

**Co-Locating Narrative and Solution-Focused Theory
In a Family Based Therapy
With Children Affected by Extrafamilial Sexual Abuse**

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**A Practicum Report
Submitted to the Faculty of Graduate Studies
In Partial Fulfillment of the Requirements for the Degree of**

MASTER OF SOCIAL WORK

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Winnipeg, Manitoba
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BY

Paula Wickenden

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

Child sexual abuse affects the lives of many children and families in Canada. Application of narrative and solution-focused therapy within a family based intervention with children recently affected by extrafamilial sexual abuse is the focus of this report. A comprehensive literature review of narrative therapy, solution-focused therapy, the co-location of these two models and child sexual abuse is provided. This theoretical examination provides the foundation for the synopsis and analysis of clinical services provided to nine families during a practicum experience. The Family Environment Scale (FES) and the Children's Version of the Family Environment Scale (CVFES) were used as both, clinical and evaluative tools within the interventions. Client feedback and clinician impressions deemed the integration of narrative and solution-focused therapy to be an effective method to provide a comprehensive therapeutic service to children and families affected by extrafamilial sexual abuse.

CHAPTER ONE

Introduction

In recognition of the prevalence of child sexual abuse (CSA) in Canadian society, I wanted to focus the practice component of my graduate studies in social work on working with this population using a respectful family therapy approach. A community-based program called Families Affected by Sexual Assault (FASA) at New Directions for Children, Youth, and Families in Winnipeg, Manitoba provided the setting that enabled me to work with families who have a child who has been affected by sexual abuse.

Given that there is a multitude of approaches to therapy available, I chose to examine the feasibility of applying a combination of solution-focused and narrative theory in therapy. Since these paradigms are considered to be based within social constructionism and “social constructionism echoes social work’s values and mission” (Witkin, 1999, p. 7) I felt that the combination of these models would respectfully serve this population while contributing to my learning endeavours. My belief is that these strength-oriented models emphasize the importance of families addressing their issues in an effort to create a balanced and harmonious future for themselves, with the cooperation and support of the therapist. “One of the most important reasons for therapy is to help clients change their lives. It is a justification for therapy, and a test of it” (Miller & de Shazer, 1998, p. 366).

Child sexual abuse has been written about in literature more and more over the last 10 to 20 years. With increased study of its incidence, the traumatic

impact of CSA has been realized and documented. Historically, CSA was viewed from the perspective of “family dysfunction” with attributions of blame, often on the mother, and this had been the guide for understanding the impact of and interventions with CSA (Durrant & White, 1992). Research in this field has expanded and contributed to a greater understanding of CSA and its affects on the developing child. Families are also affected and traumatized and, therefore, I chose to apply a family focused intervention in clinical practice. Such an approach is desirable because families are a valuable resource for their children. This has been documented in the literature but I have also experienced this to be true during my previous professional experience as a social worker working with children and families in a variety of social program areas in Nunavut, Canada. This belief in the family will be reflected throughout my interventions.

The profession of social work provides direct client services, resources and opportunities to individuals, couples, families and communities with a person-in-environment focus. Social justice, advocacy and development type activities are also key components in the practice of social work (Canadian Association of Social Workers, 1994). As such, my focus on family therapy falls within the realm of social work in that family relations are viewed as an interactive and pivotal unit of individuals blended and working together in the larger context of community and society.

Learning Objectives

My practicum was fulfilled in cooperation with the staff at the FASA program of New Directions for Children, Youth, and Families. My objective was to

work directly with families who sought help due to a child within their family recently disclosing CSA. In this endeavour, my learning goals were:

1. To be effective at helping to alleviate the negative effects of child sexual abuse;
2. To develop an overall and thorough skill base for working with children and their families affected by child sexual abuse;
3. To become familiar with and proficient in the use of narrative and solution-focused therapy in practice;
4. To demonstrate that these two models can be applied collaboratively during interventions;
5. To apply social work skills in family therapy.

I am specifically interested in family therapy with this particular population since it is both the belief of the FASA team and of myself that families are the greatest resource for their children and are also greatly affected after a trauma such as this. I believe family therapy is a strong and meaningful intervention that I wish to demonstrate an aptitude for as a social worker.

The evaluation of practice is an essential component to address the effectiveness of the process and outcome of interventions. Accordingly, I wanted to examine and use an applicable standardized measure as well as a qualitative methodology to gather input from the children and families with whom I worked. My goal in this regard was to use the Family Environment Scale (Moos, 1974) and the Children's Version of the Family Environment Scale (Pino, Simons, & Slawinowski, 1984) and develop a qualitative feedback questionnaire to be used throughout this practicum experience.

In an effort to support, supplement and enrich my practice experience I completed a full and continuous literature review that included theoretical, empirical and descriptive material in the following areas of concentration:

1. Extrafamilial child sexual abuse;
2. The impact on and reactions of parents or caregivers and family in situations involving their child disclosing sexual abuse;
3. Narrative therapy (NT);
4. Solution-focused therapy (SFT);
5. Integration of narrative and solution-focused therapy;
6. The Family Environment Scale (FES) & Children's Version of the Family Environment Scale (CVFES).

Overall, it is my belief that this literature review, coupled with the structured supervision of the practicum at the FASA program, was instrumental in contributing to my academic and professional development.

CHAPTER TWO

Literature Review: Child Sexual Abuse

Introduction and Comments on Research Issues

Academic literature has progressively documented research, clinical interventions and opinions regarding the sexual abuse of children. In the late 1970s and early 1980s, child sexual abuse (CSA) was beginning to be identified and recognized as a problem in increasing proportions, resulting in more public awareness and literature on the topic (Finkelhor, 1986; Wells, 1990).

A discussion and definition of CSA will be presented with a distinction being made between extrafamilial and intrafamilial (incestuous) sexual abuse. An examination of the incidence and prevalence of these forms of violence in Canada, the effects of sexual abuse on child victims and a commentary on parental reactions following the disclosure of sexual abuse by their child will be presented. As well, a summary of the various approaches to treatment with CSA will be included.

It is pertinent to begin the discussion by clarifying terminology. Firstly, the terms "child sexual abuse" and "child sexual assault" seem to be frequently interchanged. Many of the books and journal articles in my reference list use the word "sexual abuse". According to the Webster's dictionary (1987) abuse means, "to violate" (p. 7) and assault means, "to attack violently" (p. 27). Crouch (1999) uses the wording "sexual trauma" in her comparison of two standardized measures. Essentially to act out sexually toward a child is a violation, a violent attack and a trauma. I will, therefore, use these words interchangeably for the

purposes of this report. The Criminal Code of Canada identifies “sexual assault” as one of 16 types of CSA (Wells, 1990). Acknowledging these variations in terminology emphasizes the importance for the therapist, child protection worker, police officers or others involved with child victims to be aware of language and to clarify with the child and their family how they refer to the sexual violation.

Research serves an academic or science based interest for increasing knowledge, skills and planning in the area of CSA. It must also respect that there can be multiple interpretations of the outcome information presented. There has been a shift in the scholarly literature from a limited understanding of the impact of CSA to recognizing that all victims experience sexual abuse differently and that not all victims necessarily experience long-term trauma (Kendall-Tackett, Williams, & Finkelhor, 1993). The aforementioned statement is clearly different than saying “abuse is fine” (Haaken & Lamb, 2000, p. 15). Recognizing and understanding the intent of each of these statements is essential since interpretations can either clarify or muddle information obtained through research. Haaken and Lamb warn of the contentious undertones that research and outcomes can have if the data presented regarding CSA is not congruent with political and moral expectations. “Whether the issue is homosexuality, teenage sexuality, abortion, or rape, sexuality seems to carry surplus freight as a combustible topic” (p. 7). Clinically, scientifically, morally and politically there is unity that “declaring ones opposition to child sexual abuse is a risk-free stance” (p. 7). Haaken and Lamb reviewed a meta-analysis by Rind, Tromovitch, and Bauserman (1998) that received widespread criticism and reproach by

politicians, advocacy groups, funding agencies, conservative organizations, Christian organizations and, eventually, within the academic community.

...[O]ne of the most important aspects of the meta-analysis was its finding that the effects of poverty and other broad indicators of family well-being outweighed sexual abuse as a factor associated with mental health problems in adulthood. But the heat of sexual hysteria readily obscures these less dramatic forms of "abuse". Poverty and neglect of children do not mobilize the same moral outrage in American society as does the specter of weakening sexual taboos. (Haaken & Lamb, 2000, p. 8)

Although this discussion on the sensitive nature of research regarding CSA deserves more time, the purpose of presenting it here is to create a context for recognizing that culture, the social environment and personal viewpoints contribute to varied perspectives on certain components of CSA and to the diverse interpretations of literature. Such issues as the type or extent of short and long term impact and the best way to approach treatment are debated among victims/survivors, scholars, therapists and advocates. In the following pages I will present a broad overview of scholarly data on CSA.

Child Sexual Abuse

It might seem quite straightforward to say that CSA is any unwanted or forced sexual act experienced by a child. This statement is accurate. There are, however, variations to consider in the CSA literature. The Canadian laws were changed in the early 1980s in response to the Badgley Report (Robertson, 1984) that examined the prevalence and incidence of CSA in Canada (Wells, 1990). There are now 16 categories of sexual offences against children such as sexual interference, incest, sexual exploitation of a child, invitation to touching, anal intercourse, exposing ones genitals to a child, sexual assault and aggravated

sexual assault, to name a few.

Canadian law defines sexual abuse in such a way that children are protected and perpetrators held accountable. The laws in Canada are clear that any sexual activity without consent is considered sexual abuse and that any child under the age of 12 is unable to give consent (Wells, 1990). Furthermore, children aged 12 and 13 are able to give consent in circumstances involving peers of the same age, whereas sexual activity between peers, 14 to 18 years old, may be consensual as long as there is less than a two year age difference. If at any time one adolescent is in a position of trust and authority over another, this is considered exploitation and consent is not a defense. The intent of these laws is to eliminate exploitation of children and to keep them safe (Wells, 1990).

Child Protection Services in Manitoba treats any form of neglect or abuse toward a child very seriously, especially when harm occurs within a family context or by the person having care, custody and control of a child (Child and Family Services Act, 1999; Manitoba Family Services, 1995). The Child and Family Services Act (the Act) (1999) requires any person having information or suspicion of the neglect or abuse of a child to report it immediately to Child Protection Services so that appropriate and expedient action can be taken to protect the child from further harm. The Child and Family Services Act (1999) refers to "sexual exploitation of the child with or without the child's consent" (p. 2) as child abuse. As well the Act speaks specifically of "third party" assaults stating that the "physical injury or sexual exploitation of a child caused by a person who does not have the care, custody, control or charge of the child is not abuse"

(Manitoba Family Services, 1995, p. 15). The requirement in this type of circumstance is that as long as the parent or guardian are able to protect the child and are not accountable for the abuse, Child Protection Services does not necessarily need to be notified and only the parent or guardian must be informed. Overall, the Manitoba Child and Family Services Act (1999) provides clear guidelines to the community to ensure that the children of this province can grow up to be safe from any form of harm.

As an additional step to protecting children, Manitoba has a Child Abuse Registry that keeps a central listing of individuals who have been convicted or have substantiated claims against them of abuse toward children. This includes both physical and sexual abuse. It is a project aimed at preventing individuals known to have abused children, from working in a position of trust or authority over children (Manitoba Family Services, 1995). As of March 31, 1999, this registry had a total of 2320 abusers recorded in the province of Manitoba (Child and Family Services, 1999).

Based on their review of several studies, Peters, Wyatt, and Finkelhor (1986) have noted and discussed the inconsistency of definitions of CSA within the research community. Nonetheless, what we know today has become better defined since the early 1980s. Adult-child sexual contact is consistently regarded as abuse. Peters et al. (1986) found that some studies have included sexual acts that are of a non-contact nature such as exhibitionism, whereas other studies only include direct contact type violations. Peer sexual interaction has also been randomly either included or excluded in research studies. Similarly, criteria for

age differences have varied when examining sexual acts between adolescents. In the past, there was a tendency among some scholars to only examine CSA perpetrated by an adult or an older person (Peters et al., 1986).

MacFarlane (1986) also define sexual abuse of a child as acts perpetrated by an adult or an older person and minimize peer sexual contact stating, "it is not usually considered to be abuse unless there is some element of force, coercion, or intimidation involved" (p. 301). There has definitely been a shift in this area with increased research, literature and interventions documenting adolescents or children under the age of 12 with sexual behaviour problems. For example, Gil and Johnson (1993) and Johnson (1999) dedicate entire books to the sexual behaviour of children.

Browne and Finkelhor (1986) and Genuis, Thomlison, and Bagley (1991) also discuss the multiple ways that child sexual abuse is operationalized and used in the literature. Genuis et al. provide the following summary regarding a definition for CSA:

The clearest and yet not overly restrictive definition is provided by unwanted contact. The criterion stressing unwanted sexual contact appears to be a better method of eliminating cases of consensual sex play among peers than some arbitrary age criterion. Therefore, we recommend that for research purposes, child sexual abuse be operationalized as unwanted sexual contact (genital and fondling through to intercourse) while the victim is considered a child by legal definition. Using this definition, varying community standards are considered. (p. 3)

For the purposes of this report, I shall discuss CSA within the above context. From a therapeutic perspective, I consider and fully respect the meaning given by the victim to any personal violation of a sexual nature. For example, one child may be deeply affected by being exposed to pornography whereas another

child may give a different meaning to the same act. Different meanings, interpretations and reactions should be taken into consideration in the mutual definition, between the client and therapist, of a goal toward healing and recovery.

Extrafamilial Versus Intrafamilial Sexual Assault

Consistent with the boundaries established by the Families Affected by Sexual Assault (FASA) program at New Directions for Children, Youth, and Families, extrafamilial child sexual assault is defined by two criteria:

1. The alleged offender is not the child's parent or sibling, and
2. The alleged offender must reside outside the family home.

Thus, a parent, a person in a parental role or a sibling must not have been the perpetrator for the purposes of this program, whereas other family members such as an uncle, grandparent or cousin may be the identified perpetrator. In a study of parental distress and coping following their child's disclosure of CSA, Davies (1995) uses a similar distinction of "non-household relatives" to refer to an extrafamilial perpetrator. This definition has important therapeutic implications. That is, if the alleged perpetrator lives outside the home, there are likely no protection issues for the victim and the family can engage in counselling immediately after disclosure.

Fischer and McDonald (1998) and MacFarlane (1986) exclude all family in their definition of extrafamilial, which in their case, refers to such people as teachers, friends, neighbours or strangers as the perpetrators. Statistics Canada (1999) provides data on the prevalence of the sexual assault of children using

three categories: family, stranger or acquaintance. Within the family category, they do break down the profiles to identify parents, siblings or extended family.

Conversely, intrafamilial sexual contact or incest has historically and continues to carry the general understanding of sexual activity between family members. Tingus, Heger, Foy, and Leskin (1995) define intrafamilial as the victim's father, stepfather, mother, mother's boyfriend, or sibling, which is also quite similar to the classification criteria used by the FASA program. It helps to be aware of some of the variations to the definition of family to understand the intent of the service or information being provided. For example, individuals related through blood as well as individuals joined in a family context with different lineage may still be regarded as family, especially when considering whether a position of trust and authority had been established.

Incidence and Prevalence of Child Sexual Abuse

Child sexual abuse is estimated to affect one in four females and one in six males before the age of 18 years. According to a report by the Canadian Centre for Justice Statistics, there were a total of 126 sexual assault cases reported to the police per 100,000 people in Canada in 1992 (Roberts, 1994). They suggested that this was only about 6% of the total number of victims of sexual abuse. A profile was provided showing the total number of sexual assault cases between 1983 and 1992, and all the figures showed an increase in the aggregate numbers for each year. Giliberti (1994) identified that between 1988 and 1992, CSA accounted for 141 per 100,000 sexual abuse cases reported to the police. As well, 70 to 80% of victims during this period were identified as

female and 20 to 30% were male.

Statistics Canada (1999) reported that children represented 60% of all police-reported sexual assault victims in 1997. Of the nearly 11,000 reported sexual victimizations of children, 2% related to children under the age of three, 46% were 3 to 11 years old and 52% were 12 to 17 years old. The perpetrator was a family member in 31% of cases, an acquaintance in 47% of cases and a stranger in 15% of cases. When looking at the relationship of the accused to the victim, family initiated offences were highest for the under three age category and continuously declined for subsequent age ranges of the child. Victimization by an acquaintance yielded the most consistent occurrence rate, from 29 to 54%, across the childhood age ranges with the 12 to 17 year span accounting for the highest percentage. Stranger assaults were least prevalent for the youngest age bracket with increasing occurrence throughout childhood. The 15 to 17 year old group was most affected by stranger attacks.

Since it is likely that many incidents go undetected or unreported it is hard to rely solely on the figures presented by police records. Victimization studies have been done, however, they are limited by recall and varying definitions over time. It is difficult to access figures specific to child sexual abuse from Child Welfare agencies, which would definitely provide insight into the number of CSA victims reported to their agencies and the outcome figures of the investigations. In the 1998/1999 fiscal year, there were a total of 2516 cases of alleged physical or sexual abuse of children reported to the Child and Family Services agencies in the province of Manitoba (Child and Family Services, 1999). There is no single

source of data that provides information about the nature and extent of the problem of child sexual abuse in Canada (Statistics Canada, 1999).

Effects of Child Sexual Abuse

Child sexual abuse is a devastating personal trauma that can impact on a child's functioning in all components of his/her life well into adulthood, if there is no intervention following the disclosure (Finkelhor, 1986; Lanktree & Briere, 1995). Nonetheless, many cases of CSA go undetected or unreported for many years, thus compounding the trauma by repetition and/or avoidance. This is especially detrimental during the important developmental years of a young person.

Some common themes have been identified in the literature about the short and long-term effects of CSA. Psychological and social functioning are said to be impaired to some degree for varying lengths of time for child victims. In order to help understand these effects, Finkelhor & Browne (1985, 1986) developed a conceptual framework of four main categories of the trauma dynamics of CSA and they are: traumatic sexualization; betrayal; powerlessness; and stigmatization. "These dynamics alter children's cognitive and emotional orientation to the world, and create trauma by distorting children's self-concept, world view, and affective capacities" (Finkelhor & Browne, 1985, 1986).

A number of studies have measured a variety of symptoms associated with CSA, comparing abused and non-abused samples of children. Cohen, Deblinger, Maedel, and Stauffer (1999), Ligenzinska, Firestone, Manion, McIntyre, Ensom, and Wells (1996), Miller-Perrin (1998), Swanston and Tebbutt

(1997), and Wells, McCann, Adams, Voris, and Ensign (1995) found that the CSA victims showed more adverse effects in the areas of behavioural, emotional, physical and psychological functioning as well as in their thoughts and perceptions than did the comparison samples. Only, Ligenzinska et al. (1996) examined reactions specifically for victims of extrafamilial CSA.

Cohen et al. (1999) compared the thoughts, feelings and fears of a sample of thirty sexually abused children with a control group of non-abused children with similar attributes. The study identified that the abused group had elevated levels of distortion of thoughts and attitudes about sexuality, indicating the importance for these elements to be addressed in the therapeutic milieu. Similarly, Miller-Perrin (1998) measured perceptions and thoughts of CSA victims and found that the younger children, aged 4 to 6, were more likely to identify victim blame, whereas the older children, aged 10 to 12, identified a more negative self-concept. Recognizing the potential for skewed thoughts and perceptions following the sexual abuse of these young victims is important because it provides a context for understanding the different meaning-making processes being applied to the situation.

