prevalence rates can be found in the ambiguous definitions of sexual assault and sexual abuse. Many of the definitions of abuse and neglect leave room for interpretation. The ambiguity in definitions of abuse has been a source of concern for those interested in protecting children and researching child maltreatment (Pallone, 1994). In Manitoba, the sexual abuse of a child as defined by the Child and Family Services Act (1985) can be committed by anyone who has care or control over a child. This is most commonly referred to as intra-familial abuse as the person committing the assault is in a position of trust. Sexual assault includes but is not limited to this definition, as the term sexual assault

encompasses any sexual offence regardless of the relationship or lack of relationship between the offender and victim. In order to differentiate between intra-familial and extra-familial assaults, the literature especially separates these two types by labelling one abuse and the other assault. For the purposes of this practicum report this writer will use the term sexual assault. The reasons for this are that in the setting in which the clinical work was completed, the term sexual assault was used for all children seen in the Families Affected by Sexual Assault Program whether they were victims of intra-familial sexual abuse or extra-familial assault.

Impact

Child sexual assault can have far reaching consequences and can result in both the child and/or the family not functioning in a satisfactory manner. Gil (1996) reports that no form of child assault occurs without psychological damage. " Sexual assault can be traumatic to children since it is an overwhelming, out of the ordinary experience, and elicits feelings of helplessness and instinctual arousal" (Gil & Cavanagh, 1993, p.102). Finkelhor (1986) and Briere and Runtz (1989) concur with these findings and indicate the sexual assault of a child has been related to depression, anxiety, dissociative systems and low self-esteem. Briere (1992) states that a child may suffer from long-term effects because the trauma occurs during a crucial developmental time of a person's life. If left untreated an assault can have an affect on victims throughout their lives. In a review of the literature Simon,

Green, Rohan, and Nicholas (1996) note that adults who were sexually assaulted as children can suffer from long-term psychological effects such as depression, anxiety, interpersonal problems, dissociative experiences and sexual problems.

When a child has been sexually assaulted the impact is felt throughout the family. Parental reaction to the disclosure and their ability to support the child is critical in the healing process. Howard (1993) states that after children make statements of being sexually assaulted, parental reactions can carry great weight and have serious implications for the future health and well-being of the child. Davies (1995) states that there are a wide variety of reactions from parents of sexually assaulted children. These reactions can range from excessive protectiveness to hostility and rejection of the victim. Davies (1995) further states that in many cases the parent may be more concerned with self-protection and protection of the family unit than with the psychological well-being of the child. Sgroi, Poter, and Blick (1992) agree with this notion and indicate that although this is much more likely to happen in intra-familial abuse, it can also occur in extra-familial abuse where the offender is a close friend, neighbour, or non household relative because it can cause divided loyalties and increased stress for parents.

Carter (1993) suggests mothers experience trauma after the sexual assault of their child and they also have negative psychological, social and economic consequences to deal with. Brayden, Dietrich-MacLean, Dietrich,

Sherrod, and Altemier (1993) argue that a sexual assault can cause family functioning to deteriorate and may be associated with a negative impact on mental health. The research clearly indicates that the impact of child sexual assault has wide ranging and long- term effects on the victim and his or her family. How parents respond to the disclosure of the assault can have serious repercussions on the future mental health of the victim as well as the future functioning of the family.

It is important to note that the literature reflects that most children and their families require some assistance in resolving the issues associated with sexual assault. If left untreated, the victim and members of the family are vulnerable to repeating systematic responses that are destructive to themselves and the family unit. The traumatic effects of sexual victimization do not simply go away, nor except in some very rare cases, will such trauma cure itself. Professional intervention is seen as necessary for a minimum of a short time in the recovery process of some survivors and for a great deal of time in the recovery process of others (Pallone et al., 1994).

Sgroi (1982) states that child sexual assault becomes a family treatment issue because of the perception by family members that a child who has been prematurely introduced to sexuality is somehow changed by his or her sexual experience. Further, the family's perception nearly always reinforces the victim's belief that he or she is damaged. At minimum, there should be counselling for the child's parents which addresses all of the impact issues for

the child as well as the associated treatment implications in some families.

Sgroi (1982) further argues the need for family intervention by indicating that the family's response to the child victim's progress in therapy is the most critical factor in determining success or failure. She states that adequate treatment for the victim of child sexual abuse can never take place in a familial vacuum. Even when the victim is separated from the rest of the family, their response to his or her treatment is profoundly important. Thus, some degree of family treatment is essential for success of the treatment plan for the victim, even in cases of extra-familial sexual assault (Sgroi, 1982).

Learning Objectives

The main objective of this report was to learn to utilize the solution-focused and narrative approaches in working with children and their families after a child in the family has been the victim of a sexual assault. The literature suggests that effective treatment services are of paramount importance if child sexual assault victims and their families are going to move beyond the assault. It is this writer's opinion that therapy which combines the solution-focused and narrative approaches is an effective form of intervention in these cases. The frameworks are discussed in Chapter II.

A further goal was to assess the fit of using these approaches with a feminist perspective. The feminist perspective will be discussed in Chapter II.

The final goals were both personal and practical for this writer. They were: to gain an increased understanding of the effects of sexual assault on

children and their families, to learn how to effectively intervene so that the trauma of the assault can be alleviated, and to further develop this writer's clinical skills to more effectively help children and their families deal with the trauma of a sexual assault on the child.

Outline of the Remainder of the Practicum Report

Chapter II: A Review of the Solution Focused and Narrative Frameworks and the Feminist Perspective examines these two approaches to working with families whose child has been sexually assaulted with an overview of a feminist perspective.

Chapter III: The Practicum Experience describes in detail the physical features associated with this practicum experience. It examines the setting, client system, intervention models, supervision, and the evaluation process implemented during this practicum.

Chapter IV: Case Reviews examines in detail this writer's work with five children and/or their families and the learning that occurred in this process. The format followed in describing these cases is source and reason for referral, background information, assessment, treatment goals, interventions and evaluative case conclusions and case analysis.

Chapter V: Discussion of the Practicum Experience reflects on concluding comments of the frameworks utilized in the practicum from a feminist perspective. Also included is a brief evaluative statement regarding this writer's learning objectives.

CHAPTER II

LITERATURE REVIEW

Introduction

The use of a feminist perspective in conjunction with a combination of a solution-focused approach and narrative approach was the theoretical framework used in approaching the interventions in this practicum. The first two sections are devoted to giving a brief overview of the two practice models used by the staff of FASA (Families Affected by Sexual Assault Program) in their work with sexual assault victims and their families. A third section examines the literature pertaining to the feminist perspective in order to understand this writer's perspective.

Solution-focused Therapy

In the recent years, a new model for treatment called solution-focused therapy has gained the attention of many professionals treating problems. Solution-focused therapy offers a new way to think about and approach therapy. "It is a method that focuses on peoples' competence rather than their deficits, their strengths rather than their weaknesses, their possibilities rather than their limitations" (O'Hanlon & Weiner Davis, 1989, p. 119). Treatment that follows the solution focused model concentrates on solving the problem rather than dwelling on the cause of the problem.

The solution-focused model differs from traditional models by focusing on clients' strengths and abilities. Rather than viewing a client as sick it treats

all people as if they are normal. "The focus of solution orientated therapy lies not in seeking explanations for the behaviour but in seeking solutions to alleviate the problem" (O'Hanlon & Weiner-Davis, 1989, p. 14). O'Hanlon and Weiner-Davis (1989) state that traditional therapists concern themselves with explaining, diagnosing and understanding human nature and that although this might be worthwhile, understanding the problem does not necessarily mean that the desired change will occur.

Solution-focused therapy was pioneered by Milton Erickson who practised therapy from the late 1920's until the late 1970's. O'Hanlon and Weiner-Davis (1989) state that Milton Erickson's expertise lay in his view that what other therapists saw as psychopathology he saw as skills that could be used to create solutions. Erickson talks about neurotic symptoms in his work but he made no attempt to correct any causative underlying maladjustments. He was not interested in the details of the mistakes or in the problem, but rather in the procedure the client used to correct the mistake.

Erickson believed that clients have within themselves or within other social systems the resources to make the changes they need to make. The therapist's job is to assist the client in accessing these resources. "Erickson didn't view people as fundamentally flawed or in need of fixing. To Erickson therapy was predicated upon the assumption that there is a strong normal tendency for the personality to adjust if given an opportunity". (Ross, 1980, p. 110) Erickson further believed that it was critical that the therapist conduct the

therapy at a intellectual and emotional level that the client was capable of responding to. To do this the therapist has to pay close attention to the information provided by the client. By doing this Erickson believed therapy could be accomplished in a relatively short time period.

> Illness can come on all of a sudden; one can make a massive response all at once to a particular thing. I do not think we need to presuppose or profound some long drawn-out causation and a long, drawn out therapeutic process. You see, if illness can occur suddenly, then therapy can occur quite as suddenly. (Rossi, Ryan, & Sharp, 1983, p. 71)

Erickson thought that if one expected to find solutions and had an attitude that solutions were there, this was much more conducive to helping the client overcome the problem "than passively accepting a decree of uncurable" (Rossi, 1980, p. 202).

The assumptions held by Milton Erickson have been embraced by both The Mental Research Institute (MRI) in their development of problem-focused brief therapy and by The Brief Family Therapy Centre (BFTC). The MRI started a brief therapy project in 1966 using a model called problem focused therapy. One of their central principles was that they work towards resolving the problem rather than try to figure out how it came about.

> The treatment model is called problem-focused because therapists working this way attempt to alleviate only the specific complaints clients bring to therapy. There is no attempt to search for the underlying pathology or source of the problem. No deliberate attempt is made to promote insight. Problems are considered to be interactional in nature. They are viewed as being difficulties between people rather than

> arising from inside individuals. People experiencing problems are not viewed as flawed in character or mentally ill. In this view, problems develop when ordinary life difficulties get mishandled. Once a difficulty is viewed as a problem the problem is maintained or made worse by people's unsuccessful attempts to solve the problem. In other words the problem is the attempted solution. (O'Hanlon & Weiner-Davis, 1989, p. 18)

In this model clients are often given suggestions that they stop trying to solve the problem in the way they had been and then are given instructions for a more effective approach to handling the problem.

The model of therapy developed by the BFTC is called solution-focused brief therapy. Steven de Shazer (1985) uses the analogy of a skeleton key to describe his focus.

> He contends that the therapist does not need to know a great deal about the nature of the problems brought to therapy to solve them. More relevant is the nature of solutions. It is the key that opens the door that matters most, not the nature of the lock. Analysing and understanding the locks are unnecessary if one has a skeleton key that fits many different locks. (O'Hanlon & Weiner-Davis, 1989, p. 21)

The rationale behind the solution-focused model developed by the BFTC is that the "key to brief therapy is in utilizing what clients bring with them to help them meet their needs in such a way that they can make satisfactory lives for themselves" (de Shazer, Berg, Lipchik, Nunnally, Molnar, Gingerich, & Weiner-Davis, 1986, p. 208).

The BFTC also theorizes that there is no such thing as resistance and assumes that clients want to change. Every client of the BFTC is seen as having their own way

of working with the therapist and it is the therapist's job to identify and utilize the form of cooperation that the client is presenting with.

Another contribution of the BFTC was the development of "formula tasks". These are assignments and tasks that seem to have an effect on the problem regardless of what it is. The first session task was developed to help the client focus on the future and to create expectations that there would be change. "Between now and the next time we meet, we (I) would like you to observe so you can describe to us (me) next time, what happens in our (pick one: family, life, marriage, relationship) that you want to continue to have happen" (de Shazer , 1985, p. 137). Two other tasks that were developed were the "miracle question" and the "exception question". The miracle question centers on having the client focus on the notion of a problem free future. The basic miracle question is "Suppose that one night while you were asleep there was a miracle and this problem was solved. How would you know?" (de Shazer, 1988, p. 5). The exception question centers on the client looking at the past and the present to identify times when they did not have the problem even though they expected it to be there. This often leads the client to solutions that have already been there but perhaps were forgotten.

There are several principles of the solution-focused model that challenge the assumptions of many traditional therapies. Traditional therapists assert that there have to be deep underlying causes and that awareness or insight into these causes is necessary for change or symptom resolution. Therefore therapy has to focus on identifying and correcting pathology and deficits. In contrast with the solution-focused

therapists, traditional therapists believe that amelioration or removal of symptoms is useless or shallow at best and harmful or dangerous at worst. The traditionalists believe that long term therapy is necessary to overcome a client's inherent resistance to therapy and to produce long lasting change (O'Hanlon & Weiner- Davis 1989).

The principles held by a solution- focused orientation are as follows:

> -Most complaints develop and are maintained in the context of human interaction. Solutions lie in changing interactions in the context of the unique constraints of the situation.
> -The task of brief-therapy is to help clients do something different by changing their interactive behaviour and/or their interpretation of behaviour and situations so that a solution can be achieved.
> -There is no such thing as resistance. Clients come to therapy because they really do want to change.
> -New and beneficial meanings can be constructed for at least some aspect of the client's complaint.
> -Only a small change is necessary and can lead to profound and far reaching differences in the behaviour of all people involved.
> -Change in one part of the system leads to change in the system as a whole.
> -Effective therapy can be done even when the therapist cannot describe what the client is complaining about or what caused it. Basically all the therapist and the client need to know is how will we know when the problem is solved?
> -Clients have resources and strengths to resolve complaints.
> -Change is constant.
> -The therapist's job is to identify and amplify change.
> -Clients define the goal. There is no single or correct way to live one's life. Therefore clients not therapists, identify the goals to be accomplished in treatment.
> -Rapid change or resolution of problems is possible.
> -There is no one right way to view things, different views may be just as valid and may fit the facts just as well.
> -Focus on what is possible and changeable rather than what is impossible and intractable.
> (O'Hanlon & Weiner-Davis, 1989)

These principles have been founded on the aim of the solution process which is to find solutions and not to concentrate on complaints.