Swanston & Tebbutt (1997) conducted a study to measure the ongoing effects of CSA on a sample of sexually abused children five years after they were initially assessed for CSA. Although more life stressors affected the abused group in general, measures were taken to control for this as an influence on the purpose of this study. Overall, "the abused children displayed more disturbed behavior, had lower self-esteem, were more depressed or unhappy, and were

more anxious than controls” (p. 600). There was no description of the type, or whether any therapy was provided during these five years. The authors concluded that ongoing care and intervention is required for the abused children to minimize the impact of CSA on the social, behavioural, emotional and psychological factors in their lives.

Age, at the time of the abuse, has proven to be a key factor in determining functioning after the disclosure of CSA (Black, Dubowitz, & Harrington, 1994; Feiring, Taska, & Lewis, 1999; Miller-Perrin, 1998). Black, Dubowitz, and Harrington studied the effects of sexual abuse on self-perception and behaviour using a non-abused comparison group of children of similar age (4 to 12 years old), gender, and socioeconomic background to the children suspected of being sexually abused. The results did not show any statistically significant differences between the abused and non-abused group in how the children rated themselves using standardized instruments designed to measure self-perception in a developmentally sensitive manner. Nonetheless, there were differences within the abused group, such that preschool aged children identified higher levels of competence and social acceptance than did the school-aged children. “The difference in cognitive competence scores between school-age and preschool-age children in the abuse group suggests that sexual abuse may have a different meaning for children based on their age” (Black et al., 1994, p. 91). Parents in the abused group identified higher rates of behaviour problems than did the control group of parents of non-abused children. Overall this study found personality factors, the quality of the family's functioning, the child's age, the type

of abuse and the child-perpetrator relationship all contributed to psychological adjustment following CSA.

Gender differences also contribute to the effects experienced from CSA (Feiring, Taska, & Lewis, 1999; Ligenzinska et al., 1996). Research has historically been focused on female victims (Genuis, Thomlison, & Bagley, 1991) and prevalence numbers have consistently shown lower rates of reported sexual abuse cases for males. In a sample including 60% female and 40% male CSA victims, self-report measures from the girls indicated higher levels of fear and depressive symptoms immediately following disclosure with the difference between genders narrowing at three months post-disclosure (Ligenzinska et al.). As well, females identify more symptoms associated with post-traumatic stress disorder (Feiring et al.). Both studies found that males and females experienced a variety of traumatic reactions to CSA despite elevated levels of adverse responses being associated with certain areas for each gender grouping.

Friederich (1993) reviewed the literature pertaining to sexual behaviour in children and found that early introduction to sexuality via CSA contributed to traumatic sexualization. Sexually abused children do not inevitably turn out to be sexually aggressive toward other children. Some studies, however, have indicated that 40 to 50% of children with problematic sexual behaviours had previously been sexually abused (Friederich, 1993; Hall, Mathews, & Pearce, 1998).

Short-term effects of the abuse may be immediate, may continue as long as the abuse is continuing, or may lead to long-term effects. Finkelhor (1986)

refers to short-term as being less than two years after the abuse stopped. Although empirical data is minimal, short-term or immediate reactions may include: "fear, anxiety, depression, anger and hostility, and inappropriate sexual behavior" (Brown & Finkelhor, 1986, p. 152). Longer-term effects refer to changes in the child's perceptions of him/herself and those around him/her. These have been documented through studies with adults who were sexually assaulted as children (Brown & Finkelhor, 1986). "Adult women victimized as children are more likely to manifest depression, self-destructive behavior, anxiety, feelings of isolation and stigma, poor self-esteem, a tendency toward revictimization, and substance abuse" (Brown & Finkelhor, 1986, p. 162).

Over time, there has been greater awareness and study of the impact of CSA. The effects of the abuse may be associated with a number of variables such as gender, relationship of the perpetrator to the victim, age at onset, duration of abuse, type and extent of the sexual violation, disclosure circumstances such as parental belief and support, pre-functioning state of the family or childhood sexual abuse of the parent. Overall, the literature clearly identifies the impact on the psychosocial development of CSA victims, demonstrating that there is no single predictor of functioning or recovery. This indicates that a multidimensional assessment and continued exploration of the most appropriate intervention is necessary. Despite the seriousness of CSA, many sexually abused children do not show clinically significant difficulties in functioning (Kendall-Tackett et al., 1993; Ligenzinska et al., 1996), suggesting that resilience factors ought to be considered during interventions.

Considerations for Parents and Families

The initial effects and disclosure of CSA may be quite confusing and devastating for the child victim. Only more recently has there been an influx of literature studying the impact CSA has for the parent(s) or caregiver(s) and family of the child victim (Davies, 1995; Jinich & Litrownik, 1999; Manion et al., 1998; Massat & Lundy, 1998; McCourt & Peel, 1998; Regehr, 1990; Tremblay, Hebert, & Piche, 1999; Van Scoyk, Gray, & Jones, 1988). As well, Ray and Jackson (1997) and Ray, Jackson, and Townsley (1991) focus on the family in their examination of the family environment as a mediating factor in the long-term adjustment of CSA victims.

One of the earlier guides was presented by MacFarlane (1986) who dedicated one chapter of his book to working with parents following the disclosure of extrafamilial sexual abuse of their child. "On the one hand, such a family may experience fewer torn loyalties because the abuser is not seen as one of them (although that should not automatically be assumed, since many abusers are very close to the children or the parents), but, on the other hand, there are fewer therapeutic resources available to the family" (p. 299). According to most child protection agencies it is the responsibility of the parent(s) to protect their child. As long as this is happening following disclosure of extrafamilial sexual abuse, mandated services are not compelled to provide a service to the child victim and his/her family (Manitoba Family Services, 1995). This is where the gap emerges since incestuous cases tend to be more closely monitored or more invasive interventions imposed. The view that there was a gap in service

for families affected by the extrafamilial sexual abuse of their children was the basis upon which the FASA program was developed.

Van Scoyk, Gray, and Jones (1988) outlined their findings from a study that looked at the impact of CSA on family. In their examination, they followed thirty-seven families through a program designed to provide a service to families when a "nonfamily" person committed the sexual assault. "Brief, focused family work was undertaken in conjunction with several individual sessions with the child. [They] relied on the strengths of these families and focused on helping the family help the child" (Van Scoyk et al., 1988, p. 109).

Recognizing the uniqueness of each family's belief systems and differences within families, Van Scoyk et al. (1988) created a theoretical framework that was based on three primary concepts believed to be necessary to assess and provide a service to these types of families. The first consideration was to recognize that CSA affects the balance within a family, as it is an external force invading the family's boundaries and known existence. "...[S]exual molestation, being outside the usual range of human experience, creates a violation or breach in the family's 'protective shield'" (Van Scoyk et al., 1988, p. 110). Secondly, CSA affects the family's daily and life experiences as the traumatic event replays itself in various ways. Lastly, the family needs to be assessed for their myths and beliefs around sexual abuse because this affects their response to the trauma and eventual recovery.

It is apparent that the significance of family must not be forgotten following the disclosure of CSA given that the literature has shown correlations between

the child, his/her family relationships and immediate and long-term adjustment. In a study by Ray and Jackson (1997) the Family Environment Scale (FES) was used as a retrospective measure of the perceived family environment for a large sample of college women sexually abused as children. These researchers found "that positive family characteristics have direct beneficial effects on the adjustment of victims of childhood sexual abuse" (p. 13).

Parental support has been identified as one of the most significant indicators of children's adjustment, healing and recovery following disclosure of CSA. In a Canadian study by Tremblay et al. (1999), data showed

a link between perceived social support from parents, externalizing behaviors and global self-worth, corroborating previous studies in finding that behavioral difficulties are less intense and the evaluation of self-worth more positive when the child feels supported by his parents. Thus a warm and comforting relationship with a significant parental figure appears to have a positive effect on CSA victims' adjustment. (p. 941)

Recognizing and honouring the role of parents is essential, but it is equally important to be aware that CSA is also an overwhelming and stress inducing time for the parents. A variety of emotional reactions are common (Davies, 1995; MacFarlane, 1986; Manion et al., 1998; Regehr, 1990). If parental support is a significant mediator of stress and difficulty for their child, yet the parent is also experiencing emotional distress, then confusion or uncertainty may result or hinder the provision of the necessary support by the parent. Therapists must recognize the impact of CSA on parents in an effort to help address stressors and maximize the effectiveness of interventions. As well, education and prevention initiatives can increase public awareness and provide necessary skills, knowledge and resources to first, or crisis response services so that

children and their families affected by sexual abuse receive helpful and significant messages as soon as possible.

Jinich and Litrownik (1999) have studied the effectiveness of an educational videotape to increase mothers' belief of and support for their child following disclosure of CSA. During the investigation stage the mothers in the experimental group watched a videotape in which "social learning techniques were utilized in an effort to provide mothers with: (1) information about what they could expect from their child; (2) an explanation of why the way in which they responded to their child would impact his or her adjustment; and (3) specific examples of how they could respond in a manner that would promote positive adjustment in their child" (p. 180). As a time-effective, effortless tool, the videotape elicited more positive, supportive and knowledgeable responses from the parents in the experimental group toward their children. Similarly, these parents tended to show less personal distress since they perceived themselves to be providing the necessary support to their child. The use of this type of video may be an encouraging option for child protection agencies and police child abuse units to provide helpful information in a timely manner.

Approaches to Treatment of Sexually Abused Children

Although there has been more literature addressing the impact of sexual abuse for children, there has been a limited number of empirical studies of preferred or superior treatment modalities to use with children who have been sexually abused (Berliner & Saunders, 1996; Cohen & Mannarino, 1998).

The research reviews generally found that child sexual abuse program outcomes are only rarely assessed. A primary reason for this is that programs are poorly conceptualized. Program structure and logic, process and outcome are not usually articulated in a way that would enable programs to be evaluated. Social welfare planners, policy makers and administrators are therefore not in a position to assume that clearly defined programs are in place to serve victims of child sexual abuse. (Williams & Hudson, 1991, p. 7)

Nonetheless, some research has been undertaken in an attempt to measure the effectiveness of therapy processes at alleviating symptomatology after CSA. In an evaluation of two different treatment approaches, Cohen and Mannarino (1998) found that sexually abused children receiving sexual abuse-specific cognitive behavioural therapy showed fewer depressive symptoms than their counterparts participating in nondirective supportive therapy. Otherwise, the study did not yield statistically significant differences in wellness and distress at post-treatment.

Another outcome study followed children for a two-year period after completing one of two forms of group treatment; a conventional sexual abuse therapy group and the other group supplemented the conventional method with stress inoculation training (Berliner & Saunders, 1996). The researchers concluded that both groups continuously improved and neither showed outstanding fear and anxiety concerns at the conclusion of the study.

Lanktree and Briere (1995) conducted a study with a sample of 105 CSA victims between the ages of 8 and 15 years in which an abuse-focused treatment approach was used. Standardized questionnaires were administered at the onset of the program and at three month intervals for up to 12 months, or as long as

the family remained in therapy. Measures of anxiety, depression, post-traumatic stress, sexual concerns, dissociation and anger of the child victim were completed. The researchers found that the passage of time alone was not sufficient to decrease the effects of CSA and that the time in treatment was correlated to improvements in emotional and psychological functioning. They found that progress in treatment was highly correlated to shorter lengths between the last abuse experience and entry into therapy, the younger the age at the onset of therapy and whether criminal charges were pressed. Lastly, they identified that children remained in therapy for varying lengths of time with progress and improvement, suggesting that healing is not a uniform process.

Recognizing the significance of support and treatment, Tingus et al. (1996) examined factors that are associated with sexually abused children entering into therapy. This is an American study that followed 972 children being evaluated for sexual abuse and found that of the study sample, nearly 36% involved an intrafamilial relationship between victim and perpetrator, 42.5% involved an extrafamilial relationship and the relationship of the remaining 21% was unknown. The authors found that the gender of the victim and the relationship of the offender to the child did not yield statistically significant results as variables for entry into therapy. Statistically significant results were present for a number of other factors. The age of the child yielded curvilinear findings; children 7 to 13 years old were more likely to be in therapy than the younger or older age ranges. As well, children placed outside of their family home were more often in therapy. A positive correlation to participation in treatment was

noted for those who were victimized repeatedly and when the abuse was deemed to be of greater severity. Lastly, statistically significant differences were reported for ethnicity. In this study, Caucasian children entered therapy more often than children of Hispanic or Black descent. The authors also found that when children service authorities and law enforcement were involved, therapy was more likely to occur. Despite the limitation of not getting input from clinicians to corroborate attendance at therapy, this study provides a valuable contribution to recognizing that not all children enter therapy after being sexually abused. Based on known effects of CSA some form of therapy is beneficial for the healing and recovery process, thus intervention and prevention efforts should examine ways to ensure that all victims have an opportunity to access treatment.

Gil and Johnson (1993) and Lanktree and Briere (1995) identify that a combination of interventions including individual, group and family treatment are most effective for child victims or children with inappropriate sexual behaviours. There are a variety of theoretical models and schools of thought for addressing CSA in therapy. Examples of different approaches include: cognitive behavioural therapy (Berliner & Saunders, 1996; Cohen & Mannarino, 1998; Deblinger & Heflin, 1996); art and play therapy (Gil, 1991; Johnston, 1997; Rasmussen & Cunningham, 1995); non-directive supportive therapy (Cohen & Mannarino, 1998); psychodynamic trauma-focused therapy (Wieland, 1997) and narrative therapy (Adams-Wescott & Isenbart, 1990; Laing & Kamsler, 1990). Dolan (1991, 1994) uses a solution-focused approach in her work with adult survivors of childhood sexual abuse. Durrant and Kowalski (1992) use elements of both

narrative and solution-focused therapy in their approach. O'Hanlon and Bertolino (1998) have a book dedicated to therapy with children and families effected by the trauma of sexual abuse using a solution-oriented approach. There is also a family systems treatment program in Calgary, Alberta, for children affected by intrafamilial sexual abuse in which a combination of structural and strategic philosophies guides practice (Babins-Wagner, 1991). It is evident that many beliefs and philosophies have guided therapeutic interventions for work with CSA victims.

It is my contention that if children are seen in therapy as a part of their family unit, with the people whom are most significant in their life, then skills, knowledge and new meanings can be more effectively incorporated in their relationships, perceptions and behaviours within a safe and supportive home environment. The literature provides a valuable contribution to understanding the complexity of CSA, the effects of it on the child and family and strategies for intervention. The following chapter provides a literature review of narrative and solution-focused therapy to promote their use in work with children affected by sexual abuse. These models are strength oriented and based within social constructionism. They support a family-based approach, emphasizing the meanings that the child and family have developed and attributed to the sexual exploitation in facilitating their recovery and reorganization processes.

CHAPTER THREE

Literature Review: Theoretical Orientations

Narrative Therapy

Narrative therapy (NT) is an approach to counselling with children, adults and families that is based in social constructionism. It views reality as being constructed through interpretations of one's experiences creating meaning for one's life story. The origin of this paradigm is associated with the theoretical perspectives and clinical approaches described by Michael White and David Epston (Nichols & Schwartz, 1998). Much of the historical and theoretical discussion to follow is presented based on the work of these two therapists. There are also many other respected therapists who have expanded, clarified, summarized and applied NT with various populations (Combs & Freedman, 1994, 1998; Dickerson & Zimmerman, 1996; Durrant & White, 1992; Freedman & Combs, 1996; Freeman, Epston, & Lobovits, 1997; Monk, Winslade, Crocket, & Epston, 1997; Nichols & Schwartz, 1998; Semmler & Williams, 2000; Weingarten, 1998; Zimmerman & Dickerson, 1994, 1996).

Historical Development

This model of therapy began its development in the late 1970s with the work of Michael White and David Epston. They used information and philosophies from many disciplines including anthropology, literary theory, critical theory, feminist theory and sociology in the development of the narrative approach (Nichols & Schwartz, 1998). Feminist theory contributed to NT by emphasizing the deconstruction of the traditional power in families.

White and Epston were influenced by the work of Gregory Bateson, who looked at the subjective nature of reality, that is, how individual perceptions of differences lead to interpretation of events (White & Epston, 1990). They referred to Bateson's concepts of negative explanation, restraint and double description located within cybernetic theory. Cybernetic theory describes that events in living systems follow a particular direction because they experience barriers or "restraints" to the development of or path toward alternative courses (White, 1986). "From this perspective, habitual family interactions or the specific behaviors of family members are best explained negatively by the analysis of different kinds of restraints" (White, 1986, p. 169). News of different options involves an interactive process of understanding, explaining, and eventually choosing relevant information that remains as the story that the living system is experiencing. Thus, double description refers to news that more than one option exists to counter the restraint. White's interpretation of the narrative metaphor and the idea of story were also initially derived from the work of Bateson (Bubbenzer & West, 1994).

Furthermore, White and Epston were influenced by the work of Michael Foucault, "a French intellectual who described himself as a 'historian of systems of thought'" (White & Epston, 1990, p. 1). Although there is some question as to whether White and Epston have correctly interpreted the work of Foucault (Fish, 1993; Redekop, 1995), they have referred to Foucault's work on criticizing the notion of the expert, the notion of power and knowledge, institutionalization and

the dominant cultures influence on defining absolute reality (White & Epston, 1990).

They began to identify the significance of words and language as contributing to the narratives that organize the stories of people's lives and to understand the context in which these meanings were developed (White & Epston, 1990). The work of C. Geertz and Edward Bruner provided the preamble for looking at texts and interaction. A text analogy referred to the survival of texts across time, resulting in "lived experiences" or a story of one's life. "In two senses, the text analogy introduces us to an inter-textual world. In the first sense, it proposes that person's lives are situated in texts. In the second sense, every telling or retelling of a story, through its performance, is a new telling that encapsulates, and expands upon the previous telling" (White & Epston, 1990, p. 13).

Theoretical Foundations

White and Epston questioned previous models of therapy and thus began the formation of new thoughts and applications in family therapy that has become a more respectful approach to working with families. These origins shaped the development of narrative family therapy as White and Epston (1990) began to view problems as external to the family, that is, "the problem becomes the problem" (p.40) and recognized that problems were experienced as oppressive for families (Monk, 1997; White & Epston, 1990). NT is based on the premise that the clients are the expert of their own lives and have interpreted their

experiences based on the sociopolitical and cultural context in which they have lived.

The notion of discourses contributes to our understanding of meaning, narratives and power. "Discourses organize and regulate even interpersonal relationships as power relations. Discourses are social practices; they are organized ways of behaving" (Drewery & Winslade, 1997, p. 35). As such, people are said to develop stories through narratives, language and interactions within the dominant culture and tend to come to therapy with problem-saturated stories.

Stories are full of gaps which persons must fill in order for the story to be performed. These gaps recruit the lived experience and the imagination of persons. With every performance, persons are reauthoring their lives. The evolution of lives is akin to the process of reauthoring, the process of persons' entering into stories, taking them over and making them their own. (White & Epston, 1990, p. 13)

Narrative therapy is conducted with full recognition and attention to the influences of the macro system on people's lives. As such, it is a helpful approach for examining the influence of the dominant culture on diversity issues such as ethnicity, race, gender, sexuality or socio-economic status. All stories include diversity. Subjugating internalized truths result, however, if all situations are compared to the dominant culture rather than to unique experiences (Semmler & Williams, 2000). The emphasis on social justice is what attracts therapists to this form of therapy since it is known as "an orientation to life" (p. 404), not just an approach (Nichols & Schwartz, 1998).