> Each complaint can be constructed into many different, possible solutions, and any intervention that successfully prompts any different behaviour and/or a different way of looking at things might lead to any one of the solutions. (de Shazer, et al., 1986, p. 213)

Solutions can develop from what the client can already do, while problems result from what the client cannot do. By focusing on how the client has been able to make some progress or how the client has managed not to have the problem worsen, the therapist and client are able to focus on solutions that were previously seen as failures or were not noticed. (O'Hanlon & Weiner-Davis, 1989)

The Narrative Approach

The narrative method of therapy was developed by Michael White and David Epston in 1990 with the notion that the "person is never the problem, the problem is the problem" (O'Hanlon, 1994, p. 24). It represents a fundamentally different direction in psychotherapy by utilizing techniques which encourage the client to "objectify and at times, to personify the problems that they experience as oppressive. In this process the problem becomes a separate entity and thus external to the person or relationship that was ascribed as the problem" (White & Epston, 1990, p. 98). White and Epston (1990) argue that by externalizing problems that are seen as "fixed" or "inherent" in a person become less restricting.

White and Epston's development of narrative therapy was influenced by

Michael Foucalt, a nineteenth century French historian and philosopher who carried out a socio-political analysis of the emergence of modern medicine in western culture. He summarized that "knowledge systems like medicine can be extremely oppressive by transforming persons into dehumanized subjects through scientific classification" (Tomm, 1989, p. 54). Michael White also built upon "Foucalt's exploration of the connection between expertise and power in the establishment and maintenance or the reign of the narrative" (Golberg, 1995, p. 17). Foucalt believed that those defined as abnormal typically practice self-subjugation. White believes that therapy is political and he challenges self-definitions of abnormality and encourages self-acceptance.

O'Hanlon (1994) calls narrative therapy the third wave in psychotherapy. He states that the "first wave which began with Freud and laid the foundation for the field of psychotherapy, was pathology-focused and dominated by psychodynamic theories and biological psychiatry" (O'Hanlon, 1994, p. 22). This wave changed the view that people were morally deficient and moved the focus primarily onto pathology.

The second wave in psychotherapy O'Hanlon (1994) proposes is that of problem-focused therapies. These therapies include cognitive approaches, family therapy and behavioural therapy. These therapies focus more on the here and now instead of searching for hidden meanings and ultimate causes

> personality was no longer seen as sealed in the envelope of the skin but as influenced by patterns of communication, family and social relationship. Though change was not seen as so difficult as it was in the first wave, problems were seen as residing in small scale systems with the therapist still having the answers. Few saw their clients as decisive agent in their own change. (O'Hanlon, 1994, p. 22)

The third wave, O'Hanlon (1994) states, is that of competency based therapies. These therapies do not see the therapists as the sources of the solution but suggest that solutions reside within the client and their social networks. Third wave therapies are based on a "willingness to acknowledge the tremendous power of the past history and the present culture that shape our lives, integrated with a powerful, optimistic future vision of our capacity to free ourselves from them once they are conscious" (O'Hanlon, 1994, p. 23).

> While the first wave conceived of troubling forces as located within individual's troubled personalities and the second wave concentrated on small interactive systems like the family, the third wave draws attention to far larger systems, such as the daunting cultural sea we swim in - that tell us how to think and who to be. We're not sure where many of these messages come from; we go around thinking of them as ourselves and many of them are profoundly destructive and undermining. (O'Hanlon, 1994, p. 23)

Third wave therapists are interested in people's histories in the context of the culture(s) they live in. They do this by blurring the distinction between politics and therapy and bringing issues such as racism and sexism to the personal level. They do this not by blaming, but by "focusing instead on the insidious effects of oppressive ideas and practices, habits of actions to which all of us are subject" (O'Hanlon, 1994, p. 24). White and Epston (1990) state this is a politics of liberation on a very individual level. The theory here is that you need to recognize the effects of your culture on yourself so that you can stop thinking of these effects as inherent to yourself.

The narrative approach leads to a vastly altered view of personality itself and therefore, of therapeutic change (White & Epston 1990). Although it may explore people's histories more than any other current approach it does so with a profound difference. "It can be described as "breaking the "trance" imposed on people by the powerful forces of history and culture, making visible the invisible pattern of ordinary humiliations and terrors, routine tyrannies and acts of violence that comprise much of "civilized" life" (Wylie, 1994, p. 43). "The narrative approach levels the playing field between therapist and client to confront societal and other power inequities together" (Goldberg, 1995, p. 17). Narrative ideas "lend themselves to respect and empowerment not only for clients but for therapists as well" (O'Hanlon. 1994, p. 24).

As stated, the narrative approach, does this by using the technique of externalizing the problem. "What is basically entailed is a linguistic separation of the distinction of the problem from the personal identity of the patient" (Tomm, 1989, p. 54). According to Tomm (1989) this is done through the careful use of language in a therapeutic conversation in which the patient's healing initiatives are mobilized . In helping family members separate themselves and their relationship from the problem, externalization opens up possibilities for clients to describe themselves, each other, and their relationships from a new, non problem-saturated perspective. It enables the development of an alternative story that is more attractive to the client.

White and Epston state that the practice of externalization:

> - decreases unproductive conflict between persons, including those disputes over who is responsible for the problem;
> - undermines the sense of failure that has developed for many

> persons in response to the continuing existence of the problem despite their attempts to resolve it ;
>
> - paves the way for persons to cooperate with each other, to unite in a struggle against the problem, and to escape its influence in their lives and relationships;
> - opens up new possibilities for persons to take action to retrieve their lives and relationships from the problem and its influence;
> - frees persons to take a lighter more effective and less stressed approach to "deadly" serious problems;
> - presents options for dialogue, rather than monologue about the problem.
> (White & Epston, 1990, p. 39)

Externalizing the problem enables clients to separate from the dominant stories that have been shaping their lives and relationships. In so doing, clients are able to identify perviously neglected, but vital aspects of lived experience - aspects that could not have been predicted from a reading of the dominant story. White and Epston (1990) state that when a person experiences problems for which they seek therapy

> (a) the narratives in which they are storying their experience and/or in which they are having their experience storied by others do not sufficiently represent their lived experience and (b) in these circumstances, there will be significant and vital aspects of their lived experiences that contradict these dominant narratives. (White & Epston, 1990, p. 40)

They call these experiences "unique outcomes" and state that "as unique outcomes are identified, persons can be encouraged to engage in performances of new meaning in relation to these" (White & Epston, 1990, p. 41).

White and Epston (1990) describe the specific practices associated with externalizing the problem and identifying unique outcomes. This process which is the

fundamental structure of the narrative model is summarized by O'Hanlon as follows:

> -The collaboration with the person of the family begins with coming up with a mutually acceptable name for the problem.
> -personifying how the problem has been disrupting, dominating or discouraging the person and the family.
> -Discovering moments when clients haven't been dominated or discouraged by the problem or their lives have not been disrupted by the problem.
> -Finding historical evidence to bolster a new view of the person as competent enough to have stood up to, defeated or escaped from the dominance or oppression of the problem.
> -Evoking speculation from the client and the family about what kind of change is to be expected from the competent person that has emerged in the interview so far.
> -Finding or creating an audience; perceiving the new identity and telling the story.
> (O'Hanlon, 1994, pp. 26 - 27)

Feminist Perspective

Fook (1993) and Coates (1991) both indicate that in order to integrate theory and practice a therapist must consider several different levels of knowledge. Coates (1991) states that there are four different levels of knowledge for practice and that the first is that of the social worker's world view or perspective. Fook (1993) describes this level as that of broad theory and the general knowledge base which a social worker draws upon.

"Perspectives or world views are assumptions people hold concerning the nature and relationships of people and society and the nature of problems" (Coates, 1991, p. 87). According to Coates (1991) social workers bring their perspectives into their practice and these perspectives act as an umbrella that influences all aspects of their practice. It is at this level that a feminist framework will be detailed.

The middle level of knowledge described by Fook (1993) and Coates (1991) is the application of theory to social work practice. Fook (1993) describes this as the theory of practice or the general theoretical approach to practice, while Coates (1991) describes it as middle range knowledge which "helps the social worker understand what has occurred or what is taking place" (Coates, 1991, p.85). Middle range knowledge helps the worker understand the situation and decide what intervention should be used. It is from this level that the solution-oriented and narrative models have been described. The use of these practice models will be under the umbrella of a feminist perspective as it is this writer's opinion that the specific techniques used by these approaches during intervention can be compatible with a feminist perspective.

Feminist social work is a model that is outside of the dominant perspective. Unlike other perspectives, the feminist model has a specific relationship to a political movement and has been instrumental in effecting social change. "Feminism is also a theoretical process whose purposes are to understand the power structures, social practices, and institutions that disadvantage and marginalize women and to devise innovative strategies of social transformation that will promote women's emancipation" (Burt, Code, & Downey, 1993, p. 19), the feminist perspective is concerned with how, in a patriarchal society, women and men generally lead very different lives and have different experiences.

The feminist ideology holds the following assumptions:

- The personal is political
- a belief in the equal worth of all human beings
- a recognition that each individual's personal experiences and

> situations are reflective of and an influence on society's institutionalized attitudes and values
> - a commitment to political and social change that equalizes power among people
> - that there be equal valuing of all people by recognizing and reducing the pervasive influences and insidious effects of patriarchy on people's lives.
> (Feminist Therapy Ethical Code, 1987)

Nancy Hartsock (1983) states that "feminism is a mode of analysis - a method of approaching life and politics. It is a commitment to working in what ever ways we can" (Hartsock, 1983, p. 7). This mode of analysis addresses the effects of sexism on the development of males and females and the relationship of sexism to other forms of oppression. An essential aspect of the feminist perspective is the proactive stance towards the eradication of oppression. "It is the challenging of oppressive aspects of the client's value system while being respectful of individual differences" (Feminist Therapy Ethical Code, 1987).

The use of a feminist perspective when working with children and families that have been affected by sexual assault allows the therapist to move beyond the individual level of analysis and view the sexual assault of children from within the structure of patriarchy, male dominance and supremacy.

> Child sexual abuse can be defined under the umbrella of violence against women and children. It is sustained by a male dominated society that continues to eroticise dominance and in which women and children are defined in relation to male need. The importance of the feminist perspective lies both in taking seriously this current reality and in identifying gender and sexuality. As socially constructed and hence variable. (Hooper, 1992, p. 8)

Although feminists differ in their views on the specifics of why sexual assault of children occurs, there is agreement that interventions need to be guided by an understanding that the sexual assault of a child must be considered from within the broader context of a patriarchal system.

Conclusion

The solution-focused and narrative models are promising approaches when working with a child who has been sexually assaulted and/or their families. The specific interventions recommended in these two models allow people to gain more control over the problem. "The client is thereby empowered to resolve or at least mitigate existing symptomology, and to identify and gradually reclaim healthy patterns of perceiving and behaving in the future" (Dolan, 1991, p. xiv), Durrant (1987) suggests that it is not the "historical effects of trauma that is significant and so needs to somehow be worked through, but the way it is now made sense of" (Durrant , 1987, p. 69). One of the major aspects of being sexually assaulted, Durrant states, is feeling powerless or out of control and that therapy can help the victim regain some sense of control by addressing the issue of the context of their experience first.

> If young people can be helped to begin to interpret their world within a different context, one that implies that they can have some control in their lives, they may then be able to face their feeling more constructively. (Durrant, 1987, p. 71)

Durrant (1987) further states that by helping the client construct a different context, the inevitable ongoing distress that many children feel after being assaulted is alleviated by the child feeling that he or she has some control over the effects of the distress.

"By helping them discover a context of control, we can affirm that they were a victim of abuse but need not be a victim of effects" (Durrant, 1987, p. 73). This approach also works well with parents whose child has been assaulted because a "new context can also challenge parents beliefs that their child is irreparably damaged and so counter any reactions on their part that might inadvertently perpetuate the young person's beliefs about out-of-controlness" (Durrant, 1987, p. 75).

Utilizing a combination of the two models described in this paper gives therapists tools that can effectively lessen the stresses and symptoms children and their families feel after the sexual assault of a child. The practice techniques allow clients to regain control over areas in their lives where previously they felt powerless over what was happening to them because of the assault.

These two practice models are compatible and share many similar principles with a feminist ideology. Most noteworthy are the principles that focus on: clients' strengths and abilities; that the client is not seen as the problem; that solutions are within the client and that the therapist is there to assist in this process and not as an expert; and perhaps most significantly the acknowledgement of past history and present culture and the oppressive effects and practices that all people are subjected to as a result.

The feminist perspective would also challenge some of the assumptions held by the narrative and the solution-focused approaches. Of particular concern is the notion that to do effective therapy one does not need to have any insight into the problem, how the problem came about or how it is maintained. Feminists would argue

these points as being critical because from the feminist perspective one's life experiences both politically and personally have to be understood in order for healing to take place.

The feasibility of combining the solution-focused and narrative approaches with a feminist ideology will be further discussed from this writer's perspective in the concluding chapter.

CHAPTER III

THE PRACTICUM EXPERIENCE

The Setting

The setting for this practicum was the Families Affected by Sexual Assault Program (FASA) that is within the agency of New Directions for Children, Youth and Families in Winnipeg, Manitoba. The duration of the practicum was from November 1, 1996 to July 15, 1997. Clinical requirements of the program were completed under the direct supervision of Marlene Richert, Program Manager of the FASA Program and member of this writer's practicum committee and Harvy Frankel, Social Work Faculty member and chairperson of this writer's committee. This writer attended the FASA Program during scheduled appointment times with clients and also met weekly with the FASA team for clinical consultation.

FASA provides individual and family therapy, group treatment, parent support groups, community education, advocacy and liaison with other services. The service guidelines outlined by FASA are that the disclosure of the assault is recent, the victim is under eighteen years of age, the family resides in Winnipeg or a surrounding area and that the alleged offender lives outside the family home.

The FASA Program is a voluntary service and clients refer themselves because of a sexual assault of a child in their family. This can include families and/or individuals that have been affected by the sexual assault.

The beliefs of the FASA Program are: sexual assault affects all family members, parents play an essential role in the recovery process, children who have support and understanding suffer fewer ill effects and children, and families do recover.

The length of treatment varies with each client, but it generally lasts approximately four months and is considered short term therapy and/or crisis intervention. Termination of treatment is determined by the client in conjunction with the therapist.

The FASA team is made up of four therapists, each with an individual caseload as well as being involved in some or all of the other group and community services offered by the program.

The team meets weekly to provide clinical consultation and support. This is done through the use of a reflecting team approach in which three team members watch through a one way mirror while the fourth therapist conducts a session with a client or family. There are telephones in both rooms that allow the observing team to call the therapist and offer suggestions. When the session is almost finished, the observing team trades places with the family and their therapist and has a discussion about how they perceived the session went. The family and their therapist observe this discussion and then the switch is done once more in order for the family to discuss how they felt about what the team had said and for the therapist to assign tasks and set the next appointment. Video taping of sessions is also done so that the therapists can

review their sessions and get further feedback from the other members of the team.

The services provided by FASA are confidential and free of charge. Families are contacted within two working days to set an appointment at a time that is convenient for them in the day or evening.

Intervention Models

The FASA team uses a combination of solution-focused and narrative approaches in their work with sexual assault victims and their families. The solution-focused approach is the main model utilized by the FASA team. The narrative approach has recently been incorporated into FASA's work as the use of many of the narrative techniques compliment the solution-focused material and so enhance the overall model.

The solution-focused and narrative models view the process of interviewing as an intervention. Through the use of various interviewing techniques clients can experience significant shifts in their thinking about their situations during the course of a session. These shifts free people to act in a more productive way. In many cases, tasks that are assigned at the end of a session merely serve to reinforce the change which has occurred (O'Hanlon & Weiner-Davis, 1989).

When using a solution-focused approach, there are specific intervention strategies that need to be utilized. The first strategy is presuppositional questioning. Questions which are carefully worded using solution focused

language are designed to act as interventions by influencing clients perceptions in the direction of solutions. Presuppositional questions direct clients to responses that are self enhancing and self-promoting. Although this use of questioning is used as much as possible, the specific questions are determined by the goal at any particular point during the session (O'Hanlon & Weiner-Davis, 1989).

In the first session(s) attention is given first to joining with the clients by showing non-judgemental interest in them to help them feel comfortable, and secondly to get a brief description of the problem. The questions asked during this phase of the therapy are designed to extract information about exceptions to the problem, past solutions and the clients' current strengths and resources. Once the clients have identified even the slightest exception, questions are focused on how they got that to happen, how has it made things go differently, who else noticed, how is it different from the way it was handled in the past and if they, the clients have ever had this problem before, how did they resolve it. (O'Hanlon & Weiner-Davis, 1989) By using this technique the therapist is encouraging the client to take credit for whatever is working.

A second strategy used in the solution-focused approach is that of normalizing and depathologizing. Sessions are channelled towards viewing the client's situation as normal rather than psychological or pathological. By normalizing the difficulties clients bring to therapy, the therapist provides a calming effect which offers relief to clients and influences them to think that

perhaps things are not as bad as they thought (O'Hanlon & Weiner-Davis, 1989).

Goal setting is the next technique used in the solution-focused process. Since a basic assumption of the solution-focused approach is that a small change leads to additional changes, goal setting always starts small. Two other aspects of goal setting are that the goals should always be realistic and concrete.

The use of compliments is another technique that is utilized throughout the therapy process. The therapist always responds when clients share something that is positive or solution-prompting. This technique is most often used at the end of the session and/or therapy.

A final strategy used in solution-focused therapy is asking fast forward questions when clients are unable to identify exceptions or past solutions. This means asking the client to describe the future without the problem so that a picture of the solution can be formed. An example of this line of questioning is the "miracle question" described earlier.

The narrative approach is based on helping people develop their own self-knowledge and expertise. As a result, the process of therapy is unique for each person. (Adams-Westcott & Isenbalt, 1996) The main techniques used to achieve this in therapy are externalizing the problem and storied therapy.

There are several steps associated with externalizing the problem. The first is relative influence questioning which is comprised of two sets of

questions. The first set encourages clients to map the influence of the problem in their lives and relationships. The second set encourages clients to map their own influences in the life of the problem. By inviting clients to review the effects of the problem in their lives and relationships, relative influence questions assist them to become aware of and to describe their relationship with the problem. This takes them away from problems that are intrinsic to persons and relationships and allows clients to find new possibilities for positive action. (White & Epston, 1990)

The next step in the process of externalizing the problem is to define the problem. White and Epston (1990) state that the therapists need to work with the client to come up with a mutually acceptable definition of the problem. In this phase, the client and therapist need to be aware that definitions of the problem may not always be fixed, but more often will evolve through time. The therapist should also help the client to develop a general, rather than specific definition as this will broaden the influences of the problem that are identified. Finally White and Epston (1990) state that it is important to encourage clients to construct alternative definitions of problems such as definitions that are most relevant to their experiences and definitions that enable them to more adequately address their immediate concerns.

Once the problem has been externalized the narrative therapist works with the client to identify "unique outcomes". This technique helps clients look at alternative outcomes regarding the influence of the problem and, in some

cases to counteract the effects of the problem in that person's life or relationships.

Unique outcomes can be identified in several ways. The first way is to use a historical review of the client's influence on the problem. This can facilitate performance of new meaning in the present by allowing people to revise their personal relationship histories (White & Epston, 1990). A second type of unique outcomes that can be identified is called current unique outcomes. These are usually identified in the therapy session and are useful in that they are directly available to the client for the performance of new meaning. Future and unique outcomes are also used to help the client identify his or her plans to escape the problem.

The use of externalizing the problem and identifying unique outcomes helps clients to assume responsibility for the problem. By assuming responsibility clients can become more aware of their relationship with the problem and better able to describe this relationship. The techniques are also useful in helping clients challenge other practices, which are cultural in origin, that are objectifying of persons (White & Epston, 1990).

The use of stories is another important technique used by narrative therapists. This approach is designed to lead clients to an understanding that there are varying perspectives instead of certainties. White and Epston suggest that the therapy that is making use of this technique would take a form that:

-privileges the person's lived experience;

> -encourages a perception of a changing world through the plotting or linking of lived experience through the temporal dimension;
> -invokes a subjunctive mood in the triggering of presuppositions, the establishment of implicit meaning;
> -encourages polysemy and the use of ordinary poetic and picturesque language in the description of experience and in the endeavour to construct new stories;
> -invites a reflexive posture and an appreciation of one participation in the telling and re-telling of one's story;
> -acknowledges that stories are co-produced and endeavours to establish conditions under which the subject becomes the privileged author;
> -consistently inserts pronouns "I" and "You" in the description of events.
> (White & Epston, 1990, p. 82)

The intervention techniques used in the solution-focused and narrative models are further discussed in the case studies in Chapter IV.

The Client System

This writer received all of her clients through the FASA referral process. The total number of clients referred was ten however, the number discussed in this report will be five as the other five did not attend enough sessions for this writer to do an adequate assessment and/or intervention.

The five client systems consisted of one parent-teen dyad, one adolescent dyad, one adult and two families. The clients referred themselves to FASA on advice from Child and Family Services, Victim Services, private therapists and a school therapist. All client systems had one child in the family who had been the victim of a sexual assault.

In each case, the offender was not in the home and the assaults had

ceased. Of these five client systems, the two families completed their treatment program at FASA. The one adult system terminated just prior to completion, the adolescent dyad system terminated at the request of parents and the adult-adolescent dyad terminated at the request of the adolescent. At least one member of each client system completed the pre-test, but only the two families completed the post-tests.

The duration of the treatment process as well as the content was individualized with each client system and will be discussed in detail in Chapter V of this practicum report.

Supervision

This writer met with Marlene Richert, the program Manager of FASA on a weekly basis for the purpose of supervision. Supervision was also received from the FASA team during the clinical meetings and from Harvy Frankel at the University of Manitoba. Some sessions were video taped for this purpose.

Evaluation Process

Linking the therapeutic interventions with actual change was one of the goals for the practicum experience. To this end clinical evaluative measurement tools were utilized as well as clinical impressions to evaluate change.

The measurement tools used in this practicum had been previously selected by New Directions for Children, Youth and Families who were in the process of evaluating the service provided by the FASA program.

The children were asked to complete the Children's Depression Inventory (Kovacs, 1992), the Self-perception Profile for Young Children (Harter & Pike, 1983) and the Pictorial Scale of Perceived Competence and Social Acceptance for Young Children (Harter, 1985) depending on their age. The Children's Depression Inventory assesses the extent to which a child shows depressive symptoms, while the Self-perception Profile for Young Children and the Pictorial Scale of Perceived Competence and Social Acceptance for Young Children assesses their perception of their self-worth and looks at domain specific judgements of their competence.

The parents were asked to complete the Revised Behavioural Problem Checklist (Quay & Peterson, 1987) and the Family Crisis Oriented Personal Evaluation Scales (McCubbin, Olson & Larsen, 1981). The Behavioural Problem Checklist was used to screen behavioural problems or disorders with their children while the Family Crisis Orientated Personal Evaluation Scales was used to identify problem solving and behavioural strategies used by families.

Clients were asked on a voluntary basis to complete the pre-tests during the first or second session and post-tests during the final session. Three out of five of the client groups completed the pre-tests but only two of the client groups came in for the final sessions and completed the post-tests. Although it would have been preferable to have a complete analysis from all the client groups in order to accurately measure the effectiveness of the interventions, it is this writer's opinion that the pre-tests in conjunction with clinical impressions can

provide an adequate if somewhat limited summary of the clients' progress in treatment.

Measures

Children's Depression Inventory (CDI)

As stated in the Children's Depression Manual by Kovacs (1992) , the Children's Depression Inventory is designed for school-aged children and adolescents. It requires the lowest reading level of any measure of depression for children. The instrument quantifies a range of depressive symptoms, including disturbed mood, hedonic capacity, vegetative functions, self evaluation, and inter-personal behaviours. Several items concern the consequences of depression in contexts that are specifically relevant to children. The scale is suitable for children ages seven to seventeen years.

The CDI short form which was used in this practicum was developed to provide an easily measured, empirical assessment of the extent to which a child exhibits depressive symptoms, but either version will generally give comparable results. Reliability was tested for in the CDI form.

> The purpose of testing for reliability is to determine whether a second administration of the instrument, or responses to similar items would yield substantially the same results. Test-retest reliability refers to the temporal stability of the ratings. Test-retest reliability is a function of both the actual reliability of the child's behaviour, and extraneous conditions that may be introduced. Internal consistency reliability refers to the fact that all items on the same scale consistently or reliably measure the same dimension. Internal consistency can be measured with an overall summary coeff (the alpha co-

> efficient) or with a series of total correlations. (Kovacs,1992, pg. 37)

The Alpha Coefficients of reliability that have been reported for the CDI in various samples show the reliability co-efficient to be from .71 to .89, which indicates good internal consistency of the instrument.

In the Children's Depression Inventory Manual, Kovacs (1992) shows the item - total score correlations for three samples of youths. The CDI's internal consistency is shown to be psychometrically acceptable. Regarding test-retest reliability, the research indicate the CDI has an acceptable level of stability (Kovacs, 1992).

As stated in the CDI Manual by Kovacs,

> The validity of an instrument refers to the extent to which it correctly measures the construct(s) that it purports to assess. There is no absolute way of knowing that the scale actually measures a construct, since the construct can never be measured perfectly. Because it cannot be directly assessed, validity must be inferred. Ultimately, one wishes to demonstrate that there is construct validity or that the underlying characteristics being assessed are real. To demonstrate the validity of scales which measure constructs that cannot be directly observed, one must rely on assessments of whether the scale correlates with other scales purported to measure the construct (convergent validity), does not correlate with scales not purported to measure the construct (discriminant validity), predicts appropriate criterion behaviours (predictive validity), has an interpretable item content (face validity), correlates in a theoretically consistent way with other concurrently administered scales (concurrent validity), and correlates with observable criterion behaviours (criterion validity). To say that a scale, or an instrument, is valid rests upon the weight of accumulated evidence from a number of validity studies using various methodologies.

(Kovacs, 1992, p. 37)

Having been used, in hundreds of clinical and experimental research studies since its initial development the validity of the CDI has been well established using a number of different techniques. Overall, the evidence gained from this literature is that the inventory assesses important constructs which have strong explanatory and predictive utility in the characterization of depressive symptoms in children.

Self-Perception Profile for Children

As stated by Harter (1995) in the manual for self-perception profile for children. This measure was devised in order to tap children's domain-specific judgements of their competence as well as a global perception of their worth or esteem as a person. Thus, the scale taps three competence domains, (cognitive competence, social competence, athletic competence), as well as one's sense of global self-esteem or self-worth. These four sub-scales each yield a separate score, allowing one to examine a profile of the child's evaluative judgements. Underlying the construction of the scale was the assumption that an instrument providing separate measures of one's perceived competence in different domains, as well as an independent assessment of one's global self-worth, would provide a richer and more differentiated picture than those instruments providing only a single self-concept score.

In the manual for the self-perception profile for children Harter (1995) states that the reliabilities for internal consistency, as based on Cronbach's

Alpha range from .71 to .86 and are considered acceptable. The validity of this instrument was not discussed by Harter (1995).

The Pictorial Scale of Perceived Competence and Social Acceptance for Young Children by Harter and Pike (1983) was designed to be a downward extension of the perceived competence scale for children described above. The scale comprises of four separate sub-scales: cognitive competence, physical competence, peer acceptance and maternal acceptance.

Revised Behaviour Problem Checklist

As stated by Quay and Peterson (1987) in the manual for the Behavioural Problem Checklist the RBPC is widely used for a variety of purposes including screening for behaviour disorders, as an aid in clinical diagnosis and as a measurement of behavioural change. The RBPC consists of five scales: Conduct Disorder (CD), Socialized Aggression (SA), Attention Problems (AP), Anxiety Withdrawl (AW) and Psychotic Behavioural Motor Excess (PB) . It has been available since 1967 and a revision was undertaken in 1980 to strengthen its psychometric characteristics. The BPC has been the focus or was used in some manner in more than 100 published studies. The psychometric characteristics of the RBPC were tested using six samples representing a broad range of deviant behaviours and an age range from five to twenty-three.

Internal consistency of the individual scales was checked by noting the extent to which scale contributed to the alpha reliability in a number of samples. In one sample the ratings from two teachers were obtained on a small

subsample (n=9) of a large number of students in a public school for the seriously emotionally disturbed. The correlations were .87 for CD, .59 for SA, .74 for AP, .64 for AW and .70 for ME. All were significant at .05 or beyond. Test-retest reliability was checked using a sample of 149 children in grades one through six that were rated by their teachers in October and again two months later. The stability correlations were .63 for CD, .49 for SA, .82 for AP, .79 for AW, .61 for PB and .68 for ME. For all the scales except PB, the scale means were significantly lower at the time of the second rating, however this may reflect a combination of other factors (Quay & Peterson, 1987).