Given that stories are cultural, it is imperative to explore their constitutive parts. These stories become a specific expression of the combination of emotions and experiences that are shared in relationships between people. "Our

emotions become so embedded in the stories we identify with our reality that we call them our feelings" (Parry, 1998, p. 68). Emotions are representative of the totality of one's being such that they indicate the "commitment to a story" (Parry, 1998, p. 68). "In the absence of emotion and experience, there are only interesting facts, not a story" (Parry, 1998, p. 76).

Narrative therapy is touted for being a collaborative process. The traditional role of the therapist as the expert is absolved in favour of a stance of curiosity or not-knowing. This approach focuses on the strengths and abilities of the family. The concept of deconstruction evolved out of the examination of power, knowledge and narratives. It is a method for dispelling assumed truths and knowledges thus contributing to the identification of unique outcomes and alternative stories (Monk, 1996). White (1992) states that he does not adhere to a traditional definition of deconstruction. Accordingly,

deconstruction has to do with procedures that subvert taken-for-granted realities and practices; those so-called "truths" that are split off from the conditions and the context of their production, those disembodied ways of speaking that hide their biases and prejudices, and those familiar practices of self and of relationship that are subjugating of person's lives. Many of the methods of deconstruction render strange these familiar and everyday taken-for-granted realities and practices by objectifying them. (p. 121)

There is not a customary "assessment" process using a narrative approach in therapy since this is generally understood as a "diagnosis" presented by the therapist. In an interview about his therapy (Bubbenzer & West, 1994), White speaks about the beginning interview with a client as an opportunity to hear the client's description of their life and to explore their experience of the identified problem. Larner (1997) refers to "assessment" in the following way:

The objective is not to explain but to understand, giving meaning to the child's presenting "problem," weaving it into a pattern that makes sense of events in the life of the family. Neither the therapist nor any family member has a monopoly on the truth. The therapist in particular knows less, adopting a "not-knowing, but curious" stance. The therapist is oriented toward the child's story – the interest is in the child's narrative as it emerges in play, art, drawing, conversation, and interviews with the family. The therapist's stance is both dialogic and curious, more of a listening than an interpreting. (p. 429)

The traditional "termination-as-loss" phase of therapy is also regarded more respectfully in NT. Epston and White (1992) liken the therapeutic process to a metaphor of a "rite of passage" referring to the stages of separation, shifting to an in-between or uncertain point and reaching a stage of reintegration. This final stage is historically associated with the loss of the micro-world of therapy. Rather than take such an assuming position, these therapists assert that the ending phase of therapy should be an opportunity to emphasize the solution building and alternative knowledges that were realized in therapy.

The final stage of a therapeutic relationship follows the path of discovery and rediscovery with full respect for the family's journey. It "centres around a rejoining of the person with others in a familiar social world and would encourage the recruitment of others in the celebration and acknowledgement of the person's arrival at a preferred destination or status in life" (Epston & White, 1992, p. 15). This is also referred to as the process of "consulting your consultants" in which applicable questions help clients to experience themselves as able and the expert of their own lives (Epston & White, 1992).

Helping the client achieve personal agency is a central goal throughout the process of NT such that it enables, empowers and raises awareness for the

client to be “subjective” versus “subjected” in their discovery of alternative stories (Drewery & Winslade, 1997). Based on the belief that there is not one true reality, multiple perspectives are sought and are a way to increase options for the family in the re-authoring of its story.

Clinical Approaches

The role of the therapist is to help clients to deconstruct the problem saturated story by finding unique outcomes for when the problem did not dominate their life story (Epston & White, 1992; Monk, 1997). The search for unique outcomes occurs by locating a time in the history of the problem when the client triumphed over the influence of the problem. Likewise, the collaborative relationship with the client helps to co-create a preferred reality for the family. The intention is to help the family change the way they relate to the identified problem and to create a team approach among the family to address the issue.

The “problem” is discussed as external to the family or person who is experiencing the difficulties or worries that brought them to therapy. This creates the beginning stages of challenging internalized conversations and of the deconstruction process. Although externalizing the problem is often referred to as a technique used in NT, Dickerson and Zimmerman (1996) clarify it as “a way of thinking, not a technique” (p. 86) that is situated in the sociopolitical realm. Its use in a narrative context must take into consideration the macro influences otherwise the therapist is supporting the status quo. Externalization confirms the belief of NT that “the problem is the problem”. This objectification is achieved through the use of language and questioning, giving the problem an identity of its

own. Drewery and Winslade (1997) suggest that it is more appropriate to refer to “externalizing conversations” versus “externalizing the problem” since the first idea implies a broader or more fluid theoretical premise. The strength in externalizing conversations is that it does not pathologize, it avoids blame, labeling and scapegoating and increases co-operation among the family. As well, once the problem is externalized, opportunity is then created to increase personal agency in taking action against the objectified problem (Tomm, 1989).

Questioning is the main technique used in the therapeutic setting whereby the therapist aims to map the influence of the problem on the client and the client's influence on the life of the problem (White & Epston, 1990; Zimmerman & Dickerson, 1994). This form of exploration in therapy uses the questions to “emphasize the history of the dominant present in a very particular way” (White, 1993, p. 128). Relative influence questions assist in deconstructing the restraining features in the story of the lived experiences. During this process the therapist works toward creating awareness of the landscape of consciousness or meaning that is a reflection of events within the landscape of action for the client (Bubbenzer & West, 1994). Orientation, unique account, unique redescription, unique possibility and circulation questions empower the client to recognize the path of rediscovery they travelled. This helps to highlight their personal agency that tells them and those around them that they are functioning with alternative knowledges (Epston & White, 1992).

As the client and therapist work toward re-constructing a preferred outcome, attention is also diverted to creating a supportive community to

recognize and cheer the client's movement away from the problem-saturated story. "If stories that we have about lives are negotiated and distributed within communities of persons, then it makes a great deal of sense to engage communities of persons in the renegotiation of identity" (interview with White in, Bubenzer & West, 1994, p. 79). Often the use of a reflecting team in practice aids in the provision of multiple perspectives and the validation of alternative stories. White and Epston (1990) also use letter writing to communicate and document interactions with clients as a means to provide a tangible reference for the client. Andrews, Clark, and Baird (1997) promote the use of letters as "relational" case notes, as a way to provide additional and multiple perspectives and to support the alternative stories that are being discovered in therapy. These authors also suggest that letters encourage ongoing critical thinking of clients toward empowering them and tapping their inherent resources.

In ending a therapeutic relationship with clients, celebrations and certificates are used as reminders of the new story created by and with the client (White & Epston, 1990). Essentially this stage is a "celebration of family resources" which is much more empowering for the family than an emotional ending or setting up the final stage of the therapeutic relationship as an experience of loss.

Evaluations and Critiques

Perhaps the most blatant critique of NT is that there have been few research efforts to measure the effectiveness of the process or outcome of this model in practice. The literature is ripe with many case studies and anecdotal

accounts that “prove” or demonstrate that this method of intervention is helpful with a variety of presenting issues, yet these subjective descriptions fall short of a coordinated research project. Etchison and Kleist (2000) recently presented a review of the literature and found that there have only been four studies published that provide some outcome data on NT (Besa, 1994; Coulehan, Friedlander, & Heatherington, 1998; St. James-O’Connor, Meakes, Pickering, & Schuman, 1997; Weston, Boxer, & Heatherington, 1998). Each of the studies focused on parent-child conflict as the presenting problem, but varied in what they measured. Three of the four studies presented outcome data on eight or less families. The fourth study involved a combination of quantitative and qualitative methodology in examining the development of narratives describing parental conflict by 92 children between the ages of 5 and 12 years old.

One of the projects that looked directly at outcome data was that of St. James-O’Connor et al. (1997). They duplicated their roles from clinicians to researchers in their examination, using an ethnographic study, of what the family’s experience of narrative therapy was. Each of the eight families consistently rated their problem as less severe after participation in therapy using a narrative approach. The content analysis of the transcribed interviews found that feedback specific to personal agency and the reflecting and consulting team occurred most often. Interestingly, reference to externalizing conversations occurred least. The participants mentioned helpful aspects of narrative therapy 101 times with the remaining 16 comments referencing unhelpful aspects of the process. “Certainly this research shows how valuable it is to clients that their

problems have been reduced and that they were empowered to make changes” (St. James-O’Connor et al., 1997, p. 492).

While this is a beginning, and perhaps promising, Etchison and Kleist (2000) suggest that these four studies are limited in their ability to speak to the overall effectiveness of NT in practice. They hypothesize that there is a scarcity of scholarly literature on the efficacy of NT because a qualitative methodology is most appropriate for this constructivist and language based intervention. Unfortunately, few researchers are trained in the qualitative method of inquiry. Both qualitative research and NT are in their infancy in academia, thus accounting for the limited outcome studies in these areas. This weakness is of concern because the longevity of NT will be associated with the production of appropriate research to support its utility.

This approach places therapy within the sociopolitical and cultural realm consistently associating the issues presented as a relationship to the dominant discourses (Zimmerman & Dickerson, 1994). In response to this foundation issue of NT, Minuchin (1998) began a published dialogue by several family therapists about components of NT (Combs & Freedman, 1998; Minuchin 1999; Schwartz, 1999; Sluzki, 1998; Tomm, 1998). Albeit that there is a recognition of positive contributions of the narrative approach to family therapy, Minuchin critiques this therapy for promoting the macro system at the expense of the family. Likewise, he contends that meeting with parts of a family unit and allowing the voice of individuals in family therapy restricts the principle of social constructionism to

focus on interpersonal relationships as the mechanism for the development of meaning.

However, Combs and Freedman (1998) and Tomm (1998) respond by asserting that Minuchin misinterprets the context of family by these proponents and practitioners of NT. Suggesting that Minuchin is "immersed in first-order thinking" (p. 410), Tomm (1998) states that this way of thinking contributes to Minuchin's view that an entire family must be present to call it family therapy. In second-order cybernetics, however, "the physical presence of multiple family members is less essential" (Tomm, p. 410). This dialogue presents a variety of perspectives but it is compartmentalizing issues through the debate and negates the importance of all parts in contributing to the context of therapy. Schwartz (1999) warns that an exclusive view of the societal and cultural factors for individual and family difficulties has the potential to miss and/or negate important individual and family processes that need to be explored and rectified within therapy. A more inclusive approach is recommended in which macro influences on the maintenance of the problem are incorporated, but family patterns should also be examined as to how they contribute to perpetuating difficulties.

In order to practice narrative therapy it is essential that the therapist believe in the strength of the client, the value of narrative and the social construction of reality. Although, the basics of the narrative approach are quite straightforward, it is not a formula and if therapists' use bits and pieces of this approach the essence of it will be lost (O'Hanlon, 1994). Likewise, caution has been recommended for advocates of NT to recognize that prescribed techniques

contribute to narratives being objectified and viewed with absolute superiority (Sluzki, 1998).

Notwithstanding their support for and appreciation of White and Epston's approach, O'Hanlon (1994) and Monk (1996) suggest that despite preaching a non-directive therapy, the approach does favour the therapist's agenda. Minuchin (1998) also mirrors this proposed weakness suggesting that NT is directive and limits the ability of the therapist to freely interact with the client. "Initially, it is not apparent how direct the method is as the therapist's positioning in relation to the problem is located in a meta level question" (Monk, 1996, p. 47). NT is a collaborative and respectful therapy and does not contend to be a neutral process of interaction. Nonetheless, the suggestion is that White and other therapists promoting NT do not acknowledge the degree of power that their overt positioning has in therapy. Fish (1993) also criticizes the work of White and Epston saying that they address issues of violence or abuse minimally in their model of intervention, indicating less of a commitment to social justice than is professed. Lastly, the narrative approach is seen to be more of a cognitive process and identified as being more appropriate for higher functioning clients (Nichols & Schwartz, 1998).

Solution-Focused Therapy

As a postmodern therapy, solution-focused therapy (SFT) is a strength-oriented model of intervention that was born out of strategic therapy (Gladding, 1998). It focuses on constructing solutions to problems rather than on the nature and complexity of the problem (de Shazer, 1991). This is meant to be a brief

therapy that is interactive and collaborative with clients. Although there are several therapists who have contributed to this mode of therapy the work of Steve de Shazer (1985, 1988, & 1991), who is said to be the primary developer of this model, will guide the following review of SFT. Insoo Kim Berg, Peter DeJong, Eve Lipchik, Scott Miller, Jane Peller, John Walter and Michele Weiner-Davis are other well-known proponents of SFT, all whom have worked with de Shazer at the Brief Family Therapy Center (BFTC) in Milwaukee, Wisconsin (Stalker, Levene, & Coady, 1999).

Historical Development

Solution-focused therapy had its beginnings at the Brief Therapy Institute that was a part of the Mental Research Institute (MRI) in Palo Alto, California. de Shazer was influenced by the brief therapy team but began to explore his own ideas and expanded on the MRI model in the 1970s and early 1980s (Gladding, 1998). In 1978, de Shazer, with Insoo Kim Berg, established the Brief Family Therapy Centre (BFTC) and began to identify themselves as brief therapists (West, 1998). In an interview, Berg and de Shazer explained that, for them, the clinical work came first and out of their desire to understand and interpret the work and how it was effective, they clarified and defined their theoretical assumptions (West, 1998).

The work of Gregory Bateson and Milton Erikson had the greatest influence on de Shazer (Chang & Phillips, 1993; de Shazer, 1985). Erikson's brief therapy approaches date back to the mid-1950s with an emphasis on looking at strengths and creating a future about the problem (de Shazer et al.,

1986). Discussions and attention to the fit of the client and therapist also emerged as a result of Erikson's influence on de Shazer (Chang & Phillips, 1993).

From Bateson, de Shazer (1985) adopted the concept of double description. This helped to clarify and reify the purpose of the consulting team that de Shazer and his colleagues used in therapy. The team, as observers, provided different and multiple views to assist the index therapist and provide more options for initiating change for and with the client (de Shazer, 1985).

Theoretical Foundations

As a minimalist theory, the developers and practitioners of SFT have aimed to keep this form of therapy simple. The initial influences for de Shazer provided the thoughts that have seen SFT continue to evolve in theory and technical development. de Shazer (1988) refers to the theory as a "central map" of "the various pathways from 'complaint' to 'goal achievement' and 'solution' that cases predictably tend to follow" (p. xvii).

Solution-focused therapy is considered a post-structural therapy where language is the medium through which meaning and change occurs. "For a post-structuralist, meanings are seen as known through social interactions and negotiation; meanings here are open to view since they lie in between people rather than hidden away inside an individual (psyche, system, family structure, etc.)" (de Shazer & Berg, 1992, p. 73).

de Shazer and Berg (1992) emphasize the importance of language for all interactions and specifically in the therapeutic process. They refer to this as a

“language game” that is an activity of interaction through words, concepts and meanings contributing to a mutual shaping or social construction of reality. Thus, in therapy, the “language game” is helpful for naming complaints, structuring conversation and maneuvering change for and with the client (de Shazer & Berg, 1992). “The solution-focused language game is designed to persuade clients that change is not only possible, but that it is already happening” (Miller & de Shazer, 1998, p. 372). It is also a deconstructionist strategy (Miller & de Shazer, 1998).

As a postmodern therapy, the solution-focused model of intervention is future and strength oriented, rather than focusing on the past and the complexity of the problem. Solution-focused therapists

believe that people already have the skills to solve their problems but have lost sight of these abilities because the problems loom so large to them that their strengths are crowded out of the picture. Sometimes a simple shift in focus from what’s not going well to what they’re already doing that works can remind clients of, and expand their use of, these resources. (Nichols & Schwartz, 1998, p. 384)

Furthermore, SFT has buried the concept of “resistance” and promotes the belief that clients really do want to change (de Shazer et al., 1986; Stalker et al., 1999). de Shazer (1985) declared that, “Every client carries the key to the solution: The therapist needs to know where to look” (p. 90).

The premise of SFT is that problems are associated within interactional relationships of humans. The task is to help the client to change their patterns of interaction to achieve a solution that can be a simple, small change. The belief in the social construction of a new story does not imply that every part of the client’s life must be addressed in therapy (Miller & de Shazer, 1998). Rather, any indication or news that there has been a change in behaviour or perception

toward improvement is accepted at face value as movement toward solutions (de Shazer et al., 1986). It is purported that this will then open the door for other changes and affect other parts of the system or relationships.

The results of these interventions also suggest that, in terms of problem resolution, there is no clinical distinction between clients' perceived change and observed change. If clients perceive a change, then, in terms of their problems (for clinical and perhaps epistemological purposes), there is a change, whether or not there is an observable behavioral change. (de Shazer & Molnar, 1984, p. 303)

According to SFT, "complaints involve behavior brought about by the clients' world view" (de Shazer et al., 1986, p. 210). People develop complaints as a result of believing that there was only one choice to respond to the originating difficulty and they became stuck in their response systems (de Shazer, 1985). A therapist does not need to know much about the complaint to provide an effective service to the client (de Shazer et al., 1986).

Generally, the first therapy session provides the client the opportunity to talk about their complaint but a shift towards looking at exceptions to when the problem was not a problem and at solutions occurs rather quickly in this form of therapy (de Shazer et al., 1986). Thus, the traditional "assessment" phase is not recognized in the same manner in SFT in favour of a brief problem description that enables the therapist to expediently shift to solution talk (DeJong & Berg, 1998).

Solution-focused therapy is said to be collaborative and uses a range of questions to elicit responses aimed at change for the client system. Ultimately, the therapist aims to create more "hopeful conversations" (Nichols & Schwartz, 1998) by paying particular attention to the use of language in therapy. Thus, the

collaborative relationship contributes toward goal development and achievement (Stalker et al., 1999). DeJong and Berg (1998) assert that working from one step behind and from the client's frame of reference contributes to an effective working relationship with diverse populations.

In an effort to assist the therapist to recognize and/or understand the type of relationship that exists with a client, "a rather arbitrary" (Stalker et al., 1999, p. 470) categorization has been developed and promoted by de Shazer (1988) and DeJong and Berg (1998). They refer to different types of relationships namely, customer, complainant and visitor, that can help the therapist to know how to best help the client work toward change. The type of relationship can shift and this is largely dependent on the conversation used by the therapist to engage the clients and help them move from problem to solution talk (DeJong & Berg, 1998).

Clinical Approaches

Solution-focused therapy occurs in a manner that respects the clients as the experts of their own life. It is meant to be a brief therapy and does not contend to be a family therapy (de Shazer, 1993). Thus, when any client is attending therapy they are encouraged to bring any family members or other supports they think would be helpful to solve the identified issues (West, 1998). This attends to the concept of "wholism" described by de Shazer (1985) in which family is more than the combination of individuals. Family interactions and relationships contribute to the overall complexity, which has an impact at fostering change that can begin at any level of the human system.

The solution-focused model of intervention employs the use of questions to facilitate change with the client. The intent of these questions is to create awareness and expectation for change. In SFT there is a clear structure that the therapist follows during the process of the first and subsequent sessions (DeJong & Berg, 1998). Each session is meant to be an hour long and include a ten-minute break near the end of the session.

Therapy begins by opening space for the client to describe the complaint that brings him/her to therapy. A shift by the therapist then helps begin the process of "solution-building" (DeJong & Berg, 1998). Using the client's frame of reference and well-formed goals that are small, tangible and manageable begin the change process. "Setting a concrete goal is thought to elicit the expectation of change, as well as providing a criterion for success" (Stalker et al., 1999, p. 469).