To establish the concurrent validity of the scales against the dichotomy of clinical versus normal, normal children in grades one through six were contrasted with a much more limited number of clinical cases. The difference between the means of all six scales of the two groups was substantial and all but one was significant at beyond the .01 level. For boys a multiple discriminant function (into which all scales entered) correctly classified eighty six percent of all cases. Seventy-seven percent of the clinical group were correctly classified (sensitivity) as were eighty seven percent of the normals (specificity). Twenty-three percent of the normal group were misclassified as normal (false negatives) while thirteen percent of the normals were misclassified as clinical (false positives). Construct validity was established by validating the scales against other rating scales. Their association with other types of measures have also been assessed (Quay & Peterson 1987).

"The user of the RBPC has recourse to a number of comparison groups against which to interpret individual (or group) scores. The most appropriate reference sample to use is a function of the setting and the reasons for assessing the individual" (Quay & Peterson, 1987, p. 12).

In this practicum report the results of the writer's client scores will be compared to the clinical versus non clinical samples provided in the RBPC manual (Quay & Peterson, 1987). As there are too few samples in the practicum, T-scores cannot be extrapolated. The scale used for comparison that best fit this writer's sample is table 20 scale means and SDs for inpatient and outpatient clinical cases rated by parents (Quay & Peterson, 1987, p. 31).

Family Crisis Oriented Personal Evaluation Scales (F-Copes)

The family crisis oriented personal evaluation scales(F-Copes) was created by McCubbin, Olson, and Laren (1981) to identify problem-solving and behavioural strategies utilized by families in difficult or problematic situations. The instrument features thirty coping behaviour items which focus on the two levels of interaction:

> (1) Individual to family systems or the ways a family internally handles difficulties and problems between it's members and (2) Family to social environment, or the ways in which the family externally handles problems or demands that emerge outside it's boundaries, but affect the family unit and members. (McCubbin, et al., 1981, p. 195)

The alpha reliability for the F-Copes is .77. This was determined through a sample drawn from a University of Minnesota class with a combined population

of undergraduate and graduate students. The class was asked to administer the test to their families and friends. Cronbach's Alpha was computed on each factor separately and on the total scale. The alpha reliability for the entire scale is .77. A test-retest reliability study was conducted at a later date. The alpha reliability of the total scale is .71 (McCubbin, et al., 1981)

The validity was checked by using the same sample and splitting it into two halves. Factor analysis using varimax rotation was completed on the first half. The factor structure showed to be very similar to the initial factor analysis. Cronbach's alpha was computed for each factor separately and for the total scale on the sample. The same procedures were calculated on the second half which replicated the findings. The overall alpha reliability for the first sample was .86 and for the second was.87 (McCubbin, et al., 1981). The F-Copes has been studied with several thousand respondents, although specific demographic information was not reported (Fischer & Cororan, 1994).

CHAPTER IV

CASE REVIEWS

Introduction

The following five case reviews illustrate a solution focused and narrative framework and the use of evaluation instruments as undertaken in this practicum. All identifying details have been changed to ensure client confidentiality. The format for describing the cases will be as follows:

- Source and reason for referral
- Background information
- Assessment
- Treatment goals
- Intervention
- Evaluation and case conclusions
- Case analysis

Case "A"

Reason for Referral

Alice called the FASA Program on the advice of her Child and Family Services worker, after her two sons, Bob and John disclosed a sexual assault. Bob, age six and John, age seven disclosed to their mother that a friend of theirs, Carl, age seven had sucked their penises. The incident had taken place approximately five months previously, however the boys had only disclosed the week of the referral.

Background Information

This family consisted of the mother, Alice and her four children, George, age twelve, Beth, age eleven, John, age seven and Bob, age six. Alice and the children had moved to Winnipeg from another province two years previously. Although all of Alice's extended family resides in the province she left, she did have some friends in Winnipeg from when she had lived here previously. The reason for the move was based on wanting a "clean start".

Alice's family history is plagued with sexual abuse and alcoholism. Her step- father sexually assaulted her for much of her youth and although the family seemed to support her after disclosing this abuse Alice did not feel a sense of resolution and raised concerns about how she was having difficulty separating her sons' sexual assaults with her own victimization.

Alice stated that as a result of her own abuse and other dysfunctions in her family, she ended up on a destructive path that included her own drug addiction and subsequent inability to take care of her then, only child George, which resulted in him being placed in care. As a result of this placement Alice began a program through Narcotics Anonymous and at the time of this writer's involvement she had been straight for ten years.

Despite being drug-free Alice was unsuccessful in attempting to parent George when he was returned to her care. By this time she had three more children and did not have the attachment to handle George who was experiencing behavioural difficulties due to being in and out of care and being

diagnosed as ADHD. The final time George came back into care was after he was returned to her and they had moved to Winnipeg. Alice stated that now she is accepting of the fact that George will never live with her and has an overriding fear that should she not cope and lose the other three children she will never get them back.

At the time of moving to Winnipeg, Alice entered into a common-law relationship that ended just prior to the sexual assault. She stated that they continue to see one another, but that he was not accepting of the children and at times was physically and emotionally abusive towards them. From the information received from Alice, this relationship seemed to fit the pattern of her previous relationships with abusive and controlling partners. Regarding past relationships Alice stated that none had been healthy. All of her children have different biological fathers, none of which are involved in the children's lives now.

Presently, Alice describes her home life as very chaotic. She does not feel that she is a "good" mother and sees herself as being short-tempered and disinterested in doing things with her children. This was a concern for Alice as she stated on many occasions that she wanted to increase her parenting skills and have a happier home life. She had taken steps to do this through parenting courses and a teaching support worker which she had accessed through Child and Family Services.

At the time Alice came to see this writer she was on social assistance and

had not been in the paid work force for several years. This too was troubling for her as she expressed a desire to work in the field of auto mechanics, which was a life long dream.

Assessment

This writer initially met with Alice and her two sons. Both boys were open and willing to discuss the sexual assault and demonstrated a healthy, age appropriate understanding of this occurrence. Alice however, presented as being distraught and angry and described several complaints that she believed were the result of what had happened to her sons. Alice stated that she was blaming herself for not "street proofing" the children better, and that the boys' victimizations were bringing up her own past abuse issues, which she felt were not resolved because she had not received counselling. As a result, Alice was determined that her sons should have therapy, but also expressed resentment that they should be getting help when no one helped her.

Through the assessment phase this writer used a solution focused approach by first listening to Alice's complaints, determining what happened and what she had done to solve the problem. Questions centred on what had changed since the assault and what she and the boys needed in order for therapy to be helpful to them.

Alice was able to identify that her ability to parent effectively had been hampered by the assault. She stated that though she had always experienced difficulties in this area, they had increased to the point where she was

concerned that the child welfare authorities would intervene. Examples given by Alice were: not getting up to feed, dress and send the children off to school; going to bed early and making Beth who was only eleven responsible for making supper and putting the boys and herself to bed; and generally being very short tempered to the point of yelling and at times striking the children. Alice further noted that since the assault, she had begun to envision using past unhealthy coping mechanisms that she had utilized when she was being abused. Thus far she had not used these with the boys but she had contemplated them. One example of this was of Alice bathing herself in hot water with Javex after an assault.

When this writer discussed with the boys what had changed and what they would like to see happen, the boys were able to identify that they would like their mother to spend more time with them. They stated that this was something they had been feeling for a long time but felt the distance between themselves and their mother had been increasing. From this line of questioning, Alice and her sons were able to move from focusing on the complaints in their lives and begin to look at solutions.

Treatment Goals

From the information gathered in the assessment phase this writer assisted Alice and her sons to identify the goals they wanted to work on. The goals identified by Alice were to:

- ensure her children were not emotionally harmed by the assault.

- ensure her children had the necessary understanding of what had happened and the skills to protect themselves should someone attempt to victimize them again.
- address her own past issues so that they did not continue to interfere with her present functioning and ability to care for her children.

The goal identified by the boys was simply to spend more time with their mother.

After determining what the family saw as the problems and what goals they wanted to work on, this writer collaborated with Alice and the boys on coming up with a mutually acceptable name for their problems. In this case the family decided on bad thoughts. Through the use of externalizing, "bad thoughts" became the problem and the goals then merged into how to get rid of "bad thoughts" which were interfering with Alice's ability to care for the children and spend time with them in a meaningful way.

Intervention

The techniques utilized were determined from the goals. With the use of formula tasks developed by the BFTC, Alice and the boys were first asked to identify what was happening in their home that they wanted to have continue. Alice identified times when she was able to interact with her children without "bad thoughts" interfering. She knew that this was happening because she would have fun and play with the children and would have energy to do parenting tasks such as cooking, cleaning, etc. The family was asked if there was a miracle and the problem was solved how would they know. All were able

to expand on the times that Alice was not angry or frustrated and was parenting consistently.

The use of scaling questions was used throughout the intervention phase to determine if the problem was shrinking. During each session this writer would ask Alice to quantify the problem on a scale of one to ten with one being no improvement and ten being no more problem. Through the use of scales questions Alice was able to discuss the progress that she felt was being made.

Compliments were used by this writer to ensure a positive climate and focus in the sessions. Compliments were also used to enhance responsibility (e.g., giving the family credit for changing, enhancing resources, strengths, empowering). By using this technique, Alice's fears about change diminished and her struggles and efforts were validated. This technique also helped Alice and the boys reframe their different views of what was happening in the home in a more constructive manner so that they could be mutually supporting.

This family was involved in the therapy process for several months. The first sessions involved working with the boys around the sexual assault. Therapy was centred on assisting them process what had happened so that they would not be further traumatized by the event. They also received some education and safety planning to prevent a recurrence of the abuse and to give them some confidence that they had more control over their lives.

The sessions after this were attended only by Alice and consisted of working with her to help her separate her own abuse issues from what had happened to her sons, and to help her make the changes she wanted to regarding her parenting. In these sessions, concrete and measurable tasks were always given at the end and evaluated at the beginning of the next session. Two examples are: make a plan (and follow through) to do something fun with your family next week and begin a journal around your own abuse and allow yourself one hour a day to think and write about this. As the sessions continued, Alice and this writer worked on identifying outside supports and resources that Alice felt would benefit her in reaching goals. The task at this stage was for Alice to increase her support network so the problem of "bad thoughts" would continue to shrink. This writer and Alice decided on two resources that Alice would need to continue on with. The first was that of individual or group counselling for adult survivors of sexual assault and the second was a parenting support group that would help give her the support of other parents and help her increase her parenting skills.

The final sessions included all the family members and focused on the positive changes that were occurring. The family was able to problem solve issues that were coming up within the family in a more supportive manner. Although Beth continued to provide some respite for her mother, Alice had begun to resume the majority of the parenting responsibilities and it was agreed that "bad thoughts" were not the problem they used to be.

Case Conclusions

Termination of the therapeutic relationship was mutually agreed upon by this writer and the family. Total number of sessions was twelve. The initial goals set out had been realized, at least to the extent that this writer could continue to be beneficial. It was this writer's opinion that the boys would not benefit from further therapy regarding the assault and that Alice had a much healthier understanding of the boys' issues and needs. As stated, it was decided that Alice would continue group counselling to work on her own abuse issues and that she could also benefit with some parental supports. At the time of termination Alice had been accepted into two groups for these issues.

Evaluation of Measures

Using the Revised Behavioural Checklist Alice's pre-test scores on John (see table 1 on p. 51) showed that Alice assessed John as being within the range in the CD, SA, and AW categories for the problem group. In the AP, PB, and ME categories she assessed John lower than the problem group so in these categories he fell below the problem group norm.

Using the Pictorial Scale of Perceived Competence and Social Acceptance Scale one can note that John's perception of himself improved from the pre-test to the post-test and that he generally scores himself to be in the above average category with his only area of difficulty being maternal acceptance in the pre-test phase (See table 2 on p. 52).

Bob scored himself as slightly above the average in all categories which

Table 1

Revised Behavioural Checklist

Name: Alice

	Pre-test (John)	Norms (Clinical)
Conduct Disorder (CD)	13	20.4 (10.58)
Socialized Aggression (SA)	3	3.61 (5.00)
Attention Problems (AP)	1	12.27 (6.87)
Anxiety Withdrawl (AW)	10	6.94 (4.77)
Psychotic Behavioural (PB)	0	2.70 (2.65)
Motor Excess	0	4.63 (3.02)

Table 2

The Pictorial Scale of Perceived Competence and Social Acceptance for Young Children

Name: John

	Pre-test	Post-test
Cognitive Competance	2.5	3
Peer Acceptance	3.2	4
Physical Competence	3.5	3.8
Maternal Acceptance	1.8	2.8

can be construed as a strong sense of self (See table 3 on p.54).

In analysing Alice's scores for the F-Copes measure (see table 4 on p. 55) one can note that most of Alice's scores in the pre and post-tests fall within the range expected for the normative population. This indicates that Alice's reporting of the coping behaviours in her family is consistent with how most non-distressed families cope. The exception for Alice is in the seeking spiritual support subscale in which she scored lower that the normative population on the pre-test.

Case Analysis

This case was quite challenging as it presented some very complex issues. A major difficulty for this writer was how to keep separate the sexual assault of the boys from the previous sexual victimization perpetrated against the mother when she was a child. Alice's needs regarding her own issues were so great that she often had difficulty making the boys the priority in treatment.

The most effective solution for this problem was to allot separate times to discuss the past and the present. By doing this, Alice felt free to talk about herself without feeling any added guilt, that she should always be focused on the children.

A second issue that presented itself in therapy was overcoming Alice's belief that her children had been permanently damaged as a result of the assault. Because Alice was continuing to struggle with her own abuse issues, she believed that this would also occur for her sons. What worked well in this

Table 3

The Pictorial Scale of Perceived Competence and Social Acceptance for Young Children

Name: Bob

	Pre-test	Post-test
Cognitive Competance	3	
Peer Acceptance	3.2	
Physical Competence	3.5	
Maternal Acceptance	3.2	

Table 4

F-Copes (Family Crisis Oriented Personal Evaluation Scales)

Name: Alice

	Pre-test	Post-test	Norms
Acquiring social support	25	31	27.2 (6.4)
Reframing	24	26	30.2 (4.8)
Seeking spiritual support	8	11	16.1 (3.05)
Mobilizing of family to acquire and accept help	19	17	11.96 (3.4)
Passive appraisal	13	13	8.55 (3.01)
Total	89	98	93.3 (13.62)

situation was to attribute Alice's abuse issues to the lack of treatment after her abuse. By doing this, Alice was able to identify that the long term prognosis for her children had the potential of being very different than hers, as the boys were receiving the support and services she never did.

This issue recurred throughout the therapy process and it was difficult to separate the two abuse issues. This writer wonders if it might not have been more effective to refer Alice for her own individual therapy at the onset of the family therapy. By doing this Alice might have been more able to address the present day problems, while being supported in addressing her past issues. This could have been a disadvantage if Alice was not able to cope with parallel therapies.

It is this writer's opinion that this family worked diligently in therapy and made significant progress. However there was always a concern during the treatment process that Alice might backslide and begin again to use unhealthy coping mechanisms. These mechanisms had been physically destructive and painful so it was important to prevent Alice using them on herself or the boys. This writer safety planned with Alice over these issues and discussed how she was managing regarding this, at almost every session. This method was like a reality check and helped Alice not to move from the fantasy stage, which was thinking about doing things that were harmful, into a planning stage.

In looking at this case from a feminist perspective this writer was able to help Alice lift the burden of blame, guilt and individual responsibility that she had

been carrying on her shoulders regarding both her own victimization and that of her sons. This was done by refusing to define Alice's struggles as individual pathology and to re-define them in the context of the ongoing acceptance of violence society has towards women and children.

The feminist perspective was also used throughout the therapy process by this writer through a sharing and re-defining of the personal and political struggles Alice was experiencing in her life. By validating Alice's life experiences in a manner that was respectful, this writer was able to develop a relationship with Alice that was based on a mutual collaboration of therapy that included a healing process, an educational process, and a political process.

Case "B"

Reason for Referral

Gene called the FASA Program on the advice of the school counsellor because his son, Bill, age eleven had been sexually assaulted on two separate occasions. The sexual assaults and initial disclosures had taken place seven months previously. The assaults consisted of two occasions in which Bill was held down in the school yard by approximately eight same age boys and had his clothes taken off. During the second assault one of the boys fondled Bill's genital area.

Gene was concerned that Bill had not received any help or support from the school after the incidents and felt that he and the family needed help to deal with what happened.

Background Information

This family unit consisted of the father, Gene, the mother, Marion and their eleven year old son, Bill. The family was middle class and lived in their own home in a suburb of Winnipeg.

Bill had been attending the same school for the last several years and although academically he was functioning at an age appropriate level, socially he was seen as being somewhat delayed. The family and school reported that Bill had difficulty interacting with his peers and was seen as a bit of a loner. In the last two years, however, this seemed to have intensified in that Bill reported only having one friend and that the other children at school either bullied or

made fun of him. The one friend that Bill did have also was an outcast in school and because he had behavioural difficulties was often not let out at recess. This left Bill on his own for much of the time.

Outside of school, Bill was involved in many community and sports activities. The parents stated that he seemed to do much better in making friends on these teams and that he did not experience the same sort of hostility he was receiving from the boys at school.

The family presented as being quite close and nurturing to one another. Gene had been in an auto accident seven years ago and had suffered a head injury. As a result, his level of functioning was impaired and he was forced to leave his place of employment. Although Gene suffered permanent brain damage and his level of functioning was impaired he has found new employment and seems to be functioning quite adequately. It was evident that Marion and Bill are very supportive of Gene and have obviously taken great measures to overcome this tragedy. Marion is employed in a professional capacity and is the major wage earner in the household.

The family reported having few intimate supports in the city, as both of their families resided in rural areas. Social interaction was mainly between the three of them, and on a more casual basis through Bill's extra-curricular activities and Gene's community activities involving Society for Manitobans with Disabilities and the Head Injuries Association.

Assessment

Initially this family sought therapy because they thought that this is what should happen after such an occurrence. The family presented as being very close to one another, which was evidenced in the warmth and respect they showed during their interactions.

The initial complaint was about how the system had failed to protect Bill and then deal with the situation in an appropriate manner. Gene and Marion were very frustrated that the school personnel treated the incident as unfortunate and inappropriate, but did not believe it was criminal or serious in nature. The school did follow protocol by contacting both the police and the child welfare authorities but neither was able to intervene. The police could not charge the offenders because they were under twelve and the child welfare agency concluded that this was a school matter because the assaults were third party and outside of the home. As a result, the boys who offended against Bill were punished by the school in a manner that merely reflected inappropriate playground behaviour. Bill was never spoken to by anyone from the police or child welfare and the school principal only spoke to Bill to advise him that from now on he should wear jeans instead of track pants to school, as one of the offender's defences had been that Bill's pants had come off unintentionally during some roughhousing.

Each family member described how the incident had disrupted their lives. Gene described his anger and frustration at the system and how this had

affected him. He stated that prior to this he believed the school would ensure his son's safety and that not only had they not done that, but he felt they were minimizing the incidents and were attempting to label him as a "problem parent" because he wanted something done about it.

Marion stated that she too was fearful for Bill's safety and that she did not know if she was acting appropriately as a parent in her concerns or if she was just being an overprotective mother.

Bill described school as lonely and more isolating since the incident. He wanted to make friends with his peers (minus the boys who had hurt him) but felt totally ostracized and ashamed.

All members of the family stated that this problem had disrupted their home life as well. Gene and Marion stated that fun and family time had been replaced by long discussions at home, with the school, and other parents over how to address the problem of the boys at school.

Although everyone had a different perception of how the problem disrupted their lives, all agreed that the best name for the problem was school. Immediately upon externalizing the problem, the family began to feel hopeful and stopped seeing themselves as failures. Gene and Marion were able to look at the problem not as something they had failed to do for their son, but as something that needed still to be done. The family was able to unite in this struggle and began to cooperate with one another to eliminate the problem.

Treatment Goals

The family set their goals for therapy based on their definition of the problem. Gene stated that he needed help to work through his anger. He decided that in order to do this he needed to better understand how the systems operate and where he as a parent can have input or make changes. Marion stated that she too wanted some satisfaction from the school. She felt the problem was affecting their home lives too much and she wanted some assistance in reclaiming this part of their lives. Both parents wanted some assurance from this writer that Bill was "okay".

Bill's goals were different then his parents in that he did not want to focus on the system or even the incidents. Bill simply wanted some friends.

Intervention

The intervention with this family started during the first meeting since it was obvious that this family had many strengths. This writer used their strengths as a focus and complimented them on how well they had done in the face of this problem. This was done to normalize the problem so that the family was able to regain their perspective.

In order to move from a problem focus to solutions, this writer used exception finding questions to determine when the problem was not a problem and what strategies they were using to produce change. Other solution-focused questions were " what is different about the times when the problem doesn't happen and what will you be doing in the future when the problem is solved? "

Although Gene was very angry, he had already started to use this in a positive way. Gene had met with the school a number of times and began the task of putting together a meeting for parents and the school to address the issues. As Gene became more involved in this process, he discovered that other children were also being harassed by this group of boys. This discovery was very "freeing" for Gene and Marion, as the focus was now taken off of Bill and put on the bigger issue of what was happening in the school. Another positive aspect of this was that no longer were Gene and Marion alone with their problem. Prior to this Gene and Marion had spent a lot of their time discussing the matter between themselves. Now Gene was meeting with other concerned parents during the day and so did not feel the need to talk to Marion all of the time about how he was feeling. Marion though involved with some of the meetings was happy to let Gene take control and focused her energy on restoring their home life.

Tasks were assigned to Gene and Marion to help them build on the work they were already doing. Gene was encouraged to continue to work towards producing change within the school while both Gene and Marion were given the task of "taking a vacation" from the problem during certain times at home. These tasks helped Gene and Marion concentrate on the problem in a solution-focused manner at appropriate times and also gave them permission to not deal with the problem when they were asked to take a vacation from it.

As the sessions moved on, Gene and Marion were reclaiming much of

their family time and were also producing positive change in the school. As the therapy continued, this writer's role developed into supporting and collaborating with Gene and Marion in their efforts to overcome this problem. The resources and strengths in this family were constantly identified so that Gene and Marion could continue to build on what they were doing. At the beginning of each session, Gene and Marion were asked scaling questions to determine progress and change. This served to first identify and deal with any possible blocks and secondly allowed Gene and Marion to see where they were in the process of reaching their goals.

Bill's therapy began with discussing the sexual assaults. Questions centred around his perception of the events, what he wanted to see done and what he needed for himself now. Again, the technique of compliments was used to help Bill normalize the experience and to set a positive climate. In therapy, Bill was given permission to tell his story without fear about how his parents or the school would react. Prior to this, Gene's anger and Marion's concern had prevented Bill from speaking freely. The use of a solution-focused approach helped Bill to focus on where he wanted to go from here. Bill was able to identify that he wanted justice for what this group of boys had done to him, and that he wanted to feel supported that this was not his fault by both the school and his parents. This work was soon accomplished by discussion with his parents and through the meetings with the school and other parents. Bill could finally see that the boys were being held responsible and accountable.

The "miracle question" was utilized to assist Bill in strategising about how he could reach his goal of having some friends. Bill was able to describe certain children in other classes that he would like to play with and also what he would be doing with them. The tasks for Bill in between sessions were to ask these children if he could join them when they were playing and/or to ask them if they wanted to do a certain activity that he had listed in therapy. Scaling questions were utilized to check on possible blocks and progress, and any small successes were praised by this writer to alleviate fears and to encourage change. Bill soon found that many of these children wanted to be his friend and felt much the same way about the group of boys that had been terrorizing him as he did. He soon developed an active social life at school and both parents and Bill remarked on the noticeable difference in how Bill felt about himself.

Case Conclusions

Termination of the therapeutic relationship was mutually agreed upon, but needed to be reinforced by this writer as the family was fearful that they could not manage without it. Total number of sessions with this family was sixteen. This writer reiterated to them that they were the ones that had found the solutions and that the positive changes would continue as the strengths and resources they had developed to manage the problem were within themselves.

In reviewing the goals that were initially set, everyone agreed that they had been met in a manner that surpassed their expectations. Everyone recognized that in order for the problem not to grow again it would need to be

continually addressed and not only within the family. Outside people such as the school and other parents would need to stay involved for the solution process to continue and the final sessions were focused on how to accomplish this.

This family had come to therapy feeling overwhelmed by what had happened to their son and with a sense of powerlessness to address the inequities. Through the therapy process they were able to reclaim healthy patterns and used the traumas as impetus for positive change both within their own family and larger systems.

Evaluation of Measures

The scores for the Revised Behavioural Checklist were significantly different between Marion and Gene (see tables 5 & 6, on pgs. 67 & 68). Marion rated Bill below the clinical cases in the SA, AP, AW, and ME categories. She scored Bill to be in the clinical range in the PB and SA categories and believed Bill had moved from the clinical range to below it in the CD category.

Gene rated Bill to be within the sample of the clinical cases in all categories except in the CD category in which he placed Bill's behaviour as lower than the sample in the post-tests.

In using the Self Perception Profile for Children measure (see table 7 on p. 69) it can be seen that Bill generally fits within the range of the sample population of average students in both the pre and post-tests. The exception to this is in the social acceptance subscale in which Bill rated himself below the

Table 5

Revised Behavioural Checklist

Name: Marion

	Pre-test	Post-test	Norms (Clinical)
Conduct disorder (CD)	10	5	20.4 (10.58)
Socialized aggression (SA)	0	0	3.61 (5.00)
Attention problems (AP)	1	1	12.27 (6.87)
Anxiety withdrawl (AW)	1	2	6.94 (4.77)
Psychotic behaviour (PB)	0	0	2.70 (2.65)
Motor excess (ME)	0	0	4.63 (3.02)

Table 6

Revised Behavioural Checklist

Name: Gene

	Pre-test	Post-test	Norms (Clinical)
Conduct disorder (CD)	13	8	20.4 (10.58)
Socialized aggression (SA)	2	0	3.61 (5.00)
Attention problems (AP)	7	7	12.27 (6.87)
Anxiety withdrawl (AW)	5	9	6.94 (4.77)
Psychotic behaviour (PB)	0	1	2.70 (2.65)
Motor excess (ME)	1	3	4.63 (3.02)

Table 7

Self-perception Profile for Children

Name: Bill

	Pre-test	Post-Test	Norms
Scholastic Competence Subscale	2.3	2.5	2.85 (.69)
Social Acceptance Subscale	1.6	3.5	2.94 (.71)
Athletic Competence Subscale	3.3	3.3	3.15 (.72)
Physical Appearance Subscale	3.2	4	3.07 (.72)
Behavioural Conduct Subscale	3.2	4	2.83 (.56)
Global Self-worth Subscale	2.2	3.5	3.19 (.69)

norm in the pre-test.

In the Children's Depression Inventory Bill's T-scores were 56 at the pre-test level and 41 at the post-test level (See table 8 on p. 71). Both these scores indicate a normal pattern and as the score lowered at the post-test level it can be stated that Bill's depressive symptoms lessoned at the end of therapy.

In analysing the F-Copes measure that were completed by Gene and Marion, (see tables 9 & 10 on pp. 72 -73) one can see that both parents' scores on the pre and post-tests fall within the range expected for the normative population. These indicates that Gene's and Marion's reporting of the coping behaviours in their family is consistent with most non-distressed families. The only exception to this is in the AP category for Marion, in which she rates the family's coping abilities as higher than the normative population in the pre-test.

Case Analysis

This writer found this family very exciting to work with. The family had many strengths upon which to build on and were very motivated to change. Because the problem was not between family members, but outside of the home, this writer had the opportunity to act as a partner with the family in dealing with the problem. This role was one that this writer found very comfortable and so was able to engage with this family very quickly. It is interesting that a therapist often has many roles within the confines of providing therapy. A therapist may be a support, guide, advocate or collaborator. This became particularly apparent while working with this family, as the role this

Table 8

Children's Depression Inventory

Child's Name: Bill **Child's Age: 11**

Pre-Test T-Score	58
Post-Test T-Score	41

Table 9

F-Copes (Family Crisis Oriented Personal Evaluation Scales)

Name: Gene

	Pre-test	Post-test	Norms
Acquiring social support	18	22	27.2 (6.4)
Reframing	29	31	30.2 (4.8)
Seeking spiritual support	15	15	16.1 (3.05)
Mobilizing of family to acquire and accept help	18	18	11.96 (3.4)
Passive appraisal	18	18	8.55 (3.01)
Total	98	104	93.3 (13.62)

Table 10

F-Copes (Family Crisis Oriented Personal Evaluation Scales)

Name: Marion

	Pre-test	Post-test	Norms
Acquiring social support	16	32	27.2 (6.4)
Reframing	31	31	30.2 (4.8)
Seeking spiritual support	10	13	16.1 (3.05)
Mobilizing of family to acquire and accept help	12	16	11.96 (3.4)
Passive appraisal	14	16	8.55 (3.01)
Total	83	108	93.3 (13.62)

writer assumed was significantly different than with the other families that are discussed in this report.