Once the expectation of change has been created, the therapist elicits descriptions of any changes in any area of the client's life. Anything that prompts the client to say that "things are better" needs to be identified as verification of change, and anything new or different or more effective that the client reports needs to be encouraged or amplified. That is, any news of different behaviour and perception or news of increased satisfaction is accepted by the therapist as movement toward solution. (de Shazer et al., 1986, p. 213-214)

The therapist aims to encourage the client to do more of what has been working well for him/her. Alternatively, the client is asked to tap into other resources, that is, to do something different toward a solution (DeJong & Berg, 1998).

The miracle question is a common question asked of the client near the beginning to predict a future without the problem and how it would look. This technique essentially evolved out of Erikson's crystal ball technique (Chang &

Phillips, 1993). It supports a shift in cognition creating hope for a more favourable future. Nau and Shilts (2000) used a qualitative methodology to analyze a videotaped interview by each of: Insoo Kim Berg, Eve Lipchik, Scott Miller and Charlie Johnson. All are recognized therapists using the SFT model of intervention. The thematic analysis uncovered four necessary therapeutic actions that must take place prior to delivering the miracle question to the client: 1) joining and developing rapport; 2) developing an understanding of the presenting problem through empathic listening; 3) looking for and identifying exceptions as a way to bridge the past and future; and 4) a cautious effort to refrain from premature planning for the future without the problem. Accordingly, these elements provide the solid foundation by which to then pose the miracle question with the client.

Exception questions are used to elicit, from the client, times in their life when parts of the miracle have already been occurring or when the problem was expected to happen but did not (DeJong & Berg, 1998). "Solutions are present as exceptions to clients' problems, and as personal and social resources that clients may draw upon in solving their problems" (Miller & de Shazer, 1998, p. 371). The therapist explores these exceptions, focusing on the strengths and resources that the client has already applied to the exception times (DeJong & Berg, 1998; Miller & de Shazer, 1998). The therapist can summarize and paraphrase these times and compliment the client on the successes.

The scaling question is a rating question meant to have clients monitor the degree of impact of the problem on them (Nichols & Schwartz, 1998). It also

helps to quantify future self-perceived possibilities for the client (DeJong & Berg, 1998). Scaling questions are used at various stages of the therapeutic process to identify and monitor progress toward the goals.

Tasks, compliments and clues are also given at the end of the session after a 10-minute consultation break. This break is a trademark of the SFT framework. During this time a team of consultants who had been observing through the one-way mirror provide messages to the therapist to deliver to the clients (de Shazer et al., 1986). Even if a team was not observing, the therapist takes a break to gather his/her thoughts and feedback for the client (DeJong & Miller, 1998).

The formula first session task (FFST) and between session tasks are used with clients to have them notice what is happening in their life between meetings, focusing on what they want to continue to have happen (de Shazer, 1985). One such between session task that is asked of clients is to tell them to "do something different" when the complaint presents itself, however, no direction is provided by the therapist of what to do (de Shazer, 1985). "These interventions are minimally intrusive and yet their impact seems inordinately large. The ripple effect or the concept of wholism gives us some notions about how a small difference can become a big enough difference" (de Shazer, 1985, p.136).

Ongoing therapy centres on the search for exceptions that occurred between meetings and contribute to continuing solution building. A common beginning in subsequent sessions is to ask, "What's better?" (DeJong & Berg, 1998). DeJong & Berg (1998) state: "Once a client of yours identifies an

exception, however vaguely or unconvincingly, it is your role to explore it in detail" (p. 136). The acronym, "EARS" has been developed to represent this process.

E stands for *eliciting* the exception. *A* refers to *amplifying* it,... *R* involves *reinforcing* the successes and strengths that the exception represents, largely by noticing exceptions and taking the time to explore them carefully and, of course, through complimenting. Lastly, the *S* reminds interviewers to *start again*, by asking, "And what else is better? (DeJong & Berg, 1998, p. 136/137)

Incorporating setbacks into discussions is a way to continue to empower the clients as the expert of their lives and to recognize the ongoing nature of change (DeJong & Berg, 1998). Ending therapy is done with full regard for the clients' knowledge and confidence that changes are occurring and that they have the resources to continue on the path of solution building. Overall, this is meant to be a brief therapy with recognition that clients are the experts of their lives, hence when small changes begin to occur the clients continue to incorporate them in their own environment and in their own way.

Evaluations and Critiques

Written within a social work context, a more recent publication by Stalker, Levene, and Coady (1999) provides a thorough overview of SFT and a comprehensive discussion on research and limitations of this model of therapy. SFT is cheered for being collaborative, strength based, client-centred and believing in the client's desire to change. Unfortunately, "there is limited evidence for its efficacy because no methodologically sound studies on [SFT] have been conducted" (p.471). The authors also identify that, due to a number of shortcomings, the outcome studies of the leading theorists within the SFT school

of thought have not been accepted nor published in peer-reviewed journals. When compared to social work values and ethics, SFT is criticized for the assumption that briefer is better, its de-emphasis on the person-in-environment perspective, "the adherence to narrow models and the belief that one model can be all things to all people" (p. 474), and its disregard of the worker-client relationship and affective factors in therapy.

The focus on cognition and behaviour at the expense of emotion and affect in therapy is sited quite often in the literature as a weakness of SFT. King (1998) offers some reprieve suggesting the integration of emotions and affect in SFT at different stages of the therapeutic process such as during the joining with the client, the co-construction of meaning and goal setting, questioning and task setting. King speaks of affect as intertwined with attunement. The goal of therapy is not to specifically elicit emotions, however, "exploring and validating emotions offers a richer contextual understanding that goes hand in hand with cognition in creating meaning" (King, 1998, p. 63). King hypothesizes regarding the lack of regard for emotions stating that:

Many brief therapists fear that evoking emotions will strengthen the connection between therapist and client, making it harder to end therapy. There appears to be an implicit view that expressing feelings may help people feel better in the moment, but will not be significant in promoting lasting change. (p. 52)

Although this therapy is said to be strength-oriented, emphasizing collaboration as an integral part of the client-therapist relationship, it has been criticized as being more directive than collaborative (Nichols & Schwartz, 1998). Likewise, it has also been criticized as a therapy that does not pay attention to

context. SFT is said to work towards the problem disappearing and fails to understand the meaning of change in a context that the client can understand and incorporate into their lives (Dickerson & Zimmerman, 1996; Stalker et al., 1999).

A feminist perspective of SFT contends that the solution-focused model fails to include affect, emotion, insight and explanation within interventions (Dermer, Hemesath, & Russell, 1998). As well, the philosophies of SFT and feminist theory are said to differ on areas of blame despite agreeing on some aspects of personal responsibility especially with regards to issues of violence in families (Dermer et al., 1998).

Similarly, the proponents of SFT do not associate the relationship of the family and its issues to the cultural and sociopolitical realm, thus missing the macro influence in the life of the problem and of solutions. Interestingly, it is Michael White who has suggested that the work of Steve de Shazer evolved out of a "political" endeavour to change the culture of psychopathology. White (1993) states that de Shazer "has directly challenged not only this invention, but also the very subjugating practices that are associated with it" (p. 122), including the structuralist and functionalist traditions of thought. Likewise, in the foreword to one of de Shazer's books (1985), Lyman Wynne praises SFT adherents for challenging dominant theory or "prematurely sanctioned beliefs of the family therapy field" (p. vii). SFT proponents do not, however, describe themselves as reflecting such global factors nor would they attest to deconstructing the dominant culture. Miller and de Shazer (1998) state that "treating clients'

problems as social problems is one way in which therapists and clients cast the problems as epiphenomena, as larger than clients' immediate lives and concerns" (p. 374).

Nylund & Corsiglia (1994) warn that in an effort to focus on solutions, some therapists' can and do try to force solutions on clients. This means that therapist's must use sensitivity and be aware of the pace and needs of the client rather than trying to engage in only "solution talk" prematurely. This is a critique that surfaces in much of the literature regarding SFT. Stalker, Levene, and Coady (1999) actually take this one step further suggesting that clients do not experience a connectedness when therapists are "problem-phobic", thus hindering the overall utility and effectiveness.

Lipchik (1994) corroborates this worry that therapists can and do stress brevity at the expense of rapport building and the relationship with the client. She also states that there may be a tendency to overemphasize techniques prematurely or inappropriately to suit a misinformed belief in the solution-focused approach. "The effectiveness of this type of therapy actually depends on therapists' respecting and responding to the idiosyncrasies of clients and their situations. The process must be expeditious, but not rushed; methodologically consistent, but not standardized; efficient, but never impersonal; sharply focused, but not oblivious to more hidden messages from clients" (Lipchik, 1994, p. 39). Berg (1994) also clarifies that the techniques used in SFT must be performed within the spirit of the philosophies and attitudes that have shaped this paradigm.

The evaluation studies of SFT that have been discussed in the literature are said to be questionable and limiting. According to de Shazer and Berg (1997) their primary research question has always been, 'what do therapists do that is useful?'. They specify that in order for proper research to be done the specific techniques situated in this theoretical orientation must be fully followed. Nichols and Schwartz (1998) are skeptical of the two outcome studies completed at the Brief Family Therapy Center in Milwaukee. Nichols & Schwartz suggest that clients may indicate they are "satisfied" on a rating scale but this does not give a true indication of the helpful aspects or attend to the process of the therapy.

One of these studies (DeJong and Berg, 1998) included 275 participants from diverse cultural backgrounds and with a variety of presenting problems. Intermediate results were presented and were the difference between the response to the scaling question from the first and last session. Eighty percent of the cases indicated progress. The final outcome results included feedback from 50% of the sample during a telephone call seven to nine months later. At this time, participants indicated that their goals were met 45% of the time and some progress was noted in another 32% of the sample. DeJong and Berg suggest that their data was comparable to other outcome studies except that their analysis indicated a lower median number of interviews. They recorded the median number of meetings to be two.

Two more recent articles discuss outcome-oriented possibilities for evaluating SFT in practice. Franklin, Corcoran, Nowicki, and Streeter (1997) describe how individual rating scales, typically associated with single system

evaluation designs, may be adapted and blended with the scaling technique of SFT to gather outcome data. This is recommended as an effective, respectful and collaborative method to gather feedback on the client's progress based on their perception of the problem and goals. "The client self-anchored scales can be used to guide as well as measure progress" (p. 261). When combined, these variations of measurement scales are said to be congruent with constructivism and the idea that therapy should guide research.

A team of therapists from Spain produced outcome data gathered at a university family therapy centre from 83 cases (Beyebach et al., 2000). They present an interesting and creative approach to identifying effectiveness of SFT. Psychologists, using SFT, worked with clients presenting with a variety of issues. Two independent judges observed the initial and last session of therapy on videotape, classifying the clients dialogue in particular areas about the problem, their goals and outcome to determine the level of success of the therapeutic intervention. Unfortunately, a pure solution-focused therapy was not used since elements of narrative, structural and psychoeducational approaches were incorporated when necessary, thus outcome measures cannot be attributed to any particular intervention. Nonetheless, this study compared its findings to other SFT outcome studies, reporting such results as 84% of cases were successful at termination and 74% were described as successful at follow-up. They also noted that there was an average increase of three points on the scaling question during the course of therapy and the average length of treatment was 4.67 sessions.

Interestingly, the success rate was higher for personal issues (such as anxiety concerns) than it was for relational type issues (such as parent-child conflict).

Three other studies of SFT have focused on evaluating practice techniques. The formula first session task (FFST) (Adams, Piercy, & Jurich, 1991), between-session change (Reuterlov, Lofgren, Nordstrom, Ternstrom, & Miller, 2000) and the miracle question (Nau & Shilts, 2000) have all been examined. The FFST study was a process design used with 45 families. This technique was said to be effective at the onset of a therapeutic relationship “for gaining family compliance, increasing the clarity of treatment goals, and initiating improvement in the presenting problem. It was not effective in increasing family optimism regarding treatment outcome” (Adams et al., 1991, p. 289).

Another study measured between-session change for a sample of 129 Swedish cases in which SFT was the model of intervention used (Reuterlov et al., 2000). A simple calculation was done without interrupting the therapeutic process. Team members, behind the one-way mirror, recorded a positive or negative response to the question, “What is better since the last visit?” that was posed at the outset of each meeting. As well, they then recorded the response to the scaling question posed at the end of the therapy session documenting whether the number increased, decreased, or stayed the same. Six outcome combinations were possible. Positive changes between sessions were identified by 76% of the clients, and 81% indicated, based on the scaling question, that there had been some improvement. This is a new contribution to supplement previous studies on pre-treatment change. It emphasizes that, for those cases in

which clients did not identify any changes between sessions, the therapist needs to take the client's feedback at face value and alter treatment to maintain the relationship and increase success. "This conclusion is bolstered by other studies that have found that the client's experience of meaningful change in the first few visits is one of the best predictors of eventual treatment outcome" (Reuterlov et al., 2000, p. 114).

These more recent studies seem to be helpful evaluations of some parts of SFT. The studies by Nau and Shilts (2000) and Reuterlov et al. (2000) use a non-intrusive and theory specific design that may be a resource for future studies. Increasing our understanding of client's perceptions of the solution-focused approach to therapy must continue as a way to support this model and/or to help adjust it to be more effective and user friendly in practice.

Co-Locating Narrative and Solution-Focused Paradigms

At a glance, SFT and NT seem very suitable to effectively be used together to provide a quality and comprehensive service to families. Each of them is considered a postmodern therapy of second-order cybernetics adhering to social constructionism. Both of these therapies are strengths-based, focus on solutions or alternatives to the identified problem and they are non-pathologizing. NT and SFT are collaborative approaches to working with families. Both include the beliefs that families have untapped resources and that clients have the ability to change. They value the clients' expertise of their life. Each emphasizes the use of language in therapy and relies on the use of questions during interactions with client systems. Both of these approaches use a team approach in therapy.

NT uses a reflecting team and SFT a consulting team.

Perhaps before entertaining the use of these therapies together with one client system, the practitioner needs to first consider whether he/she is integrating or simply, co-locating these paradigms. Integration implies the blending of two or more things together to create a new entity. Co-location, on the other hand, connotes a collaborative and parallel introduction of two or more items, each of which maintains its original characteristics. Language and interpretation contributes to how the process of joining two therapies is named and the meaning given to it by the reader. Some authors have referred to “weaving the techniques together” (Shilts & Reiter, 2000), “blending ideas” (Dykes & Neville, 2000), “mixing techniques” (Beyebach & Rodriguez Morejon, 1999), and “the shared influence” (Chang & Phillips, 1993) in their discussion of integrating SFT and NT.

It seems plausible that each of NT and SFT can be present in their original form and intent as well as having the two approaches located within the therapeutic journey with a client. The objective of using these therapies for this project is to co-locate them, thus respecting the unique theoretical foundations and clinical approaches of each model while using them collaboratively in therapy. The rationale for this direction is a belief in their compatibility and that co-location will enhance service to client systems.

There is a beginning body of literature that directly discusses the integration of these two models or parts of them. Most recently, Dykes and Neville (2000) and Shilts and Reiter (2000) discuss adding creativity to the

integration of externalization and scaling questions for use with children and their families. The first of these articles (Dykes & Neville, 2000) illustrates how children can actively be engaged in naming and objectifying a character that represents the identified problem. The use of scaling questions helps children and parents to describe the size of the externalized character using their hands, body, or through drawings, and to work toward shrinking the identified symbol. Within their discussion, Dykes and Neville also speak to the use of celebrations and recruiting an audience to promote the good news, both of which are associated with NT. These authors contend that they provide a service based within the SFT framework such that they set small, tangible goals and they look for exceptions that contribute to solutions and successes.

Similarly, Shilts and Reiter (2000) blend the technique of externalization with a “visual scaling”. For them, visual scaling might include such methods as using building blocks to show how big the externalized problem is. They believe that this approach is effective to engage the child in therapy at the child’s developmental level and enlist the resources of the child and parent(s) during and between sessions. “In essence, externalization initiates the change and scaling provides the opportunity to gauge progress in therapy, thus maintaining change” (Shilts & Reiter, 2000, p. 86).

Beyebach and Rodriguez Morejon (1999) provide a critical analysis of the different elements to consider if and when a clinician is deciding to integrate SFT with any other orientation or techniques from other therapeutic models. The authors break down their discussion to consider the researcher-academic

perspective, clinical perspective and the theoretical perspective. They conclude that from a practical point of view, importing thoughts and ideas from therapies such as narrative, systemic, structural or strategic is possible as long as the philosophies of the solution-focused model continue to direct the intervention. They "like to think of Solution-Focused Therapy as a kind of flexible umbrella under which a lot of different practices and techniques could find shelter" (p. 27). The authors refer to their clinical intervention as "technical integration" in which non-solution-focused techniques are drawn upon and included in therapy to best meet the needs of the client; differing from "theoretical integration" in which a more complex model evolves or a sequential application of different theory occurs. It is recommended that the principle of simplicity and fit should direct integration. According to Beyebach and Rodriguez Morejon (1999) challenges to integration include the following risks: changing the position of the therapist; more of a focus on problems; being too complex or fancy; or the therapist working "too hard" toward change.

In an interview with Bubenzer and West (1994), White refers to the significance of history for the location of unique outcomes and exceptions toward the awareness of alternative stories. He asserts that he would not describe his therapy as solution oriented and that SFT does not direct attention to history, yet he still associates techniques from these different perspectives. de Shazer (1993) staunchly opposes any suggestion that unique outcomes and exceptions are similar concepts or terms. "Unique outcomes' are used in practice as part of the war against the problem, while 'exceptions' are used as proof that the

solution has already begun" (de Shazer, 1993, p. 119).

Another discussion situating NT and SFT together concludes that these second-order cybernetic therapies are "theoretically very compatible" but they have "stylistically and operationally very different" therapeutic approaches (Chang & Phillips, 1993, p. 111). The intent of the article by Chang and Phillips is to compare and contrast theoretical and practical details of the work of Michael White and Steve de Shazer. Perhaps their discussion directly addresses the "co-location" versus "integration" of these models depending on one's interpretation of the material. They refer to NT as having a "macro" focus, attending to the sociopolitical context, whereas SFT "maintains a 'micro' focus that is pragmatic and apolitical" (Chang & Phillips, 1993, p. 97). The article also discusses the influence of Gregory Bateson and the use of a narrative process for both of these therapies. They explore other similarities such as the use of questions, the lack of focus on causal explanations for problem development, the opposition to hypothesizing, the rejection of the idea of resistance and that both are strengths-based.

Chang and Phillips (1993) suggest that both White and de Shazer rely on the concept of deconstruction, albeit in their own way. In a commentary to the Chang and Phillips article, de Shazer clarifies his use of deconstruction as a method of utilizing the client's language to discuss the identified issue thereby opening space for, or constructing new meanings. He goes further to suggest that White applies deconstruction by dismantling "the clients construction of reality" (de Shazer, 1993, p.116) in an objective and directive manner.

White and de Shazer each offer a commentary to the Chang and Phillips (1993) article. Overall, de Shazer (1993) believes there are more differences than there are similarities in these two approaches. He does qualify his critique of White's work, however, by admitting that his interpretation of another's work is only one possible interpretation. White (1993) responded to both of these discussions by trying to offer clarification of his theory in an effort to contribute to, and expand the dialogue. He approached it this way because he felt that de Shazer had presented such an abstract and convoluted muddle of words regarding NT that "it rendered it mostly unrecognizable" (White, 1993, p. 122) to him. Now that White has a better understanding of SFT he also supports the contention that there are more differences than similarities between these models despite his earlier comparisons of parts of NT and SFT.

In practice, specifically with the effects of sexual abuse, Durrant and Kowalski (1992) have demonstrated that the joint use of theory and applications from SFT and NT has provided a worthwhile framework for their interventions. They present a model based on strengths, competencies and the belief that it is the effects of sexual abuse that may be restraining for the victim. The authors are guarded in presenting a therapeutic approach specifically for sexual abuse because this can suggest or result in a regimented blueprint. Beyebach and Rodriguez Morejon (1999) speak to this issue warning that importing multiple techniques "could easily turn into ready-made 'recipes' for certain *types* of problems. The risk here is that eventually therapists may make their decisions on the basis of what the problems (and not the solutions) of the clients are" (p. 39).

Nonetheless, Durrant and Kowalski (1992) have discovered that certain client groupings have found particular experiences in therapy helpful. Thus the focus of their framework for working with sexual abuse victims is on “solutions and new meanings” (p. 81).

Durrant and Kowalski (1992) present ten principles that guide their work such as their belief that sexual abuse victims have resources and strengths that help them to solve their difficulties and that victims are not inevitably going to experience long standing personal problems. Other beliefs include, “complex problems like sexual abuse don’t necessarily require complex solutions” (p. 73) and a common effect of sexual assault is the assault on the self-perception of the victim. Since behaviour is consistent with self-perception, it is necessary to create a view of self-competence by beginning to notice and emphasize exceptions and abilities. Questions dominate the approach by Durrant and Kowalski that begins by a joining process and identifying the issues, and immediately incorporates suggestions of solutions in the future. Normally some discussion occurs about the identified problem, following the client’s lead, but the therapist asks questions that create a context to externalize the problem from the person. By the therapist taking a stance of curiosity, exceptions can be uncovered and personal agency increased. Solution building occurs more in line with Michael White’s strategy of reconstructing or co-creating a new or alternative story such that changes to self-perception are overtly addressed.

Since the development and evolution of both models of therapy there have been many processes described for NT and SFT, but they are not necessarily

overtly connected in the literature. For example, White (1986) described how the life of the problem and relative influence could be mapped out as a percentage or ratio within the experience. This is similar to the scaling question of de Shazer in which the perceived problem and solutions are rated on a scale. As measurement techniques, that quantify difficulties and goals, these therapeutic applications have the potential to be used jointly or interchangeably. This is just one additional example to add to the previously documented thoughts about the similarities and differences of NT and SFT.

Much of the debate and thoughts presented regarding the co-location or integration of NT and SFT become a moot point if the client's needs and the goals of therapy are not being attained. Both SFT and NT are lacking in research on their effectiveness and utility, thus, measuring an integrated approach may prove to be even more convoluted. Beyebach & Rodriguez Morejon (1999) suggest that the complexity of an integrated approach supports process-outcome versus outcome-only studies. They assert, however, that research and clinical application are clearly two different mandates to be considered in their respective domains.

CHAPTER FOUR

Intervention

Practicum Environment

In partial fulfillment of my learning objectives, I completed my practicum at the Families Affected by Sexual Assault (FASA) program of New Directions for Children, Youth, and Families in Winnipeg, Manitoba between January and June 2000. In 1985, this program was established in response to an identified gap in service in the community. Families who had a child who disclosed extrafamilial sexual assault and the parents were able to provide safety without Child Protection Services being involved did not have a specific service that could meet their needs. Mandated child protective services tended to focus on children requiring protection and those that were a victim of incest. In the FASA program, extrafamilial refers to anyone from outside the family home, but it must not be a parent, parental figure, or sibling who committed the sexual violation. The FASA program will accept referrals if the alleged perpetrator is a cousin, grandparent, or other extended family. A child is deemed to be anyone under the age of 18 years.

The FASA program is a free, confidential and voluntary service that prefers to receive referral information directly from the parent or guardian of the identified child. These families are also often recommended to the FASA program by any variety of community professionals such as school counsellors, child protection workers, investigating police officers, victim services workers or medical personnel. The program is aimed at providing a family based service

when a child has made a disclosure of sexual abuse within the previous six months. Understandably, the length of time since the last abuse incident varies depending on the length of secrecy forced upon the child. The FASA program prides itself on not having a waiting list allowing for new referrals to be contacted by a therapist within two days of the intake date. Appointments are usually made within one week of the referral/intake date.

The FASA program is based on the premise that CSA affects both the child and his/her family members, but that both do recover. As well, the important role of parents in believing and supporting their child is recognized as the best resource to promote recovery with fewer adverse effects. Individual, family and group interventions, as well as consultation and professional development training, are all available services through the FASA program. The clinical team provides therapeutic services based within narrative and solution-focused paradigms. They also provide service using a reflecting team model one morning per week. The models of intervention used coupled with the belief in the abilities and resources of the parents and child to recover contributes to the primarily short-term nature of service provision.

The FASA program has been established and providing a service within the above framework for many years. Within the last year, however, the program has begun to expand its services. The FASA program team is in the process of developing a second program component that provides intervention to families when their child, under the age of 12 years, has been identified as having problematic sexual behaviours. I did not work with families in this category but

have been involved in team meetings and discussions about professional development. Once again this organization is developing a new service that will fill a service gap in the community. Throughout this report, I refer to my work with the FASA program within its original context.

Professional Team

A team of therapists has been with the FASA program since its inception. Marlene Richert, Program Manager of FASA, was the primary supervisor of my practicum and a member of my Advisory Committee. The other clinicians, Billy Brodovsky, Alison Lund, and Barbara Quesnel provided supervision on several cases. All team members have their Master in Social Work (MSW) degree. Having different supervisors provided me with the opportunity to get diverse feedback, consultation and guidance. To accommodate the different work schedules of all team members, I met with the appropriate therapist either before or after appointments with clients. Marlene Richert provided the ongoing overall supervision to ensure that my clinical experience was coordinated to best serve the families and to promote my growth and development. The clinical team at FASA includes a peer support and supervision model as a part of their growth and development. My practicum supervision was similarly orchestrated.

Dr. Harvy Frankel was my primary faculty advisor and provided ongoing consultation and supervision throughout the planning, experiential and report-writing phases of this practicum experience. Dr. Maria Cheung of the Faculty of Social Work was the third committee member for my Advisory Committee,

providing feedback on the written and theoretical components during the preparation, mid-way review and final stages of this process.

Administrative Procedures

Each family session was held at the FASA offices and was video taped. Live supervision involved the use of a one-way mirror and telephones between the observation room and interview room. This process allowed the supervisor of the particular case to directly observe my interventions and provide immediate feedback when necessary. In the absence of live supervision, review of videotapes and direct consultation with the supervisor supported my clinical efforts.

Recording family interventions was done in accordance with the policies and procedures of the FASA program. Client files were kept in a locked cabinet at the FASA office. Confidentiality was fully respected. Appropriate consent forms were required by the family to videotape each session, to meet with a client under the age of 18 years alone without parental involvement and to communicate with other agencies when this was necessary. The clients were also advised verbally, and in a consent form, that I am a graduate level student and that an MSW clinician was directly supervising my work.

The intake procedure involved taking basic information from the referral source over the phone. Identifying information including names, address, phone number, school of the identified child, names of household family members, date of disclosure, name and relationship of alleged perpetrator and an indication of when the abuse occurred was gathered. The office administrator normally takes

this basic information, but in some circumstances a therapist may complete it. Once the intake information is gathered a therapist receives the referral, contacts the parent, and makes appropriate arrangements for further consultation and intervention. A letter is also sent to all families describing the services and requesting they complete a family information form to be brought with them to the first session. The form asks primarily demographic data required by the agency. There are also questions regarding the assault that assist with the therapy being most helpful to them.

Clients

During this practicum, I was assigned ten cases from new referrals made to the office. A full service was provided to nine families, since one family moved out of the city after our first session. Consistent with the criteria of FASA, each family was responding to the disclosure of the sexual abuse of one of their children.

The purpose and length of interventions varied depending on the needs of the child and family and the mutually established plan with the parents and/or child. Two cases involved a one-time consultation with only the parents after their child disclosed sexual abuse. In both situations the parents requested a one-time consultation with a therapist to alleviate some of the crisis issues and to get some validation that they were attending supportively to their child. Supporting the parents in this manner is consistent with the belief of the FASA team and consistent with the literature (Davies, 1995; Manion et al., 1998; McCourt & Peel,

1998; Tremblay, Hebert, & Piche, 1999) that purports that parents are the best resource for their child.

Another parent requested service at the insistence of school personnel. An assessment during two sessions determined that the child and parent did not have outstanding worries from the sexual violation, which occurred four years previously. The mother was offered a referral to a more appropriate program for other stressors and issues present that were not related to the sexual assault.

The length of service to the remaining six families ranged from six to fifteen sessions. The intervention process for these six cases involved identifying the concerning issues created by the disclosure of sexual abuse, developing goals for intervention, providing therapy and celebrating survival or family resources as a final stage of the therapeutic relationship. Although a comprehensive service was provided to one of these families over 19 weeks, this case was transferred to another therapist on the FASA team for longer-term follow-up. The child, family and therapists mutually decided on this transfer as a means of additional support, since the child was experiencing greater trauma effects. As well, the judicial process was outstanding. Similarly, one family did not attend the final session but this was considered a full service since we had mutually agreed to terminate the therapeutic intervention.

Sessions involved different combinations of the family systems but this will be elaborated on in the case analyses to follow. A profile of the nine cases is provided in Table 1.

Profile of Nine Case Studies

Family	Age of Identified Child At entry into therapy	Gender	Age at time of abuse	Family Size (Household) Adult/Child	Alleged Victimizer	Repeated/ One Time	Number of Sessions	Length of Therapy
"A"	9 ½ years	Male	9 ½ years	2 Adults 4 Children	Adult, stranger	One time	12	17 weeks
"B"	10 ½ years	Female	5 to 6 years	3 Adults 3 Children	Adult, close family friend	Repeated	15	19 weeks
"C"	6 years	Female	6 years	1 Adult 1 Child	Adult, distant relative	One time	1	1 week
"D"	5 years	Female	5 years	2 Adults 1 Child	Child, friend	Repeated	1	1 week
"E"	13 years	Male	12 years 11 months	1 Adult 2 Children	Adult, step-grandfather	One time	9	11 weeks
"F"	8 years	Female	5 to 8 years	1 Adult 2 Children	Adult, grandfather	Repeated	8	16 weeks
"G"	7 ½ years	Male	4 years	1 Adult 2 Children	uncertain	uncertain	10	11 weeks
"H"	9 years	Female	3 years	3 Adults 1 Child	Adolescent, Acquaintance	One time	2	5 weeks
"I"	13 years	Female	5 to 6 years	2 Adults 2 Children	Adolescent, male cousin	Repeated	6	9 weeks

Table 1

I provided service to a diverse group of families who all sought service for a similar antecedent, child sexual abuse. The family compositions varied. Family "E" and "G" are single female parent families with no involvement from the father. Family "C" and "F" are also single female parents, however, the father was actively involved in the child's life and in therapy. Family "A", "H", and "I" are comprised of the biological mother and a male partner living in the home, however, the father figure was not involved in the therapeutic process. In family "I", the biological father was active in the child's life but not in therapy at the request of the mother. In family "A", only four of eight siblings live in the home with the identified child and his mother. In the case of family "F", the identified child lives with her mother and one sibling. Her other sibling lives with the father of all three children. Family "B" and "D" are two parent families. Family "B" and "H" are three-generation households, each with a grandparent residing with the family. One family was of Aboriginal descent. Another family had only been living in Canada for about seven years after immigrating as refugees from a war torn country. Another family spoke openly about the mother being lesbian. The remaining families are Caucasian. The families varied in socio-economic status.

Six of the nine child victims were female and three were male. The age range of the children at the time of disclosure was 5 to 13 years. Only 7 children attended sessions and their age range was from 8 to 13 years old. In a large study involving the full childhood age range, Tingus, Heger, Foy, and Leskin (1996) found that the majority of children who entered therapy were between the ages of 7 and 13 years.

In the group of practicum cases, four involved repeated sexual abuse incidents and four cases involved a one-time violation. One case involved an unclear disclosure and circumstances were uncertain, however, this child and parent had clearly given a meaning to the sexual violations and we did work collaboratively to resolve their outstanding worries about it. I have considered eight of these cases and categorized them according to the relationship to the alleged perpetrator. The abovementioned case, involving an uncertain identity has been excluded in this overview. Fifty-percent (4 of 8) involved an extended family as the alleged perpetrator, 37.5% (3 of 8) were victimized by an acquaintance and 12.5% (1 of 8) involved a stranger as the assailant. This is comparable to police-reported CSA cases in Canada in 1997 in which the relationship to the child was a family member in 31% of cases, an acquaintance in 47% of cases and a stranger in 15% of cases (Statistics Canada, 1999).

Evaluation Measures

As I have previously stated, CSA is a traumatic experience for both the child victim and his/her family. In this regard, I chose to use a standardized questionnaire that would elicit information on self-perceived family functioning at the beginning and end of abuse-specific therapeutic intervention. The Family Environment Scale (FES) or the Children's Version of the Family Environment Scale (CVFES) was administered to the family members at the second session and normally on the last session. In one case, the post-test was completed at the 10th of 12 sessions because it was initially intended to be the last session. The measures were not completed for the cases that only sought service for a

consultation or a brief assessment. Family "F" was not able to attend the final session and, therefore, they did not complete a post-test of the FES and CVFES. Overall, three families completed both pre- and post-tests of the FES or CVFES and three other families completed only the pre-test. A brief qualitative questionnaire was also completed at the last session to address the quality of service as perceived by the family.

The FES and CVFES were chosen as applicable measures since they were believed to be congruent with the philosophies of NT and SFT. Despite being standardized and providing an opportunity to compare results to large samples of "normal" versus "distressed" families, these measures ask for self-perceived interpretations of the family environment, thus, they respect the social construction of reality and emphasize individuality. The FES and CVFES were introduced to families as an additional avenue through which the family could describe family life, as they perceived it to be, which could be helpful to the therapeutic process. I was always clear to stipulate that the instrument was not a test of accuracy, but rather an exercise to empower and support the various views of family life. I also explained that the qualitative evaluation measure was an opportunity for the clients to provide input about their perspective of the effectiveness of therapy. The post-test of the standardized measures may also be regarded as an indication of the productiveness or helpfulness of therapy. That is, self-perceived responses may be indicative of changes related to the therapy process.

Family Environment Scale (FES)

The Family Environment Scale (FES) is a social climate scale that is used to measure the current functioning of the family by self-report (Moos & Moos, 1994). Sample questions from the FES can be found in Appendix A. The rationale for using this instrument was that it provides another mechanism to consider the meaning attributed to aspects of the family environment when an external factor causes a crisis and disrupts the harmony within family life. According to Moos and Moos (1994) the FES is meant to help understand how families adapt to life crises and how different family members view their family and the impact of crisis, as well as to monitor change, promote growth, develop interventions and measure outcomes for families. I chose to purchase this scale. I, therefore, have permission from the publishers to use it in practice (Appendix B).

The FES is a 90-item instrument that has 10 subscales and measures the following three broad social environmental dimensions within the family: system maintenance dimension, personal growth dimension, and relationship dimension. Each subscale dimension measures specific characteristics of the family as a way to assess family functioning in these particular areas. Cohesion, conflict and expressiveness are grouped as relationship dimensions. Independence, achievement orientation, intellectual-cultural orientation, active-recreational orientation and moral-religious emphasis are considered personal growth dimensions. Lastly, organization and control are referred to as system maintenance dimensions (Moos & Moos, 1994). I had expected that the

relationship dimensions and the system maintenance dimensions would be most affected by the disclosure of CSA and would also be most significant in contributing to a helpful response. The following two studies demonstrate how the FES can be used to examine the family environment and elements of it when CSA has been identified.

In a study by Chandler, Jackson, and Townsley (1991) a sample of college students completed the FES referring to their family of origin. The researchers found that “compared to nonabused subjects’ families, the intrafamilial and extrafamilial abused subjects’ families can be described as being less cohesive, less involved in recreational activities, less likely to encourage personal growth by emphasizing moral-religious issues, less likely to encourage independence, and less organized in terms of mutual responsibilities, family activities and family rules” (p. 372). This study contributes to an understanding of family environments in which CSA occurs but it is regarded cautiously as it relied on recall from the sample.

A further study, using the FES and retrospective reports by an adult sample of CSA survivors, supplements our understanding of the role of the family environment for mediating and mitigating the long-term adjustment of children effected by sexual abuse (Ray & Jackson, 1997). This study sought to demonstrate that the family environment would have a buffering or immediate effect on reactions and adjustment of the child. There was a lack of evidence to support this hypothesis. The authors purport that the family environment was

measured in terms of social support and not crisis support, which may account for their findings. Overall though they summarize that:

victims from cohesive, adaptable, yet structured families may have coped sufficiently well with the abuse that they suffered few long-term effects. On the other hand, victims who lacked a cohesive and organized family environment in childhood may evidence poor adjustment subsequent to even "milder" forms of abuse. Clearly, family environment should be considered in any attempt to explain or predict long-term adjustment of child sexual abuse victims. (p. 15)

The FES has been designed for children 12 years of age and older and is produced in a true-false question format. In situations where the person completing the FES stated that both answers seemed to fit I would instruct them to ask themselves, "how is your family most of the time".

A scoring key helps for quickly tabulating the raw scores. These raw scores are converted into standard scores using the table in the manual. Standard scores for a normal family fall within the range between 30 and 70. These scores can be plotted on a graph to visually demonstrate the figures, which was done for the cases fully discussed in this report. Although the scores can be interpreted for many purposes, I will focus my case analysis discussions on the incongruence scores, which is the different views or perceptions between family members who complete the questionnaire. This will contribute to a more thorough understanding of the construction of meanings within the family. As well, I will comment on pre- and post-test scores for the individuals, paying particular attention to changes before and after intervention. "The FES can be used to describe family social environments, to contrast parents' and children's

perceptions, and to compare actual and preferred family climates” (Moos & Moos, 1994, p. 5).

Moos and Moos (1994) present a series of support from the literature for the following psychometric properties. The internal consistency of the 10 subscales is reported to be from average to substantial, with the Cronbach's Alpha ranging from .61 for independence to .78 for cohesion. Intercorrelation between the subscales is said to produce distinct yet complimentary measures of family environments. Test-retest reliability was shown to be good at two and four month intervals and up to one year when the range is still .53 to .84. The authors contend, “although the Form R profiles can be quite stable over intervals of as long as a year, they also reflect changes that occur in the family” (Moos & Moos, 1994, p. 22). Construct, discriminant, content and face validity are addressed by clearly describing the process that was used in the development of this scale and supported by studies that sought to measure these qualities. In their support of the use of the FES to assess and classify families, with the goal to improve service to clusters involving certain characteristics, Reichertz and Frankel (1993) caution that there have been some recent criticisms of some forms of reliability and validity of this measure.

Children's Version of the Family Environment Scale (CVFES)

A Children's Version of the Family Environment Scale (CVFES) was developed to adapt the FES to use with children aged 5 to 11 years (Pino, Simons, & Slawinowski, 1984). It provides an opportunity for children to identify their perceptions of their family environment. A sample question from the CVFES

can be found in Appendix C. The CVFES is a 30 item, multiple choice, pictorial scale in which the child is asked to look at three black and white diagrams of family situations and choose which picture looks most like their family. The diagrams are uniformly presented with two adults and two children but the manual recommends asking the child to pretend that his/her family was in the pictures to accommodate for variations in family units. The instrument measures the same 10 subscales as the FES but it only has three questions per subscale. The ten subscales are cohesion, expressiveness, conflict, independence, achievement orientation, intellectual-cultural orientation, active-recreational orientation, moral-religious orientation, organization, and control.

Even though this questionnaire was pictorial, I always offered to read the question to the child. The question was always "which picture looks like your family?". The responses to the questions are tabulated into raw scores that can then be converted into standard scores using a table of norms specifically for children. The raw score conversions are done separately for the FES and the CVFES but both can be plotted on the same profile sheet.