There are two difficulties that stand out from working with this family. The first was a frustrating lack of response from the school. This writer often felt a sense of powerlessness in the role of advocate because recognition from the school to address the problem was very slow.

The second difficulty was understanding and dealing with the limitations Gene had because of his head injury. During therapy, Gene presented at times with erratic behaviour and thoughts and it was a struggle not to let Gene take over the sessions. He would start talking about one idea that was not relevant to the discussion and would not be able to let it go. This writer had to be very assertive with Gene to keep him on track and to ensure that Marion and Bill received equal time to speak. This was a difficult task at the beginning of therapy, but became easier after the FASA team viewed a session behind the one way mirror and validated and encouraged the method being used to combat this issue.

It was extremely gratifying on both a personal and professional level when this family completed therapy. The family had worked hard on the problem and had overcome many obstacles in their pursuit for justice and peace within their home. The most rewarding moment for this writer however, was when the school began to work with these parents and when Bill came to therapy and announced that he had made a new friend.

This family may have been so successful in the therapy process because their middle class status gave them advantages that other less privileged families might not have known how to access. The family was able to articulate clearly their problem and had the abilities to seek out and utilize appropriate resources.

In using a feminist analysis of the situation this writer looked at the school as being an oppressive system. This required the family to take the problem from a personal family issue to a more global and political level. The injustices inflicted on this family were as a result of the sex role stereotypes that tolerate violence between boys and blame victims for the crimes committed against them.

By having a feminist understanding of society that recognizes the oppressive effects of patriarchy this writer was able to help this family link their personal struggles to within a political context and then worked with them to produce change.

Case "C"

Reason for Referral

Lisa, the mother of this family called the FASA Program on the advice of the Victims Assistance Program. Her youngest daughter, Diane age two had been the victim of a sexual assault, one month prior. The sexual assault consisted of fondling by a friend of Diane's father. It was witnessed by Sandy, Diane's older sister and the offender had already been charged, pleaded guilty and been sentenced to nine months in prison.

Background Information

This family consisted of Lisa, the mother and her two daughters Sandy, age fourteen and Diane age two . Fred, the father of Diane was still involved with Lisa, but at the time of referral he was not living in the home due to ongoing domestic violence.

Although Lisa was employed with the same company in a semi-professional position for the last eight years, she reported that she had been on stress leave for the last two weeks because of the sexual assault. She had no immediate plans to return to work.

Lisa reported that her home life was fairly chaotic. Sandy, herself a victim of sexual assault by her biological father when she was nine, was reacting negatively to what had happened to Diane and had become very challenging towards Lisa. Diane was having a difficult time dealing with all of the upheaval in the home, but did not seem to be adversely affected by the

assault and Lisa did not think she even knew what happened.

Assessment and Treatment Goals

This writer met individually with Lisa at her request. She did not think that Diane required therapy and though Lisa wanted Sandy to come with her, Sandy refused. Lisa reported that she felt her life was out of control and that the assault on Diane was the final blow. Prior to this, Lisa stated that she was struggling to hold things together. She had been working very hard on her relationship with Fred and felt betrayed by him when he had brutally assaulted her about four months previously. This betrayal was compounded by Diane's assault because he had the children visiting with him when this occurred and it was his friend who was the offender. Lisa could not shake the anger she felt towards Fred as she felt that once again he had broken her trust.

Although Lisa and Fred were no longer living together they continued to have contact, with Fred wanting to reunite. Lisa stated that she did not want this to happen and that she recognized that much of her stress and feelings of being out of control were due to this relationship. She also believed that Sandy was rebelling because she wanted Fred out of the home for good and that she did not believe her mother would follow through on her promises to do this.

Using scaling questions such as: "How over is the relationship with Fred?" and " how much did she, Lisa want the relationship over?" Lisa was able to identify that she saw Fred's continued involvement in her life as the problem, ending this relationship, she realized was what she needed to work on

in order to reclaim her lost sense of control. When asked what would be different if she knew it was over, Lisa replied that she could let go of her own feelings of betrayal and begin to mend her relationships with her daughters.

As a result of these questions Lisa and this writer determined that the focus of therapy would be to help Lisa regain her independence and decrease her sense of powerlessness.

Intervention

The initial intervention was structured around having Lisa identify times when things were okay at home and when she felt more in control. Lisa was asked to pay attention to what was different about these times and how long they lasted. This approach assisted Lisa in seeing that not everything was negative in her life and helped her focus on the strengths and positives so they could be increased.

Lisa and this writer worked on making small changes that Lisa identified. The successes allowed her to redevelop her self-confidence and her ability to move forward in a positive direction. As a result of a new sense of self -worth, Lisa began to distance herself more and more from Fred. She then started to report that things at home were much calmer. Lisa credited this to Sandy beginning to trust that perhaps this time would be different and Fred would not be returning.

This writer's role in the therapy process was to amplify and at times identify the changes Lisa was making. Within a short time, Lisa was reporting

that Fred was permanently out of her life, that much of the anger was gone and that she felt ready to go back to work.

Evaluation and Case Conclusions

At the point that Lisa was benefiting from the positive changes she had made she terminated the therapeutic relationship. Total number of sessions was eight. This writer would have preferred to stay involved for a further short time in order to reinforce the changes, and enhance Lisa's self-confidence. Although termination was slightly premature, the therapeutic relationship was no longer necessary since Lisa was identifying and making changes in her life without needing this writer's input.

Lisa did not complete the evaluation measures as she was not able to concentrate long enough to complete the pre-test and terminated prior to the post-test being administered.

Case Analysis

This case was very difficult on a personal level as this writer had to work very hard to separate her own personal issues and not rush in and rescue Lisa and her daughters. The guidance and supervision from the FASA team were critical for maintaining objectivity in this case. The team helped this writer to understand and process what was happening in a manner that was supportive and non-judgemental.

The case itself was difficult because of the trauma Lisa had experienced at the hands of her partner just prior to the sexual assault of her daughter. Lisa

required a high level of non-judgemental support to help her overcome these experiences. This was critical in working with Lisa because she was already suffering from low self-esteem from remaining with a partner who was physically abusive to her and had failed to protect their daughter from a sexual assault.

The focus throughout therapy was to help increase Lisa's sense of self-worth. By focusing on her strengths and her ability to continue to function in her role as mother to her children throughout the trauma, this writer was able to help Lisa regain confidence in herself again.

Therapy provided Lisa with support and guidance so that she would be able to make positive changes in her life. Although at times it was tempting to give Lisa advice, especially regarding her relationship with Fred, supervision with the FASA team made it apparent that inflicting another point of view on Lisa would not help her increase her self-esteem. To increase her self-esteem Lisa needed help in feeling a sense of control in her life. This accomplished by empowering her and validating how she felt and the directions she has chose.

In analysing this case from a feminist perspective, this writer recognized Lisa's need and right to be a functional, decision making person in society. The feminist perspective allowed this writer to share in the personal struggles in Lisa's life and helped her to place them in a political context in which women and children are oppressed through the structures of patriarchy and male dominance.

The therapy process with Lisa was based on the premise that Lisa had a vested interest in changing her situation and had the potential power to do so. This writer was able to help Lisa reclaim her sense of power through validating both her past life experiences and present day decisions.

Case "D"

Reason for Referral

Heather, the mother of this family, contacted the FASA Program on the advice of her private therapist. The reason for referral was that her teenage daughter, Angie had been found late at night by a passing motorist without shoes and only partially clothed. The incident occurred in winter and Angie was intoxicated at the time. Angie was denying that she had been sexually assaulted, however she had been at a party with older people and stated she had no recollection of events that led up to her being on the street in the state she was in. The police were investigating and believed an assault had occurred, but due to Angie's refusal to cooperate the investigation was not moving forward.

Background Information

There are two units in this family. Heather has been divorced from Angie's father, Doug for four years. They have three children together: Lloyd, age nineteen, Angie, age fifteen and Penny age eight. Although Heather has custody, Angie is residing with her father and his new wife. This decision was made by Angie and although it is not supported by Heather, she does not feel she can make Angie stay with her.

The relationship between Heather and Angie is very conflicted. Heather stated that this is a result of tension between herself and Doug and his belief that Angie can do no wrong. This belief, she stated, is the reason Angie is

living with her father. Heather holds Doug responsible for the sexual assault, as in her opinion he does not set appropriate rules and consequences.

Heather stated that in the last year there have been some major behavioural changes in Angie. Until the age of thirteen to fourteen Angie was doing well in school, was involved in community events and had a positive, supportive peer group. Now Angie's peer group is much older, she has little interest in school and has been picked up for drinking on two prior occasions. Angie does not deny the changes, however, she states that her mother is too strict and making too much of what she believes is not a big deal.

Assessment

Heather initially made the referral because she believed that an assault had taken place and that Angie was too afraid to disclose. Heather hoped that a confidential relationship with someone trained in this area would alleviate Angie's fears enough to talk about what had happened. Heather also wanted this writer to explore with Angie why she had made some of the changes she had, as Heather believed that Angie was having a difficult time dealing with the family situation and her present behaviour was as a result of this difficulty.

This writer met individually with Angie since she did not want her mother present. Angie stated that she was only attending therapy to make her mother happy and that there really was no reason for her to be there.

This writer joined with Angie by empathising with the problem of her mother and asking questions about how we could make this problem more

manageable. It was agreed that Angie would continue in therapy for a short period to see if this would alleviate the problem.

Treatment Goals and Intervention

Once the goal of dealing with the "problem" mother was determined, this writer asked questions about how often this was a problem, how long had it been a problem, and when was it not a problem. By externalizing Angie was able to answer these questions in a manner that was not blaming of herself or her mother. In therapy it was determined when the problem was small and when it was larger. Angie was able to identify that the problem grew in direct relation to her behaviour and that the reason it grew was because of her mother's concern and fear.

This writer and Angie then discussed how to keep the problem small. Angie was asked to identify what had worked in the past and what had not. From the answers given by Angie, tasks were developed to build on the times that the problem was manageable. Angie identified that her mom felt less anxious when Angie was talking about what was happening in her life, and so made a commitment to include her mother more often. Angie also identified possible blocks and strategies were developed to overcome them. The biggest block was that Angie was engaging in activities that she herself was not particularly happy about and she wanted to keep these secret from her mom. An example of this was the night in which Angie became intoxicated and was possibly sexually assaulted. Although this writer did not receive a disclosure

regarding a sexual assault, Angie was able to talk about how it felt not knowing what had occurred, her disappointment in herself and her fear of disappointing her mother. Angie came up with a plan to prevent this from occurring again and agreed to discuss this with her mom. This would provide her mom with some reassurance that the destructive path Angie had started on was not entrenched, and that Angie was making some changes to improve her life.

Case Conclusion

Unfortunately, it was not far into the intervention when Angie terminated the therapy sessions. Total number of sessions with Angie was four and total number of sessions with her mother was three. This writer would have preferred to stay involved longer in order to give her an opportunity to make some of the changes she had identified as necessary.

This writer met with Heather at the conclusion of therapy and while being mindful of confidentiality left Heather with a sense of hope and encouraged her to build on the communication aspect of her relationship with Angie. This writer and Heather further strategised on how Heather and Angie could overcome some of the family history that was affecting their present day lives. Both Heather and this writer agreed that many of the negative behaviours exhibited by Angie were in all probability a result of unresolved family issues. As these problem accumulated Angie reacted with distrust and anger at her mom for the divorce.

Although therapy ended prematurely, the therapeutic process did help

Angie and Heather to focus on strengths and positives and assisted them in developing some tools to expand on these strengths. The emphasis in the intervention phase was on how to increase the strengths and not to belabour the problem. It is this writer's opinion that Heather and Angie developed some useful tools that will encourage change in a healthy manner.

Evaluation of Measures

In using the Self-Perception Profile for Children measure one can note that Angie's perception of herself is within the range of the sample population of average students (see table 11 on p. 87).

In the Children's Depression Inventory Angie's T-score at the pre-test level was 52 (see table 12 on p. 88). This score indicates a normal pattern with Angie exhibiting few depressive symptoms.

In the F-Copes measure (see table 13 on p. 89), Heather's pre-test scores indicate that she is reporting the same coping behaviours that are consistent with the normative population of non-distressed families. The exception to this is in the passive appraisal subscale in which Heather rated the coping abilities of her family as lower than the normative population sample.

Case Analysis

This case was difficult for this writer for two reasons. First of all it would have been preferable and more beneficial to have worked with Angie and Heather together. The issue that presented itself during therapy for both of these individuals was a lack of communication between them. The result of this

Table 11

Self-perception Profile for Children

Name: Angie

	Pre-test	Post-Test	Norms
Scholastic Competence Subscale	2.6		2.65 (.68)
Social Acceptance Subscale	3		3.14 (.63)
Athletic Competence Subscale	1.8		2.56 (.74)
Physical Appearance Subscale	1.8		2.62 (.69)
Behavioural Conduct Subscale	2		2.96 (.55)
Global Self-worth Subscale	2.8		2.91 (.64)

Table 12

Children's Depression Inventory

Child's Name: Angie **Child's Age: 15**

Pre-Test T-Score	52
Post-Test T-Score	

Table 13

F-Copes (Family Crisis Oriented Personal Evaluation Scales)

Name: Heather

	Pre-test	Post-test	Norms
Acquiring social support	32		27.2 (6.4)
Reframing	29		30.2 (4.8)
Seeking spiritual support	6		16.1 (3.05)
Mobilizing of family to acquire and accept help	15		11.96 (3.4)
Passive appraisal	14		8.55 (3.01)
Total	96		93.3 (13.62)

for Angie was that she felt isolated from her mother and did not trust her enough to confide in what was happening in her life. For Heather, Angie's withdrawl from her, coupled with the negative behaviours Angie was engaging in increased Heather's need to exert control over Angie which just pushed Angie further away. If Angie would have allowed her mother to be a part of the sessions this writer would have been able to focus on their relationship more and help them overcome the sense of betrayal and general lack of trust that each was feeling towards the other.