According to the developers, this scale has been tested on a limited number of normative samples, thus, scores should be interpreted with caution. They suggest that the child's scale was developed out of the FES, therefore, some of the studies on the FES may be transferable to the CVFES. "Since the children's version was based on items taken from the Family Environment Scale itself, the match between the two scales has thus far been clinically very good and the utilization in family therapy is seen as the most proper clinical usefulness

of the tool" (Pino et al., 1984, p. 7). High results of .80 were produced for test-retest reliability over a four-week interval. Content validity has been deemed to be good based on testing of a small sample in which the children aged 6 to 12 years were asked to write a sentence describing each picture.

Client Feedback

A qualitative, open-ended questionnaire was developed as a measurement of each family's perception of services received (Appendix D). The family was asked for this feedback during the final session with me. The information obtained served as additional information to contribute to my learning and to determine if the method of intervention was deemed to be helpful. Unfortunately, the feedback questionnaire was not completed by the families receiving short-term services since I did not have it fully prepared at the time they accessed services, and mailed copies, with return envelopes, were not returned. One family presented verbal feedback because of a language barrier, specifically with writing in the English language. One family did not attend for the final session so they did not complete the feedback form. Overall, five families provided feedback.

It is also important to note that I regularly elicited feedback along the way from each family to determine whether they were feeling that the process was addressing the issues they had expected. This is a way to deconstruct the expert role of the therapist, empowering the family, and to practice the collaborative co-authoring of an alternative story. Asking for feedback along the way allowed for changes and adjustments to be made when necessary.

CHAPTER FIVE

Case Analyses

Overview and Process of Interventions

This section is dedicated to providing the reader with a profile and analysis of each of the nine families with whom I was involved with as a practitioner with the FASA program. I will begin by highlighting the intervention process used with each case, provide a full examination of three of these cases and present a synopsis of the remaining six cases. As well, throughout this chapter I will integrate discussions on trends and thoughts recognized across the cases with particular reference to theoretical issues.

Consistent with SFT and NT, each family was respected for the strengths and resources that they brought with them to therapy. Likewise, the use of their language was incorporated during therapy. Both of these endeavours were efforts to empower the family as the experts of their lives and in their healing process. This aided the collaborative nature of the therapeutic relationship. Nine cases were opened between January and March 2000. Background information will help to provide a platform for the discussion of each case. Information is presented in an accurate manner, but also fully protects the identity of the families discussed. A clear analysis of each case reflects the process-oriented nature of these therapies. A continuous discussion for each case is presented rather than trying to fit the process into sequential and structured headings.

During the initial phone contact with the parent of a child affected by CSA I introduced myself, and the FASA program since the parents normally had little

information about the program other than they wanted help to deal with the recent disclosure. This phone call also provided an opportunity to get some clarification about the sexual violation and what had taken place between disclosure and contact with the FASA program. For example, I was particularly interested to know if Child Protection Services and/or the Police Child Abuse Unit were investigating the matter. This type of information is helpful because it lets me know how many times the child has had to tell their story to other sources, thus indicating what apprehensions or meanings might have developed prior to meeting with a therapist. A plan was then established for a first meeting at the office.

Although there was some variation, I normally met with the parents alone for the first session or part of this session. This was useful to give the parents an opportunity to tell their story and ask questions that are more appropriate for adult conversation. Consultation with the parents also served to alleviate some of their immediate worries. Providing accurate information from the literature and past professional experience, as well as dispelling common myths associated with sexual abuse assisted the parents in this endeavour. For example, parents in five of the eight cases presented in the first session asking if their child would grow up to be “normal” or if they are “ruined for life”. Viewing therapy through a sociopolitical lens was helpful to situate a therapeutic stance. It was effective to begin to deconstruct the misinformation about sexual abuse at the macro level while respecting the micro influences of this trauma.

This first session with the adults also created a context for the significant role of parents in adjustment and recovery for children. This is reflective of the view of SFT that only a small change is required to facilitate change in the family system and of NT that any combination of the family constitutes family therapy. Basic joining and engagement processes were instrumental in developing rapport with the parents during this meeting, which facilitated the eventual shift to looking at the future without the effects of sexual abuse. In an effort to ease the uncertainty and worries of the parents, I dealt with technical parts of the process at the onset. This helped to put a framework in place for such issues as the length of sessions, how often sessions would occur, who would be present, having the appropriate consents signed, presenting a rough idea for duration of therapy and a description of the approach I would use. Lastly, and perhaps most important to the parents, we explored their goals for their child. This included emphasizing exceptions to when the effects of the sexual abuse did not seem to interfere in the child and family's life and strengths that they felt would contribute to their hope for their child's future (solution building).

Intervention occurred in accordance with what the parents believed would be most beneficial. This leads me to introduce the most striking theme that was apparent across all cases; parents and families were so dedicated to their child and to the well being of their entire family. They truly were the experts of their family. The devotion by all families became blatant at the onset when variations of each family committed to doing whatever was necessary toward this end. For example, one couple had been separated for 10 years, with little communication,

yet both parents committed to the child that they would participate fully in any way necessary to help alleviate the stressors brought on by the CSA. Another child was actively involved with two sets of blended families and all parental figures expressed their desire to contribute to the healing process with their child. In several cases, the child and their parents included siblings in at least one session. Thus, family therapy was the mode of intervention because service was provided to the identified child within the context of their family and social environment no matter what combination of family attended sessions.

Practice occurred within the theoretical orientations of NT and SFT. As such, a collaborative meeting of these two paradigms complimented and supplemented one another for a quality and dynamic service. A variety of techniques from NT and SFT were employed during the process of therapy and the use of questions was central to all stages of the process. I was also guided by social constructionism, recognizing that there are multiple perspectives of reality, thus the impact of CSA and healing efforts would vary depending on the meanings attached to the trauma experience.

Assessment does not occur per se according to NT and SFT because this assumes an expert role of the social worker. However, a telling of the abuse-dominated story contributes to an understanding of how the problem is being experienced and to the formulation of client specific goals. Meeting with the child was approached using non-threatening and creative measures to develop rapport and work toward an alternative story free of the effects of the sexual abuse. The ending stage of the therapeutic relationship was approached as a

recognition or celebration of the strengths and resources of the child and family to continue in a forward movement toward a preferred way of being.

Full Review and Analysis of Family "A"

The mother of this family sought service from the FASA program after a stranger sexually assaulted her nine-year-old son. Seven children were born to this mother and her previous husband of many years. The three youngest children of the marriage, as well as an infant child born of a new union, live in the household with the mother and her new partner. Two sons, 12 and 14 years old, live with the biological father. The next oldest son is a resident at a youth centre and the eldest child is the only female and has two of her own children. The family is of Aboriginal descent. Perhaps it is fitting to also mention that the infant child was born within a few days of the sexual assault on child "A", which may or may not have implications as a trigger or association for memory recall in the future.

There was about a three-month period between the assault and entry into therapy. As is often the case with stranger attacks, this assault was reported to the police immediately. Medical and Child Protection Services were also involved forthwith as precautionary measures. As a result of all of these agencies investigating this matter, child "A" was questioned, interviewed and had to tell his story many times over. Child "A" used the word "molested" to describe what had happened to him. In any case, it is important to discover the terminology and definitions used by the child and family to incorporate their language and

meanings into therapy. The terms used to describe a “sexual assault” or “molested” can imply everything from touching in a sexual manner to penetration.

Mother and child “A” attended a total of 12 sessions over a 17-week period. Upon presentation, mother “A” indicated that the most outstanding issue was concern from the school that this child’s behaviours had become worrisome. The school recommended that, mother “A” seek counselling for her son. The child referred to himself as being “bad” when discussing his understanding of why they had come to therapy. This mother had not noticed any changes at home and spoke very positively about this child’s helpfulness and cooperation at home. I complimented them for the positive attributes shared with me. Nonetheless, I did privately wonder what meaning this child had given to stability and “being good” at home since three of his older siblings were moved to alternative residences when they became “too much of a handful”.

The first meeting was used for joining and to establish rapport with this family. I was unsure of the intent of this mother to seek help thus I was aware that it might be a complainant-type relationship. This is a classification described by SFT theorists when a problem can be identified but the solution to it is associated with someone or something else (DeJong & Berg, 1998). At the following appointment I shifted my thoughts about our therapeutic relationship believing that we had established a customer-type relationship, which speaks to a collaborative and mutual relationship working toward solutions. My perception is that developing a trusting and respectful relationship at the onset contributed to a more committed therapeutic alliance. Once this mother, who had been involved

with many service providers for other reasons, realized that there would not be any blaming or judging, she seemed to be more relaxed and committed to being a part of the helping team.

The family was able to identify strengths at home and exceptions to the “bad behaviour”. As well, this child could describe some times at school when things did go better so he was asked to pay attention to the good days at school and identify what was happening on those days that made them good. I had situated this initial response and between session task in a context that they were familiar with. Between-session tasks continued to be used throughout therapy with this child. Focusing on strengths, I mainly had him paying attention to the positive aspects of his days and changes in thoughts. This was also useful to introduce the notion of supportive others who could bear witness to the alternative stories developing, since his mother, her partner and the child’s teacher were all noticing the positive changes. The child expressed pride in the realization of any new development and this became quite empowering for him to know that others were noticing. A focus on strengths and possibilities was being associated with this child rather than the more common, problem or deficit view of him.

Having this child pay attention to the “good days” and then linking the escalation of unacceptable behaviours to his victimization seemed to clarify and normalize his feelings. Externalizing conversations were of great significance with this child who identified a series of feelings such as anger, embarrassment and fear that would primarily sneak up on him at school. Such phrases as “the

feelings that have been pushing you around” and “what seems to fuel the anger at school” were well received by this family. The use of the miracle question also helped to join the various parts of the story. Mother “A” envisioned that her son’s positive behaviours from home would transfer to the school environment after the miracle. Involving school personnel was suggested to this family, however, the child did not want this to occur, as it was perceived to be another way to fuel the embarrassment. Following the lead of the family empowered them further.

Based on some of the clarifications and a clearer understanding of the impact of this sexual assault, we were able to establish goals. The initial goal was to shrink the feelings of anger and embarrassment, replacing it with more “good days at school” and a safer feeling at school. Essentially these initial goals were to move from a lack of control over the responses imposed by the trauma, to more overall positive functioning. New words, concepts, feelings and meanings were added during the process but the basic goal of developing an alternative story provided the framework for therapy. Also, despite the original contention that worries were only sneaking up at school, more information showed that the trauma responses were affecting this boy while at play in the community and at home. Hence, this highlights that initial goals are not static, which was a common element across other cases as well.

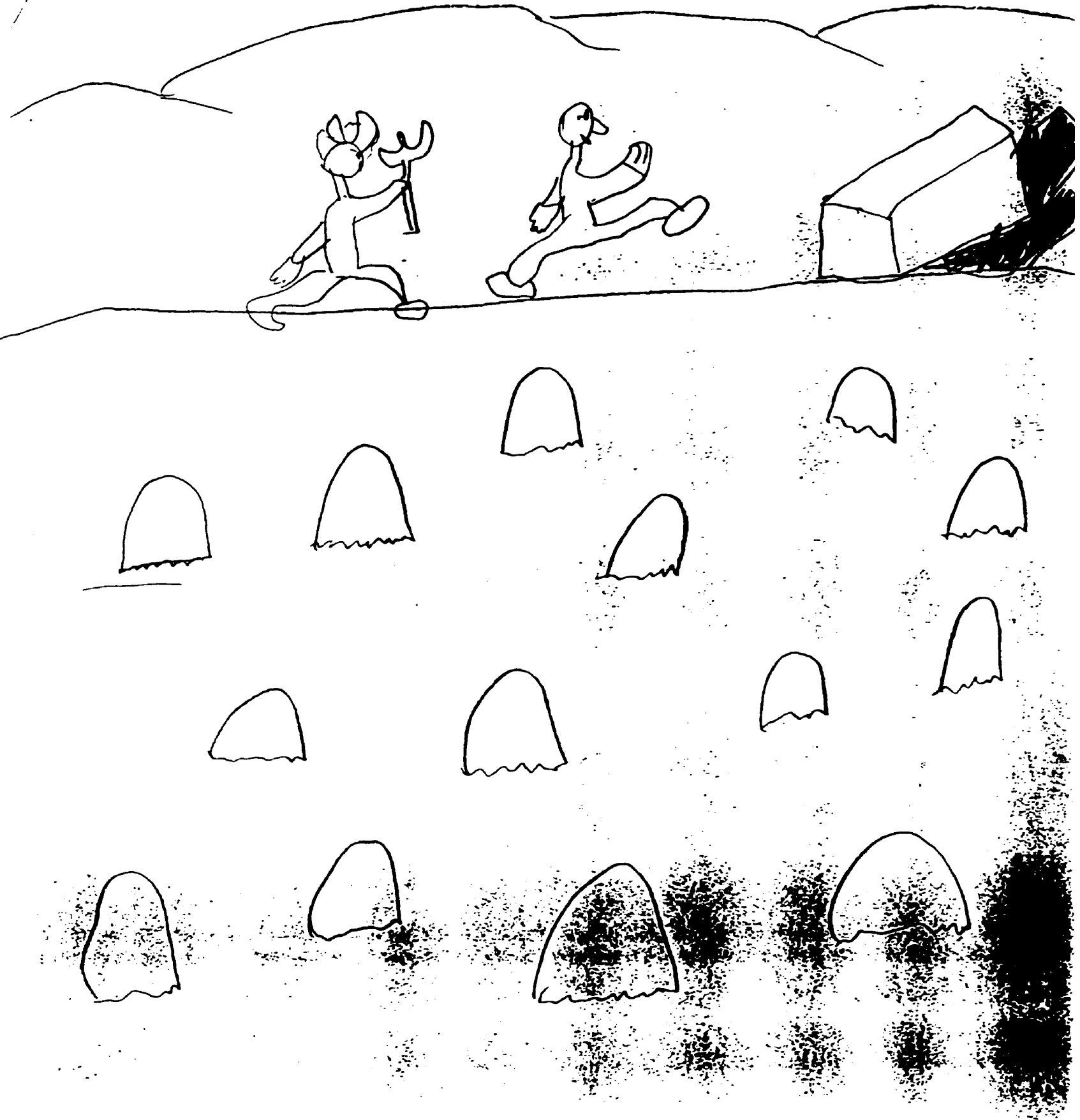
One of the tools I sometimes suggested in therapy was for the child to write or dictate their story, emphasizing their development of control and power over the influences of the effects of the sexual violations. Although I did try this in a number of cases, it was effective in only two, one of which was with child “A”.

The written story became running progress summaries from the child's perspective. Through questions I was able to elicit the child and his mother's perception of the new meanings and information being discussed along the way. Sometimes the story telling was another avenue to hear one more version of the child's words and meanings.

For example, child "A" began his story by telling that "it feels like the devil is in me", which had not previously been expressed. It was important to clarify the meaning of this phrase, engage in externalizing conversation and link "the devil" as the objectified combination of all the feelings and reactions introduced after the molestation. The devil was often responsible for "bad thoughts" sneaking up on this child. Using the metaphor of "the devil" proved to be helpful in discussing the child's triumph's over the influence of the trauma reactions. A drawing of the devil chasing this child through a graveyard vividly demonstrated the relationship of the problem for this child (Figure 1). The child chose to draw the picture with a pencil without any colour despite many coloured pencils and markers being available. These graphic and creative measures provided additional clues to the parent and to myself to be able to be most helpful to the child at his level of understanding and comfort.

Throughout this therapeutic process scaling questions were used in a creative and age appropriate manner. We used our hands to visually show how big or little a particular feeling was. This was applied to the size of the devil, to sadness, embarrassment, anger, happiness and "niceness". I noticed that this process was very well received and fully incorporated by child "A". Along the way

Figure 1. Drawing of "the devil" by child "A".



he took the lead in introducing new words to replace the unwanted feelings. Age appropriate scaling and the use of the child's language were effective at demonstrating his relationship to various feelings and issues in a non-threatening manner. The positive impact and success of scaling questions and the use of metaphors struck me when child "A" told me that happiness was as big as the therapy room now. When I asked what happiness looks like "through his eyes" he responded with, "there is more sun now shining through the clouds". He defined this for me saying that the "sun is the happiness" and the "clouds are the meanness". This vivid and extraordinary description is demonstrative of the mutual language developed and shared between us.

As unique outcomes were discussed we explored the precursors that fueled the devil on a day-to-day basis. My intention was to explore triggers associated, through the senses, with the sexual assault. Although we did uncover some relationships, this was a topic that did not seem to have as much meaning for this family. Nonetheless, I provided more awareness or another perspective for this mother and child to be cognizant of in the future. Perhaps this was an area that may have more meaning at a later time in this family's story.

This child had already been strategizing with the teacher and other school personnel to team up and take control of the "sneaky bad thoughts" by choosing an acceptable alternative such as going for a drink of water or going to work on the computer for a period of time. Thus, the child was creating "good thoughts" to shrink and replace the "bad thoughts". Ongoing sessions continued to emphasize the small changes being introduced, promoting that the child "do more of the

same". My role was to help clarify these new meanings and to help facilitate this family's recognition of the developing alternative understandings of their lived experiences.

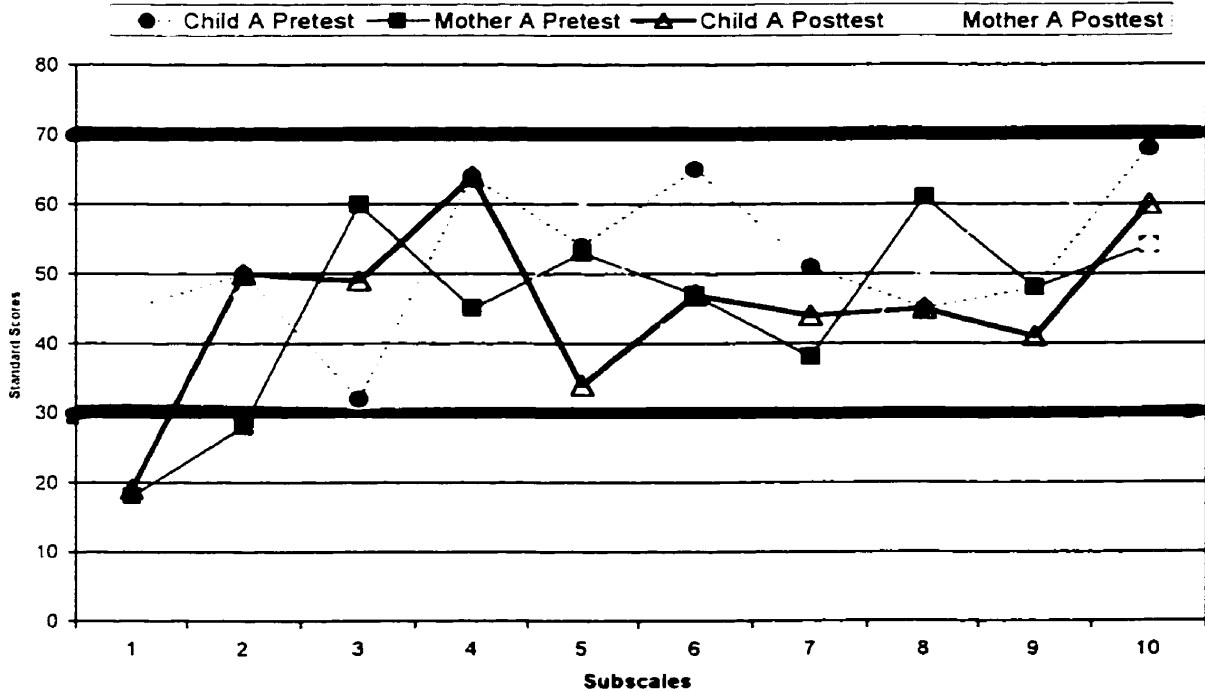
The final sessions with this family were very useful for complimenting and emphasizing their changes toward their preferred reality. Providing information and education about the continuing nature of the change process and possible triggers and setbacks was standard in all cases. Given this child's early introduction to unhealthy sexuality, we decided to watch a videotape on growing up and healthy sex and sexuality as a way to promote a healthier attitude and knowledge of this topic. I noticed that mother "A" communicated openly during this video and told me how she had recently begun speaking to her children about these issues at home. Once again, compliments served to empower this mother. The final session also provided the platform for celebrating the successes of this child and his mother. A certificate was given to the child as a reminder of his accomplishments. The family also took home the story written by this child. I promoted the story as a work in progress such that the child and mother's strengths will continue to contribute to alternative and more preferred stories of themselves and their family.

The CVFES and FES were completed pre- and post-test with this child and his mother (Table 2 & Figure 2). The incongruence score between them was 66 at pre-test and 68 at post-test. Most scores were within the normal standard score range for families, however, there were opposite perceptions presented by each for some subscales. The normal range of results supports the premise that

Table 2
Family Environment Scale (FES) & Children's Version (CVFES)
Standard Scores for Family "A"

Subscales	Child A		Mother A	
	Pre-test Session 2/12	Post-test Session 10/12	Pre-test Session 2/12	Post-test Session 10/12
1.Cohesion	45	19	18	45
2.Expressiveness	50	50	28	47
3.Conflict	32	49	60	44
4.Independence	64	64	45	37
5.Achievement Orientation	54	34	53	59
6.Intellectual-Cultural Orientation	65	47	47	36
7.Active-Recreational Orientation	51	44	38	33
8.Moral-Religious Emphasis	45	45	61	51
9.Organization	48	41	48	63
10.Control	68	60	54	54
Incongruence Score Between Son & Mother	66	68		

Figure 2. Graphic illustration of scores on FES & CVFES for Family "A".



Standard scores for normal family have been identified between 30 and 70 (Moos & Moos, 1994).

sexual assault is an external trauma influencing the family. Thus, some of the results may be reflective of an everyday environment for this family and cannot undoubtedly be associated solely with the sexual assault. Comparing the CVFES and FES has not been supported with research thus these results are discussed with caution.

I have hypothesized that the post-test results may have been affected by the possibility of family violence in the home since the mother attended two appointments in a row with a bruised eye area. Although I questioned about this the mother chose not to elaborate on it, confirming that she was fine. The first of these two appointments is when the FES and CVFES were completed; hence, these results may be skewed by the recentness of the suspected family violence. Initially this was to be the final session but the family chose to attend two subsequent appointments. I noticed that the child perceived conflict to increase from beginning to end whereas the mother perceived it to decrease; yet they were similar on their post-test scores. Parent-child conflict was not mentioned as an issue during this process and there were no other "conflicts" discussed by the family other than the issues pertaining to the sexual assault.

I would suggest that my impression as well as the verbal feedback from the family corroborates the results on the expressiveness subscale. The child remained the same pre- and post-test but the mother showed an increase on the expressiveness subscale, which was congruent with her descriptions of more communication at home. In regards to the cohesion subscale, it is somewhat alarming that the mother and child differed substantially. They had opposite

results at pre- and post-test with a substantial drop for the child and large increase for the mother. It makes sense to me that the mother would show such an increase, as it was congruent with her verbal indications. My hypothesis in regards to the boy's scores is that there remained an element of uncertainty about safety in the home and in the community for child "A". During the course of therapy the child and mother both indicated that there was improved cooperation and play between this child and his two siblings at home, which would normally be indicative of increased cohesion. Hence, the child seems to have given a meaning to the family cohesion dimension that is in the range for distressed families. This was the child's perception on that particular day.

According to ongoing verbal feedback from both the mother and the child they were finding therapy helpful. My observations of their shifts and terminology supported this view. On the final feedback questionnaire mother "A" stated that the process had been "very helpful" because it helped them "understand more about the situation". As well, she stated that it helped their family "be closer, be open more and honest" and it helped her to "be closer to my children and give them more attention". All the comments were very positive. The following comment speaks to the therapeutic alliance that is such a large contribution to therapy being effective: "most therapists should be very nice and understanding like" this therapist.

Creativity seemed to be an essential component of the process of therapy with this family. It supplemented the cognitive processes in a non-threatening and client specific manner. This became a very comfortable approach for me and

I found that our conversation evolved from the client's meaning system. Besides the previously mentioned artistic strategies, we also developed a paper hand game that was used to document the various worries. The child always took the lead in playing the game, thus giving him the control of what part of the worries and issues we would explore during a given session. This provided an avenue to slowly map out the influences contributing to the overall story and the re-authoring of it.

Reflecting on the issues for this family, it seems to me that this mother has made very much effort and progress in many areas as a parent. Although we had collaboratively discussed plans to increase a feeling of safety for this young boy, it seems to me that an element of discomfort still exists when this child is permitted to travel alone from an activity in the community to home later in the evenings. The meaning and parameters for individuality and independence in this family are such that the 9, 10 and 11-year-old children are permitted to walk outdoors after 10:00 p.m. This was brought up and discussed since child "A" associated it with the influence of fear on him. Many shifts had been realized during therapy and incorporated into this family's lifestyle. I would suggest that the change process will continue to evolve and hopefully the discussion on safety will be an impetus for continued family strategies to be implemented in this area.

This case provided an opportunity to see and hear changes that any child is capable of and the joy that it brings into his/her life when it occurs. The process seemed to open space for both the mother and son to challenge internalized subjugating truths and experience personal agency in their alternative story. As

the therapist, I often provided an educative component to the families that I worked with since I had accumulated information and knowledge on the topic of child sexual abuse. Nonetheless, a not-knowing or curiosity stance contributed to a collaborative relationship that supported the family's expertise of their unique experiences and the re-authoring of the abuse related parts of their story.

Full Review and Analysis of Family "B"

Child Protection Services referred family "B" to the FASA program after the eldest daughter disclosed that a very close, adult family friend had sexually assaulted her repeatedly between the ages of five and six. Now 10 years old, this child participated in a lesson at school on "good touch, bad touch" that was the impetus to tell her mother. This is a two-parent family with three children between the ages of 5 and 10, and the paternal grandmother also living in the home. The family came to Canada as immigrants from a war torn country about seven years previous to this referral, thus, English is not their first language. Both parents are employed in full-time positions with the grandmother providing an active childcare role in their absence.

The alleged perpetrator of this young girl was a male from the same country that this family was from. He was considered "like family", as he was a single man without his own family, therefore spending a lot of time at this family's home. The sexual abuse occurred in Canada and at the time of disclosure, the alleged perpetrator was living elsewhere. Child Protection Services initially became involved after the parents called them for help to determine what had happened. No further involvement occurred beyond the one interview. At the time

this matter was referred to the FASA program no one else had spoken to the child about this abuse.

The use of language was particularly important in this case. It is through our language that we interact and communicate our meanings and understandings of the world around us. Our cultural, political and social climates shape this. As such, I was aware that there were multiple influences for this family developed from their country of origin and from the acculturation process in Canada. They can and do communicate in the English language, however, their meaning systems and interpretations were unique to their lived experiences. As such, the family brought a family friend as an interpreter for the first meeting and we communicated in both languages with the interpreter's help. For subsequent meetings it was just the family and myself and we were able to develop a collaborative and respectful therapeutic alliance. Keen listening and clear speaking became especially helpful during the relationship with this family.

In beginning therapy, I was clear with this family that we may need to clarify meanings and intent with one another as we proceed. Perhaps one of the first indications that words can mean different things to different people and that functioning in a second language is arduous was the process of completing the standardized measure. The father asked me to clarify such words as "independence", which was more difficult than I had anticipated, and the mother completed less than half of the questions on the FES in more time than the father took to complete all questions. As a result of limited responses and cultural inappropriateness, I have considered the scores of the FES invalid and will not

be including them in this analysis. The child's score on the CVFES seemed to be more in line with my impressions of the family but she too had difficulty with the concept of choosing the picture that looks most like her family and was continuously asking her parents to help her choose.

The nature of SFT, NT and the philosophy's of postmodernism were very useful for facilitating an effective therapeutic process. That is, leading from one step behind, taking a not-knowing stance and honouring the family's expertise were significant beliefs and concepts that demonstrated that diversity issues did not have to pose a barrier in this therapy. Over the course of therapy I heard of many atrocities experienced mostly by the adults in this family. These stories as well as the stories about immigration and acculturation put some of the family's experiences in context for me.

We began the first of 15 sessions with both parents and the 10-year-old child present. This posed a barrier for comfortable dialogue because daughters and fathers within this culture do not normally talk about personal matters in their family environments and the parents were shielding the daughter from their worries. Thus, meeting with the parents alone for part of the session provided them an opportunity to tell their story and discuss their worries without letting their daughter know the deep level of hurt, anger and fears they were experiencing. These parents felt extremely betrayed by a man whom they had shared very much with. Similar to other parents where a family or close friend sexually abused their child, these parents were perplexed and anguished as to how such a situation could have occurred. Normalizing their fears and questions,

and providing some information from the literature seemed to ease their minds somewhat.

The beginning stages of therapy took longer with this case than other cases because of the cultural difference, the child's emotional and reserved presentation and the family's need for additional clarification regarding services and processes within a Canadian context. The parents and child were given an opportunity to tell their story and I listened carefully to their construction of meanings and the worries they presented. Child "B" was extremely shy, was embarrassed with the introduction of any body part or sexual type words, and she would burst into tears during silences after I posed a question to her. Emotions and affect were undoubtedly a large part of this family's story and I would have been negligent if I had disregarded the intense feelings being expressed. Mother "A" was very attuned to her daughter's pain and feelings and this was expressed through words and through her own tears.

The joining process and the telling of their story lead to the establishment of an overall goal that the family and child wanted to be "okay". Both parents were very supportive and willing to do anything necessary to help their daughter. We agreed that for future sessions only the mother and her daughter would attend based on the family's preference. Although being "okay" is a rather broad goal, it became a starting point for therapy and it gave me the flexibility to follow the family's lead on what was important for them. Smaller goals and plans were established along the way, contributing to the recognition of a future without the influence of the effects of the sexual assault.

Being an advocate for and with this family was an important role. Through their information and questions it became apparent that the child was very confused about her physical health. As well, the family was patiently waiting to be contacted by the police to give an interview. I made arrangements for the child to have a medical examination to make sure she wasn't "broken inside". There was some miscommunication and the police had not even received a referral at this point. An appointment was made with the Police Child Abuse Unit and I accompanied the family to this meeting at the child's request. Although I did not have an active role, it seems that I became a source of comfort and familiarity at a time when there was so much disruption and uneasiness for this family. I remained the intermediary between the investigating officer and the family for the duration of our therapeutic relationship. This was a mutual decision with the family who appreciated the opportunity to focus on therapy and alleviate some of the extra confusion the criminal process brought on.

The sexual assault was called "the secret" or "the bad touch" and it brought feelings of confusion and sadness into this child's life. I had to work extremely hard at times to ask questions in various ways that would elicit any type of response from this child. I chose not to pose the miracle question as a technique with this family because of my hypothesis that they would have difficulty conceptualizing it. Nonetheless, future oriented questions served a similar purpose being that they created the realization of hope and possibilities. The parents, and specifically the mother were very receptive to these hopeful conversations as the disclosure of their daughter's sexual assault challenged

many of their values and beliefs that had been an inherent part of their family story.

Nonetheless, it eventually became clear that one of the difficulties with moving to solution talk with the daughter was that the secret had dominated many of her developmental years and no one really had heard her story. Her parents seemed to know bits and pieces since they had not been a part of the Child Welfare nor police interviews. Child "B" did not offer information so we had not heard much in our therapeutic relationship either. In response, I shifted my approach and asked questions about the abuse that would create a map of its influence in this young girl's life. This created an opportunity to link the past to the present and clarify questions about the future.

Understandably in any telling of lived experiences, bits and pieces of the story come out along the way to contribute to a more whole story. For example, early on this child told us that this man had used his adult authority to force her into secrecy. That is, in this family's culture children are adamantly told not to question an adult's directions. Likewise, the alleged perpetrator had introduced this young girl to body image concerns. He told her that she would grow up to have a certain type of body which, at five years old, she interpreted and internalized this to mean being unattractive and different. The small parts of the story help map the influence of the effects of the sexual abuse.

I had also tried to discuss the concept of triggers and flashbacks with this child. This was a cognitive process that she engaged in at the time, however, we were able to expand and illustrate this discussion later on, partially by chance

and because space had been freed for this daughter and mother to communicate openly about this trauma. The child asked her mother to refrain from buying a certain type of chocolate, which she explained, had been used as coercion for secrecy. In therapy then, it provided the opportunity to link the past experience to present reactions, which then opened space for the daughter and mother to explore other triggers and to determine how they would be able to take control over them. Mother "B" was extremely delighted with this development as it was associated with a forward momentum. This supplemented other discussions on empowering the child to be in charge of the "bad thoughts" that sneak up on her. The child's reaction to the chocolate in the present was clearly an exception to when the effects of the abuse could have continued to dominate her but did not.

Scaling questions were effective with child "B". We employed a visual scaling using our hands to show the size of such worries as confusion and sadness. The child's hope was that therapy would help her to shrink these undesirable feelings so that she could be "more happy". My role as a guide was instrumental in helping this child to discover that she had influence over the effects of the abuse. As previously mentioned, I had to work extremely hard with the use of questions and mapping the influence, however, coaching the child in some self-talk worked toward giving her a voice in her healing. For example, her mother and I had spoken at length and explained to this child that she was not to blame for the abuse but when we asked her to say the words, "it's not my fault", she was unable to do so. Through the use of humour and play she eventually said the phrase in the session and this became one of several statements that I

emphasized and complimented her on throughout therapy. It was also a small change that supported other self-talk statements throughout the process.

Over the course of therapy this young girl and her mother experienced and described many troubling effects such as the child isolating herself, hiding in a closet, withdrawing from social activities and play with friends, having nightmares and flashbacks, sadness, worry and confusion. This child's affect and emotional presentation would change dramatically within and between sessions. With the guidance of the case supervisor, I explored the possibility that this child was dissociating since her mother described that the child would often not hear others speaking to her and she would seem to be "out in space". As such, I needed to educate myself on this trauma response.

Using some suggestions and techniques from the work of Yvonne Dolan (1991) I was able to engage this child and her mother in a process of increasing awareness and noticing these dissociative reactions. This was also linked to our previous discussions on triggers, thus, the alternative story continued to evolve. The plan developed was to do something different when a "spacing out" type behaviour was noticed. The mother would gently draw the child out of her internalizing behaviours. This plan continued to build on other solutions that were already in progress. It seemed that the child was displaying conditioned responses but she was not aware of these times therefore the team approach with her mother and household family members was helpful.

As a reminder of her safety in the present, the child picked out a "special rock" from a collection at the office. This rock was kept on her person and it was

a symbol that emphasized her newly developed control over parts of the influences and promoted “good thoughts”. Externalizing conversations dominated this therapy and was especially necessary given the development of harmful internalized truths from the child’s lived experiences. There were many unique outcomes and exceptions present in this family’s life. My role was to do whatever was necessary to tap into them and use them with the family to co-construct an alternative story of bravery, survival and achievement.

Ending therapy was a mutual plan however the family would have liked to resume sessions in the fall on a more irregular basis or to have me available for future consultation. Based on the degree of impact that I observed and learned about I also felt that ongoing therapy with sessions spanning longer intervals would be necessary. So despite a comprehensive service being provided, I did introduce this family to another therapist as a contact for the fall. One of the outstanding issues is the criminal investigation, which I anticipate will create the need for this family to debrief and sort out their relationship to the process.

Lastly, I believe it would have been more helpful to conclude therapy with the father involved in a session since he is part of the support system who is noticing and cheering the alternative story for and with his daughter and family. This, however, was my preference and was not the family’s decision, which I respected. Mother “B” explained to me that she is a sort of filter through which information flows before it gets to her husband whom also has his role in the family. She communicated whatever was necessary to her husband.

In retrospect, I wonder if it would have been helpful to consider the type of relationship that existed with this family. This may have accounted for between session tasks being minimally followed. On the other hand, I would be skeptical to think in these terms because it seemed that the cultural factors might have also contributed to the understanding and meanings of tasks. For example, near the end of therapy the child agreed to write a "rainy day letter" between two sessions. This was explained verbally and in writing to be a note to herself that talks about all the good things about her so that she can read it when she has a hard day in the future. This was very clear to me, but the child's translation was literal so she wrote a very nice story that was about good things on a rainy day.

The above example is another indication that language and meaning was such a big factor in this case. Language can be a barrier in therapy no matter what efforts are made to be respectful of diversity issues. Functioning in social situations in their second language was manageable but it seems that when the family was required to communicate within the context of the entirety of their story it became more complex for them. This speaks to the preference, if available, of being able to provide services in the first language of clients even if a cross-cultural relationship exists. I suspect that comprehension and contextual obstacles may become more prevalent as this child advances in the Canadian school system in the English language.

This case tugged at my emotions, as I was very attuned to the ups and downs experienced by the child and mother. I sometimes felt that we were taking one step forward and then two steps backward. All the pieces seemed to fit

together at the end, however, I am aware that our different reference points may have contributed to a rocky process. This child clearly demonstrated indications of many internalized trauma reactions that seemed to be uncovered within the safety of the therapeutic process. As hard as this was, therapy became understood as the avenue to explore and heal the feelings, questions and worries. There was a sense of relief expressed by the child that she did not have to come to therapy any longer but perhaps not a full comprehension of her personal agency for her life.

Often the parents would say they hoped that they could just forget about all of this and not talk about it, as if it would be swept away. This seemed to be a coping mechanism that may be related to their sad war experiences that had also introduced elements of post-traumatic and critical stress in the past to the family and intensely to the father. I got a sense that the family would have preferred a "quick fix" so that they could extinguish the pain and worries that this "bad guy" brought into their lives, which would create space for them to move on with all the positive parts of their life. Clearly, and above all, it was their hope and determination that perpetuated the shift to solutions and new meanings for their family.

Overall, there was progress and shifts throughout the therapeutic process with this family. When asked for feedback, the mother was always very polite and positive about therapy. Even though they had difficulty expressing their feedback, they made me a banner in the last session that simply said, "THANK YOU", which to me is rich with meaning.

Full Review and Analysis of Family “E”

This family consists of the identified 13-year-old male adolescent, his mother and his older sister living in the same household. The biological father has been absent from the home for about nine years and is currently residing in another country with little communication with his children. Sister “E” was described as being a special needs child from a very young age. Accordingly, she has required ongoing specialized care and supervision. This mother identified herself as lesbian, with both she and her son speaking openly about how she communicated and met partners on the internet.

Mother “E” called the FASA program about two months after her son was sexually assaulted by his step-grandfather. This child considered this man his grandfather, however, the mother identifies with him as her “step-father”. The grandfather, a feeble and unwell man over the age of 70 years, was charged for sexual interference after he touched this 13-year-old boy’s penis. Essentially, the grandfather disguised his abusive intent with his age and limitations. Child “E” disclosed to his mother within a day of the incident and police were notified. The mother identified that there was a gap between the assault and entry into therapy because she had difficulty locating an appropriate resource. She reiterated this worry on the final feedback questionnaire recommending that the community be better informed of the FASA program.