The second difficulty with this case was the premature termination of therapy. Angie presented as being quite confused about what had happened the night of the party and was afraid that she had been assaulted. Because Angie did not trust anyone, this writer was concerned that she would not be able to process and deal with the possibilities of an assault without some sort of support. Although Angie was able to identify changes that she would like to make in her life, her low self-esteem and her isolation from her family may make it difficult for her to follow through.

This writer would have liked to work further with Angie and Heather on the problems in their relationship. This would have given Angie a much needed supportive person which is important for adolescents so that they get positive feedback and direction while making life and lifestyle choices.

From a feminist perspective this writer saw the communication breakdown between mother and daughter as a result of both feeling powerless over their

lives. The main roles that society places on women are to be a wife and mother. Heather was struggling through her feelings of guilt and inadequacies at not fulfilling either of these roles. Angie was also suffering from this sex role stereotype in that she was left without the continual nurturance of a full-time mother and which societal norms indicate every child should receive. Had therapy continued it would have looked at redefining the roles each of these two women had in a manner that reflected themselves as persons worthy of respect and dignity. Therapy would have provided them with an educational component in which they were able to see their personal struggles from within a political context.

CASE "E"

Source and Reason for Referral

Karen called the FASA Program on the advice of Victims Services after her daughter, Kate age fourteen had disclosed being sexually assaulted by a neighbour and his wife. Karen stated that Kate and her best friend Sadie were playing with the neighbour's two small children at their house when the assault occurred. The assault consisted of the neighbour, Mr A sitting one of the girls on his lap, touching her between her legs and licking and kissing her face while Mrs. A kept the other girl in another room. Mrs. A also "groomed" the girls prior to each being assaulted by talking to them in a sexually explicit manner. At the time of the referral Mr. A had been charged with two counts of sexual assault and was pleading not guilty.

Background Information

Kate and Sadie are two fourteen year old girls that have been best friends for most of their lives. Both girls attend the same school and spend most weekends sleeping over at each other's houses.

Kate has lived with her mother, father and older brother in the same home for all of her life and describes her family in positive terms. Kate is doing well in school and has strong community ties.

Sadie resides with her mom, her mom's boyfriend and her younger sister, who is age seven. Sadie has moved several times in the last four years and is currently residing out of the city, although she continues to attend the same

school.

Sadie stated that her mother and father have been separated for four years and that her father was physically abusive towards her mother and sexually abusive towards her. Though she currently has no contact with her father, she stated that she recently had to attend court because her father has requested visitation.

Sadie describes her home life as somewhat turbulent because she does not like her mom's new boyfriend and her father is attempting to re-enter her life.

Both girls stated their mothers were very supportive after they disclosed the sexual assault. However, this writer only spoke to Kate's mother and all attempts to engage Sadie's mother were unsuccessful.

Assessment and Treatment Goals

The referral was made by Kate's mother in order to ensure Kate had someone to talk to as she was not sure Kate felt comfortable telling her everything. Kate's mother was further concerned about the court process and wanted to ensure Kate had support and understanding about this process.

This writer met with both girls throughout the therapeutic process, although Kate initially was the only one referred. The girls were counselled together because they insisted they felt more comfortable together. This proved to be problematic because Sadie often had a difficult time separating her family issues from the current sexual assault.

Both girls were very open in discussing the sexual assault and both had a healthy understanding regarding Mr. and Mrs. A 's responsibility, the crime, and the charges. Both girls wanted justice to be done and felt some confusion and anger over Mrs. A not being charged and Mr. A pleading not guilty. As the first court appearance was in one month, it was decided by the girls that this process was what they wanted to focus on. Both admitted to being quite anxious about testifying, and confused about the whole court process.

After talking with the girls and determining how and when this issue was affecting their lives it was ascertained that the current problem was not the sexual assault but the prospect of testifying. This became the problem and the goals and intervention centred around how to manage this problem, as it was going to be in their life for some time.

Intervention

The intervention phase of therapy with Kate and Sadie consisted of discussing the court process so that they each developed an understanding of what would be involved. By doing this the girls were able to determine what they controlled and what they did not. By focusing on the part of the problem where they did have control, the girls were able to feel more empowered and were able to develop strategies that increased these strengths.

The tasks in these sessions for the girls were often reading information and writing questions for the next session. This writer also had tasks, as in the role of advocate for the girls it was often this writer's responsibility to find out

information from the courts about their particular case.

Compliments were used to reinforce how well the girls were doing despite this big problem, and to help normalize their fears by validating their struggles and efforts, as they went through the court process.

As the anxiety caused by the court process was often interfering in other aspects of their lives, scaling questions were used to check progress and also to determine if and when there were times that this was not happening. This allowed the girls to identify these times, develop strategies for expanding them, and reinforced the positive growth by allowing them to see the improvements they had made in managing the problem.

Case Conclusions

Therapy ended abruptly after Sadie's mother called to say that the family was now involved in family counselling and she did not want Sadie to attend to the FASA Program as she was missing too much school. Total number of sessions with the girls was ten. Although this writer asked for a final termination session, Sadie's mother was adamant that Sadie not return. In a telephone conversation Kate was quite upset about not continuing the counselling but said she did not want to come by herself.

Although therapy was not completed, it was in its final stages as both girls had for the most part met the goals they had established in the beginning. The only outstanding issue was that of testifying in court since it had been adjourned several times. This writer would have preferred to fulfil her obligation

to be there and support the girls but felt confident that they had sufficiently developed in their strengths and had shrunk the problem down to a manageable size.

Evaluation of Measures

In analysing the data on Kate and Sadie with the Self-Perception Profile for Children (see tables 14 & 15 on pp. 97-98), one can note that the girls rated themselves within the range of the population group of average students.

In the Children's Depression Inventory Kate and Sadie's T-scores were both at seventy during the pre-test phase (see tables 16 & 17 on pp. 99-100). A score of over sixty-five indicates clinically elevated levels, so this could be construed that both girls were having trouble with depression (Kovacs, 1992).

Case Analysis

This case was different from the others in this practicum report in that the therapy involved not family members, but two best friends. Because the girls came from different families, the therapy process presented some unique issues.

The first issue for this writer was how to keep the girls focused on the sexual assault. Sadie in particular had present family and past abuse issues that kept surfacing in the sessions and which she struggled with throughout therapy. Kate, who basically came from a supportive, stable background had a much higher level of self-confidence and so was able to move through the therapy process very quickly. This writer had to be sensitive to how each of the

Table 14

Self-perception Profile for Children

Name: Kate

	Pre-test	Post-Test	Norms
Scholastic Competence Subscale	1.6		2.65 (.68)
Social Acceptance Subscale	2.5		3.14 (.63)
Athletic Competence Subscale	2.6		2.56 (.74)
Physical Appearance Subscale	1.6		2.62 (.69)
Behavioural Conduct Subscale	2.2		2.96 (.55)
Global Self-worth Subscale	2.2		2.91 (.64)

Table 15

Self-perception Profile for Children

Name: Sadie

	Pre-test	Post-Test	Norms
Scholastic Competence Subscale	3.4		2.65 (.68)
Social Acceptance Subscale	3.6		3.14 (.63)
Athletic Competence Subscale	3.8		2.56 (.74)
Physical Appearance Subscale	2.6		2.62 (.69)
Behavioural Conduct Subscale	1.8		2.96 (.55)
Global Self-worth Subscale	3		2.91 (.64)

Table 16

Children's Depression Inventory

Child's Name: Kate **Child's Age: 14**

Pre-Test T-Score	70
Post-Test T-Score	

Table 17

Children's Depression Inventory

Child's Name: Sadie **Child's Age: 14**

Pre-Test T-Score	70
Post-Test T-Score	

girls understood and processed the assault. A solution for this was to contract with the girls at the beginning of each session about what was going to be discussed. This was helpful in keeping the sessions focused on the sexual assault issues. It would have been perhaps more beneficial for the girls to have met with them individually instead of together so that therapy could have proceeded at each girl's own pace. As the girls were so determined to see this writer together another therapist for Sadie might also have been helpful. Sadie and Kate would have been able to work on the sexual assault as a pair and Sadie would still have had the support to address family and past abuse issues.

Another difficulty with this case was the different level of support each received from her family. Kate's mother was involved in the therapy process and what was happening in the courts, while Sadie's mother resisted all attempts to engage with this writer. Comments made by Sadie revealed that her mother showed little interest in how Sadie was dealing with the assault or in the court process. As support and caring are so important to the healing process, the lack of this from Sadie's mother caused Sadie to have a much more difficult time than Kate in coping with the sexual assault trauma. The termination of therapy by Sadie's mother, just before court and at a critical time in therapy furthered Sadie's feelings of powerlessness. This writer would have liked more involvement with both mothers but especially with Sadie's mother who might have been able to be more supportive to her daughter if she had

been involved in the therapy.

The therapy provided in this case reflected a strong feminist perspective that included a healing process, an education process, and political process. The therapy strove to link the girls' personal struggles to within a political context. Sessions reflected an atmosphere in which the girls were reclaiming the power taken from them by the offenders. The girls were asked to look at their victimization in relation to a society that condones sexualized violence and a court system that often perpetuates the ongoing victimization through a process that puts victims on trial and allows offenders to take little responsibility for their actions.

CHAPTER V

DISCUSSION ON THE PRACTICUM EXPERIENCE

Concluding Comments re: Clinical Issues

In doing this practicum, this writer had the opportunity to learn more about two models of intervention, her own therapeutic style and to gain an increased understanding of the issue of child sexual assault.

The clinical setting provided an opportunity to implement solution-focused and narrative approaches. It was challenging to integrate both the terms and line of questioning used by these models into the intervention in a comfortable, non-assuming manner.

The solution-focused material uses specific language, metaphors and verb tenses and has therapists ask specific questions such as the miracle question or the exception question. The use of these questions and the language prescribed by solution-focused therapists requires a considerable amount of practise, if one wants to put the client(s) at ease and join with them.

Narrative therapy technique of externalizing the problem was also quite difficult to get used to, though this writer believes in the therapy behind this technique that problems are not inside people but are situational. This technique calls for naming the problem as a separate entity and in the course of therapy speaking or having the clients speak to it as such. It is important to the therapeutic relationship that the therapist appear comfortable and this writer found using this technique often difficult and so recognizes the need for ongoing

training with this approach in order to gain more skill and a higher comfort level when using it.

Another challenge in using a solution-focused approach was that of beginning interventions without already understanding the problem or relevant history since solution-focused therapists believe that you do not need to understand the problem to intervene. This model often begins the initial sessions by helping the clients discover how they have already overcome the problem. This can be a difficult task, if the therapist is not adequately skilled in this area. It is this writer's opinion that most clients who enter therapy want to spend a significant amount of time discussing the problem and their histories. The other drawback is that unless the therapist is quite skilled, she/he runs the risk of moving too fast towards a solution that the client(s) are not ready to see.

This writer found these models to be interesting and challenging when attempting to implement them with clients. Although the models are relatively simple and straightforward, the strict use of the techniques that the literature suggests is necessary if one is to be effective, make these two approaches much more complex than they first appear.

The solution-focused and narrative approaches to working with children and their families is very client-centred. Though the mandate of the FASA program is to work with child victims of sexual assault and their families, very little mention of the assault can occur during therapy. Once the client identifies the problem, the therapist's role is to collaborate with the client on setting goals

and looking for solutions and exceptions to the problem. The problems are rooted in the effects of the sexual assault on the victim and family members, but because a problem can manifest itself in different ways, therapy can move in many different directions that at first glance seem to have little relevance to the sexual assault. An example of this can be noted in Case B, where the goal of the child was simply to make more friends. Although the sexual assaults had further isolated Bill from his peers, this writer and Bill did not focus on this, but rather worked on identifying possible solutions to Bill's lack of friends problem. It is interesting to this writer that although therapy may not directly focus on the sexual assault, the outcome may be the same as if it had. By reducing problems that have come about as a result of the sexual assault, the therapy at FASA allows children and families to lead more satisfactory lives.

The client groups this writer worked with at FASA differed but they did, however have one common characteristic that is worth noting. At least one person in every client group was very motivated to change and was committed to the therapy process. This is important to note because the solution-focused approach suggests only a small change is needed for larger changes to occur. This writer noted that each client who was working towards positive change, influenced others in the family who did not have the same level of commitment. During therapy sessions, this writer noted the effects these individuals had on the more reluctant members and how this effect produced changes in the interactions between them and other members of the family.

A final thought in working with these families is that it is this writer's opinion that all the clients regardless of when termination occurred benefitted from therapy. As the solution-focused and narrative models look at exceptions and solutions almost immediately upon the start of therapy, all clients left therapy with some new tools for change.

The final issue that this writer would like to comment on is that of supervision. It was an invaluable learning experience to be part of a reflecting team for clinical consultation and supervision.

> The reflecting team allows therapists to share their own versions of reality that are neither too different nor too similar from the family pictures or explanations of their world. The reflecting team also helps to demystify the one-way mirror and be respectful to families and members of the larger system. A sense of equality can then be promoted between the reflecting team and clients and as clients become party to the teams thinking, they may become more receptive to change. (FASA Reflecting Team Summary Notes, 1995, p. 1)

Concluding Comments re: Theoretical Issues

Current theoretical approaches to working with children and their families after a child has been sexually assaulted are now beginning to recognize that in order to be effective one has to look beyond the individual or family and take into consideration the societal context in which children are victimized. As this writer has already described the frameworks utilized in this practicum, attention now will be given to discussing how they fit within a feminist perspective.

When abiding by a feminist perspective, therapists move beyond the

limitations of traditional therapies and take into consideration issues on a more global level. Hooper (1992) suggests that choices are always made within an economic, political and social context. Economics, the law, and social policy all show, and are reinforced by dominant perspectives about the family. These frameworks she suggests, act to constrain people rather than motivating them to take action. Gilligan (1982) has argued that women have commonly been judged and found wanting against a model of decision making in situations of moral conflict derived from the psychological development of men. Models that perpetuate inequities between men and women and support patriarchal values by privileging men and subordinating the interests of women and children contribute to victimization and violence. It is therefore important that individual responses are understood in the context described if one is going to be effective in intervening.

The fit between narrative therapy and a feminist perspective can be seen in that narrative therapy recognizes the sociopolitical context that perpetuates gender inequality. "The therapist assumes responsibility for asking questions that invite people to consider the fit between cultural beliefs and practices and their own preferences about gender roles and expectations" (Westcott & Isenbart, 1996, p. 15).

The narrative use of externalizing conversations and the solution-focused technique of calling the problem the problem and not the person the problem works to look at beliefs and behaviours as outside of the person and thus help

people to understand their experiences from within a context of oppression.

Similarities with the solution-focused and narrative approach and a feminist perspective can also be found in the notion that people don't come to therapy with personal deficits or permanent damage. The solution-focused approach looks at strengths and abilities and how to expand on these while the narrative model helps people identify unique outcomes that help them recognize the possibility that they can make a difference in their lives. A feminist approach would concur with these thoughts as it believes that personal problems and struggles are not located within the individual but generated from patriarchal society, artificial sex role stereotypes and power differences. The feminist approach points out social roots to oppression rather than sickness.

A further similarity between these three approaches is that the therapist's responsibility is in helping people develop their own expertise and self-knowledge. All three recognize that therapy is unique for each person and that the therapist's role is that of guide or facilitator and not expert.

Further examination of these approaches would reveal discrepancies and other possible similarities but it is evident from this writer's perspective that the basic assumptions held by all three are compatible and can be used together when working with child sexual assault victims and their families. Attention throughout the treatment process must be given to the limited economic, emotional and social support that society offers. The use of the models described allows therapists to gain a deeper understanding of both the

complexity of the problem of child sexual assault and the issues that family members face when this occurs.

A feminist ideology in combination with models that have an understanding of the complexity of this issue will give therapists essential tools in effectively treating this client population.

Concluding Comments re: Learning Goals

The main learning objective of this practicum was to utilize a solution-focused and narrative approach to assist children and their families after a child had been sexually assaulted. This writer felt this goal was met, evidenced by the test measures and this writer's own clinical evaluations of the cases presented. A further goal was to analyse the effectiveness of using these two approaches from a feminist perspective. As discussed previously, it is this writer's opinion that the models are congruent with a feminist perspective in that many of the assumptions used are similar. Both models urge questioning of how one defines one self and challenge the notion that problems are within. The narrative approach goes even one step further in that it reflects a personal/political relationship that must be taken into account when working with people and which is the root of the feminist ideology.

The final goals of this practicum were to develop an increased understanding of this topic area and to increase this writer's clinical skills. The clinical setting of this practicum was very beneficial in meeting these learning

objectives. The ability to focus one's work using specific models challenged this writer to develop and increase clinical skills and helped deepen this writer's understanding of the issue of child sexual assault.

REFERENCES

Adams-Westcott, J., & Isenbart, D. (1996). Creating preferred relationships: The politics of recovery from child sexual abuse. Journal of Systemic Therapies, 15 (1), 13 - 31.

Avis, J. (1988). Deepening awareness: A private study guide to feminism and family therapy. Guide to Feminist Family Therapy, New York, Harrington Park Press, 15 - 47.

Brayden, R., Deitrich-MacLean, G., Dietrich, M., Sherrod, K., & Altemeir, W. (1995). Evidence for specific effects of childhood sexual abuse on mental well-being and physical self-esteem, Child Abuse and Neglect, 19 (10), 1255 - 1262.

Briere J. N. (1992). Child abuse trauma theory and treatment of last effects. Newburg Park, Ca: Sage Pub.

Briere, J., & Runtz, M. (1989). The trauma symptom checklist: Early data on a new scale. Journal of Interpersonal Violence, 4, 331 - 341.

Burt, S., Code, L., & Downey, L. (1995). Changing patterns: Women in Canada. Toronto: McCelland and Stewart.

Carter, B. (1993). Child sexual abuse: Impact on mothers. Child abuse and neglect, 8 (1), 72 - 91.

Coates, J. (1991). Putting knowledge for practice into perspective. Canadian Social Work Review, 8 (1), 83 - 95.

Cowley, G., & Spangen, K. (1995). Rewriting life stories. Newsweek, April, 70 - 74.

Davies, S. (1994). Parental distress and ability to cope following disclosure of extra-familial sexual abuse . Child Abuse and Neglect (4), 3 - 12

Deitz, C., Craft, A., & John, L. (1980). Family dynamics of incest: A new perspective. Social Casework Journal of Contemporary Social Work, 602 - 609.

De Shazer, S., Berg, I. K., Lipchuk, E., Nunnally, E., Molnar,, Gingerich, W., & Weiner- Davis, M. (1986). Brief therapy: Focused solution development. Family Processing, 207 - 221.

De Shazer, S. (1988). Clues investigating solutions in brief therapy. New York: Norton.

De Shazer, S. (1985). Keys to solutions in brief therapy . New York: Norton.

De Shazer, S. (1982) Patterns of brief family therapy. New York: Gulliford.

De Shazer, S. (1984). The death of resistance. Family Process, 23 (1), 11 - 17.

Dolan, Y. (1991). Resolving sexual abuse: Solution-focused therapy and Erickson in hypnosis for adult survivors. New York, London: W.W. Norton & Company.

Epston, D. (1994). Extending the conversation. Networker, 32 - 63.

Everson, M., Hunter, W., Runyoin, D., Edelsohn, G., & Coulter, M. (1989). Maternal support following disclosure of incest. American Orthopsychiatric Association, 197 - 207.

Families affected by sexual assault program. (1995). Reflecting Team Consultation Summary Notes. Winnipeg.

Feminist therapy ethical code. (1987). Feminist Therapy Institute, FTI Incorporated.

Finkelhor, D. (1986). A source book on child sexual abuse. Newbury Park, CA: Sage Pub.

Fisher, J., Corcoran, K. (1994). Measures for clinical practices. The Free Press, New York.

Fook, J. (1993). A theory of practice. Radical Casework, 39 - 54.

Frazer, S. (1995). Process problems and solutions in brief therapy. Journal of Marital and Family Therapy, 3, 265 - 279.

Gil, E., (1996). Systemic treatment of families who abuse. San Francisco: Jossey-Bass Pub.

Gil, E., & Cavanagh, T. (1993). Sexualized children: Assessment and treatment of sexualized children and children who molest. U.S: Launch Press.

Goldberg, J. (1995). Is narrative therapy the way. Family Therapy News , 16 - 19.

Goodrich, T., Rampage, C., Ellman, B., & Halstead, K. (1988). Feminist family therapy: A case book. New York: Norton.

Harter, S. (1985). Manual for the self-perception profile for children. University of Denver.

Harter, S., & Pike, R. (1983). Procedural manual for the pictoral scale of perceived competence and social acceptance for young children. University of Denver.

Hooper, C. (1992). Mother's surviving child sexual abuse. London & New York: Routledge.

Howard, C. (1993). Factors influencing a mother' s response to her child's disclosure of incest. American Psychological Association, 24 (2), 176 - 181.

Kovacs, M. (1992). Children's depression inventory . Toronto: Multi-Health Systems Incorporated.

McCubbin, H., Olson, D., & Larsen, A. (1981). F-copes: Family crisis oriented personal evaluation scale. Family Health Program.

Miller, S. (1992). The symptoms of solution. Journal of Strategic and Systemic Therapies, 1, 1 - 11.

Nes, J., & Iadicola, P. (1989). Toward a definition of feminist social work: A comparison of liberal, radical, and socialist models. National Association of Social Workers Incoproated, 12 - 21.

Nylund, D. & Thomas, J. The economics of narrative.

O'Hanlon, W. & Weiner-Davis, M. (1989). In search of solutions: A new direction in psychotherapy. Markham Ont: Pengin Books.

O'Hanlon, B. (1994). The Third Wave. Networker, 19 - 29.

Pallone, N. (Ed.). (1994). Young victims, young offenders. New York: Haworth Press.

Quay, J. & Peterson, D. (1987). Manual for the revised problem checklist.

Rossi, E. (1980). Collected papers of Milton Erickson on hypnosis, 4 , New York: Irvington.

Rossi, E., Ryan M., & Sharp, F. (1983). Healing in hypnosis. New York: Irvington.

Rossi, E., & Ryan M. (1986). Mind-body communications in hypnosis . New York: Irvington.

Sgroi, S. (1982). Social work and child sexual abuse . Massachusetts: Haworth Press.

Sgroi, S., Poter, F. & Black, L. (1982). Validation of child sexual abuse in Sgroi, S. (Ed.) Handbook of clinical intervention in child sexual abuse. Lexington M A: Health and Company.

Sigmon, S., Greene, M., Rohan, K., & Nichols, J. (1996). Coping and Adjustment in male and female survivors of child sexual abuse. Journal of Child Sexual Abuse, 5 (3), 21 - 29.

Stacey, J. (1993). Untangling feminist theory in thinking feminist: Key concepts in women's studies, 49 - 73 New York: Guilford.

Study of national incidence andprevalencee of child abuse and neglect . (1988). National center on child abuse and neglect, Washington.

Sykes Wylie, M. (1994). Panning for gold. Networker, 40 - 48.

Tomm, K. (1989). Externalizing the problem and internalizing personal agency. Journal of Strategic and Systemic Therapies, 8 (1), 54 - 59.

Wells, R., McCann. J., Adams, Jr., Voris, J., & Ensign, J. Emotional, behaviourall and physical symptoms reported by parents of sexually abused, non abused and allegedly abused prepubescent females. Child Abuse and Neglect, 19 (2), 35 - 41.

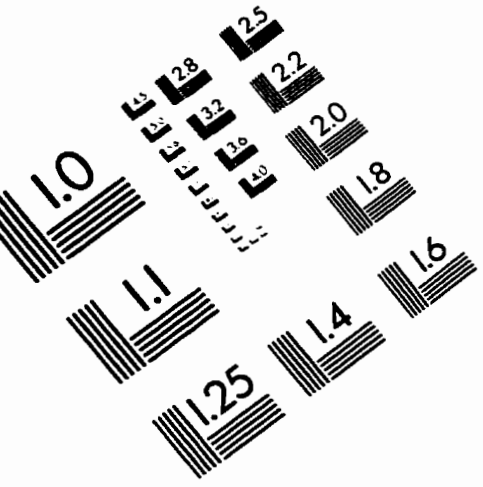
White, M. (1987). Addressing the in-the-corner lifestyle: Family therapy and schizophrenia. Dulwich Center Newsletter.

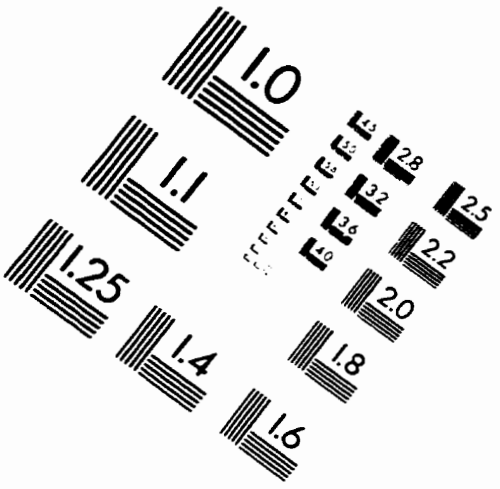
White, M. & Epston D. (1990). Narrative means to therapeutic ends . New York, London: W.W. Norton.

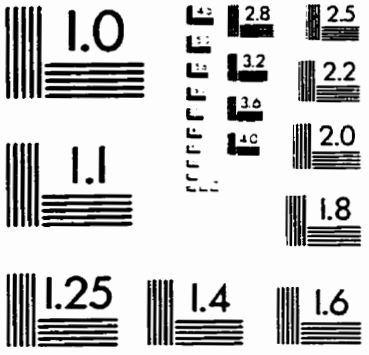
White, M. (1986). Negative explanation, restraint and double description: A template for family therapy. Family Process, 25 (2), 169 - 184.

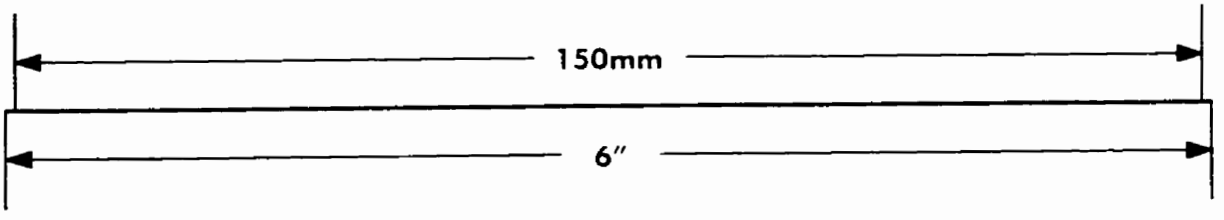
White, M. (1988). The process of questioning. A therapy of literary merit? Dulwich Center News Letter.

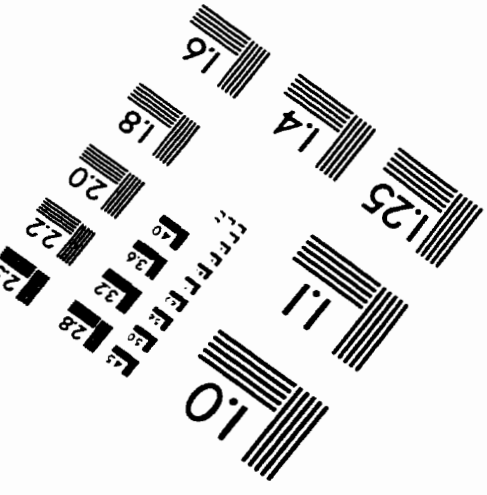
IMAGE EVALUATION
TEST TARGET (QA-3)

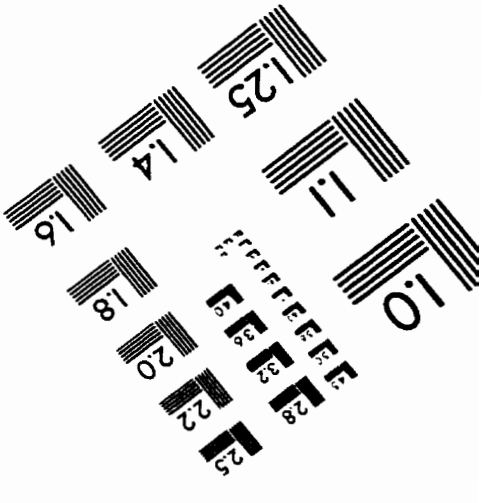












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