This family presented an extremely problem-saturated life story. It was described to me that this child had experienced 30 residential moves in his lifetime, one previous incident of inappropriate sexual touching, he was hit by a

car causing him serious injury and he saved his family from a house fire when he was a toddler. Consistent with the models of intervention being used, the beginning stage of therapy gave this child and his mother an opportunity to tell me about their life and their complaints. The mother described wanting a stable lifestyle but that “many unexpected things happened in [her] life”. She reported that this same man had sexually abused her and several of her siblings when they were children. By self-report she has lived with very much anger in her life as a result. At this stage, I was already able to hear unique outcomes and exceptions in the life descriptions but I was careful to not prematurely jump to strengths and solutions. I had been purposefully paying particular attention to my pacing in sessions with families.

From the beginning, this mother tended to dominate conversations leaving little opportunity and perhaps, desire for her son to speak up. Unfortunately, this mother relied on a more dated written resource to help her with her own abuse issues, she used deficit-based language in dialogue, and she tried to bring both into our sessions. More than likely, this had been a familiar way of communicating and living life for this woman. Her pessimism was evident from the onset and I felt that complimenting her strengths and resources proved to be a very effective and empowering approach to help her to add these descriptions to her repertoire of memories and of life. Mother “E” was respectful and empowering toward her son, giving him the option of how sessions should be approached. They suggested that the son have an opportunity to meet with me individually at times to allow him to freely explore his concerns and worries.

Consistent across all cases, the beginning stage of therapy was also a significant time to address questions and concerns about the reactions to sexual abuse as well as myths and misconceptions about the short and long term impact on the child. Such ideas as blame and accountability, normalizing reactions and creating a possibility for healing and recovery were themes that were carried on throughout ongoing sessions with children and their families.

Adopting the notion of language games became relevant from the very first interview with family "E". For example, in the joining process the child was describing activities that he participated in, including playing a musical instrument, being in the school band and taking dancing lessons. His mother actually coaxed him into telling about the dancing which is a sensitive topic for him since he feels that if his friends find out they will think, "he is a fag". I used this opportunity to rephrase the meaning of these activities stating that, "it sounds to me like you are quite artistic and cultured in your interests". Although this did not invoke a noticeable reaction from the child, I suggest that these types of purposeful conversations contributed to the therapeutic relationship.

The formula first session task was posed at the conclusion of the first meeting with the child and mother, inviting them to pay attention to what is working well in their lives at the present time. I also supplemented this with asking them to consider what impact the sexual abuse has had on both the child and family. In retrospect, this may have supported the family's problem focus and as the therapist I should have used my language to remain strength-oriented. Initial goals identified by this family were that worry would be less, playing with

friends would increase, school performance would improve and self-esteem would improve.

The miracle question opened space for emotion and affect to be demonstrated as an integral part of this boy's story. His affect noticeably changed as he vividly described himself after the miracle being at a 10 on the scaling question. He would be happy, excited, joking, playing with friends, relaxed and talking about his feelings with his mother. My initial hunch that there were exceptions became evident when the boy told me that between the time of the assault and entry into therapy he had moved from a zero to a five on the scaling question. Family support and having the belief and strength of his mother were identified as two primary factors associated with his move up the scale. At this time, neither the mother nor the child could identify personal characteristics and skills that were helpful despite being able to describe each other very positively.

The use of language helped the deconstruction process particularly regarding the family's focus on the negative aspects of their lived experiences. I engaged the mother and child in search of a metaphor to refer to their story of their past experiences and their successes. Mother "E" immediately provided a creative comparison stating that their lives have been similar to being fishermen at sea. Basically, fishermen must be prepared to handle any type of weather such as sunshine, calmness and storms to make their living and survive. Similarly, in the family's life they have weathered many different types of "storms"

that have passed and “rocked their boat” but their self-confidence and family support has helped them to deal with and heal from these uneasy times.

Adaptation was identified as an integral factor in this family’s life. Thriving and surviving was terminology used by this child and was an indication that the dialogue and descriptions of their story were shifting to strengths and resources.

Clearly, there were a number of ongoing issues that were interrelated to this child’s current functioning that were brought up at different times in therapy. Believing that a small change begins the path to a preferred story, I remained focused on the family’s goals and their ideas about the most effective process to achieve them. This also supports a premise of SFT that the goals of the client shift and may not necessarily be related to the originating complaint. Thus, when child “E” announced at about the third session that he thought that the sexual assault was not affecting him, I surmised that his suggestion was a matter of semantics and association, however, I followed his lead. Topics such as school attendance, physical wellness, task completion, puberty issues, the court process and family loyalties were introduced at different times. Although each is not necessarily directly related to the reason for the referral it is hard to isolate the worries or topics as a singular component of the story.

Between-session tasks gave the child and his mother the responsibility and opportunity to discuss some parent-child issues and school difficulties at home. I did not provide any specific direction and on both occasions they had developed their own goals and solutions to the identified concerns. Their expertise was evident.

One session was spent on defining and describing self-esteem and self-confidence. The mother and child dominated this discussion and I sat back waiting for the need to ask a question, to clarify explanations and meanings and to compliment on the thoughtful and schematic illustration presented. The child identified self-esteem as something one has and learns but that it only flourishes with support. It is a feeling and thoughts inside a person. For him, self-esteem leads to increased confidence, the ability to conquer his fears, helping others, self-initiative behaviours, it improves school, helps him to be articulate, contributes to his leadership ability and helps him to function well overall.

The previously formulated metaphor and the new definition of self-esteem became relevant in a discussion about feelings of anger and the desire for some form of revenge. Normalizing these feelings as a valid reaction to a very intrusive act was essential, but differentiating between feelings and actions was also included. As such, we established that child "E's" ability to "weather the storm", to speak up and to continue to live a healthy and happy life are forms of revenge since he is protesting the control this could have had on his life. This analysis was especially important to the mother who wanted to ensure that her son had more opportunity to flourish despite his victimization.

As we approached the final two sessions of the total of nine we revisited and highlighted the shifts, changes and strengths realized through the process of therapy. In response to the scaling question, this child now rated himself at a 9 out of a possible 10. Congruent with his earlier miracle picture, this child used the following language to qualitatively describe what the nine looks like: "life is going

good right now”, “getting good marks”, “have new friends and am on the internet a lot”, “am doing homework”, and “not a worry”. When asked to clarify what it was that he had done to move from a 5 to a 9 on this scale, child “E” stated that he “out-confused confusion”. As well, he has hope that things will continue to get better and that he will “be prepared to solve problems” as they come up. This was an indication that the child identified with the self-defined confidence to continue on a happier path for the present and future.

The final session was a celebration of the family’s survival and resources. These latter meetings also included a discussion of future “storms” eliciting responses from each as to what will help them to be in charge when being tempted by lack of confidence or hopelessness. Predicting setbacks and discussing social supports to honour their new stories was incorporated at this time as well. Certificates presented to both the mother and child emphasized their strengths using their language. The mother’s certificate stated: “In honour of your strengths and resources in navigating your family forward through storms”. The child’s read: “A certificate honouring *child “E”* for his confidence and survival skills in ‘out-confusing confusion’. Your positive outlook, humour, determination, beliefs and hope will carry you forward.”

Overall, both this child and his mother indicated that the process had been very helpful on the feedback questionnaire. The child was vague in elaborating but the mother did provide a qualitative description that included the metaphors used throughout therapy. She noticed that therapy gave her son an opportunity to talk about his confusion and anger, thus improving his self-esteem and

showing “a belief in his survival skills”. Likewise, she appreciated that this process strengthened their “mother and son bond”. Mother “E” suggested that she would have found it more helpful to have information on the long-term effects of sexual abuse and what she should “look out for” as a parent.

My intent on associating the strengths and resources that had contributed to this family “weathering previous storms” was to identify these same qualities as helpful for future obstacles. The feedback from mother “E” helped me to recognize that perhaps I was not as clear as I had hoped to be in this regard. Or perhaps, my positive and strength based language was still somewhat foreign to this mother so it was interpreted in a different way. I also propose that this is indicative of long standing pathology-based beliefs in society about sexual abuse inevitably causing ongoing negative effects for victims. Lastly, it is possible that the individual sessions with the son had satisfied some of the future planning specifically regarding setbacks, however, the mother was not adequately apprised of those developments.

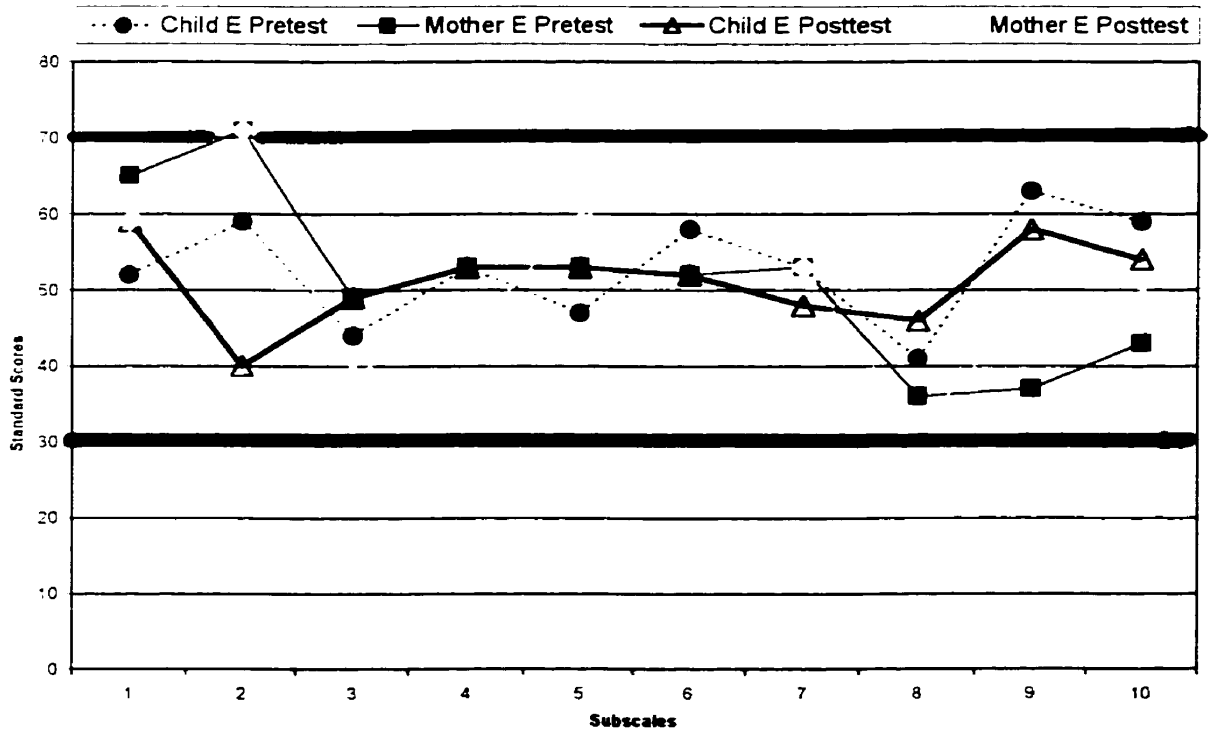
Both this mother and child completed the FES at the first and last session (Table 3 & Figure 3). Overall, the mother and child reported very similar results on all subscales and all were within the normal range. The child recorded higher but minimal differences on organization and control, which may be indicative of this mother’s uncertainties about her parenting decisions albeit the child’s positive perception of them. This is also suggested because the mother’s scores increased from pre- to post-test while the son’s decreased on these two subscales. The one outstanding and confusing score was that of the son’s on the

Table 3

**Family Environment Scale (FES)
Standard Scores for Family "E"**

Subscales	Child E		Mother E	
	Pre-test Session 1/9	Post-test Session 9/9	Pre-test Session 1/9	Post-test Session 9/9
1.Cohesion	52	59	65	59
2.Expressiveness	59	40	71	71
3.Conflict	44	49	49	39
4.Independence	53	53	53	45
5.Achievement Orientation	47	53	53	59
6.Intellectual-Cultural Orientation	58	52	52	69
7.Active-Recreational Orientation	53	48	53	53
8.Moral-Religious Emphasis	41	46	36	32
9.Organization	63	58	37	48
10.Control	59	54	43	49
Incongruence Score Between Son & Mother	51	57		

Figure 3. Graphic illustration of scores on FES for Family "E".



Standard scores for normal family have been identified between 30 and 70 (Moos & Moos, 1994).

expressiveness subscale at the post-test. Although it is within a normal range his score dropped from pre- to post-test, which is contrary to my observations and his verbal descriptions and dialogue of the changes in his life.

The incongruence score between this pair at pre-test was a standard score of 51, and at post-test, it was 57. The gap seems to be mostly related to the son's lower score on the expressiveness subscale at post-test, and the mother's jump on the intellectual-cultural orientation subscale. I believe this was indicative of the mother participating in more community activities and feeling more empowered to do so.

In summary, I felt that there were many remarkable characteristics for this family and that this contributed to an effective therapeutic process. Both the child and his mother were very communicative, both initiating conversation and responding to questions in a variety of ways. There was a clear sense of collaboration among all of us. Mutual dialogue served to emphasize all the successes that had previously been disregarded for this mother and child. I hope that the strength-based language is the beginning of ongoing shifts in meaning for them.

Perhaps the most challenging part of this process for me was to allow space for both the mother and child to speak up. The mother reported to me at one of the final sessions that she has taken the initiative to locate a therapeutic resource for herself. Without my suggestion, I believe this was an appropriate decision by her that may help her to deal with her individual worries. There seems to be a variety of interwoven issues for this mother and I suspect that

being able to deconstruct some of the restraining sociopolitical values and beliefs would be a liberating process. Such issues as sexuality, victimization versus survival and socioeconomic achievement might be helpful to explore.

Summary and Analysis of Family “C”

The six-year-old female child of family “C” had been sexually victimized just days before her mother, the primary caregiver, had contacted the FASA program. As a newly separated couple, these parents were experiencing distress due to their relationship break-up. They had, however, been making every effort to jointly parent their only child. The sexual assault of child “C” was invasive, resulted in some physical injury and occurred while she slept in her own home with her mother present. The male perpetrator was an adult cousin of mother “C” who had permission to remain in the home after a gathering of several adults.

A consultation was requested and both parents attended without their child. Consistent with NT and SFT, the couple was given an opportunity to tell of the circumstances of this incident and their reactions since finding out, and throughout the police and medical investigation. When exploring the impact of this sexual assault both parents felt that their daughter had not exhibited any drastic changes in behaviour nor affect. Although both parents had different ways of responding to their daughter, both were consistent in their messages to support her and provide safety.

Unfortunately, this incident exacerbated other life stressors for both parents and they felt that the father was the most affected by this incident. Efforts were made to normalize their feelings and compliment them for their supportive

nature with their daughter. Nonetheless, the parents differed on the amount of control and type of communication that needed to occur specifically with their daughter. There seemed to be an undertone of blame toward the mother by the father, however, he also indicated that he was making efforts to alter this direction of thought. Father "C" was involved with an individual therapist for other reasons but was hoping to utilize the resource to also support him during this trauma.

Given the family dynamics at the time of this abuse, as well as the age of the child, the parents and mostly the mother felt that they would continue to address this matter as parents. Literature was provided to support their efforts and to provide additional guidance. Mother "C" presented her view that the adults' responses to her daughter would greatly determine the outcome and her daughter's adjustment. It seems that the mother had developed meanings and responses to chaos and difficulty from her own childhood. She was applying her belief in resilience to her daughter's situation and clearly saw this situation as an external force rather than a problem within the family. Father "C" was also attributing meaning but his association with sexual abuse was more related to understanding it from a perspective of hopelessness for the future or as "damaging" his daughter for life. He was more influenced by the socio-cultural ideologies about the inevitable negative effects of sexual abuse.

My consultation with this family occurred during the crisis period, hence the stress was at a peak. In a follow-up phone call a few weeks later with each parent they both indicated that the sexual abuse was not dominating their lives,

the effects were minimal, and there had been progress in other parts of their lives. The father returned to work after being off for stress leave and the mother found employment. These parents seemed to recognize new possibilities that will hopefully be helpful for their daughter especially given the multiple changes being experienced. Although I did not meet the daughter, I would hypothesize that any negative effects of the sexual abuse would be blurred with reactions and symptoms of drastic changes in the family. This was likely true for the parents as well.

Summary and Analysis of Family “D”

A two-parent family requested a consultation with a therapist after their only child, a daughter who is five years old, was the recipient of inappropriate and questionable sexual play with an eight-year-old female neighbour friend. I approached this meeting with the assumption that I would need to address normative versus non-normative sexual play of children due to the ages of both children. This proved to be an accurate hunch and was helpful in guiding me to ask appropriate questions to elicit the parents understanding of the circumstances of the sexual interactions.

These parents demonstrated compassion for their daughter’s well-being and for the safety of the eight-year-old friend. Perhaps the sexual play could have been interpreted as exploratory, but of concern to the parents was the fact that the older child was using bribes of gifts and goodies as well as coercion to get their daughter to be subjugated into looking and touching type sexual actions, and into secrecy. Child “D” seems to have been tricked into actions that her

mother had tried to teach about and guard against. I believe it was helpful to frame the incidents as “trickery” because this places the sexual interactions as an external influence on the child that helps the parents and child to team up together against it. Mother “D” had been sexually abused as a child and wanted to prevent this for her own daughter. Unfortunately, this family’s teachings involved remaining safe from strangers and adults and overlooked the impact and pressure peers and other children can exert.

Nonetheless, it is important to recognize in any situation where past abuse issues exist for a parent that their expedient utilization of resources and strengths as a parent must be complimented. The parent’s actions provide an opportunity for a quicker and healthier recovery for his/her child; one that had not been present for the parent (in most circumstances). Several of the parents written about in this report had voluntarily told of their own childhood sexual abuse experiences.

Overall, parents “D” made every effort to explain and co-construct new parameters around the friendship in such a way that their child would not be traumatized from the loss of a “best friend”. The parents identified being more worried than their child who had developed an understanding of the actions as play between friends. Nonetheless, these parents had begun to build solutions and recognize the alternative story that was developing in response to this incident. The consultation seemed to provide the validation and information sharing that they required.

Summary and Analysis of Family “F”

This family presented for therapy after their 8-year-old daughter (child “F”) disclosed that her maternal grandfather had been “touching” her for about three years. Interesting family dynamics exist in this family and contribute to an understanding of the context of intervention. Mother “F” had been the custodial parent for all three children up until about a year ago when the biological father became active as a parent and took on the custodial role for the oldest, pre-adolescent son. The 10-year-old son currently lives with the mother, however, he too will be relocating to the father’s home in the near future. Behaviour issues were instrumental in the shift in childcare responsibilities and for the involvement of other support services. It is significant to note that this father has completely shifted his commitment and has become a partner with this mother in parenting all three children, hence his active involvement in therapy when child “F” disclosed the sexual abuse.

Completion of the FES and CVFES with both parents and their daughter showed that the incongruence scores between this mother and both the child and the father were high at a standard score of 72. The difference between the father and the child was lower at 55. These results are regarded cautiously, yet they may contribute to an understanding of the different family environments at the homes of the mother and father. I also believe they are reflective of the mother’s own abuse history. At this beginning stage the mother recorded low on cohesion, independence, active orientation and intellectual-cultural orientation and scored high on conflict and control. Only the independence, intellectual-cultural and

control scores were outside the range for normal families. This seems to be indicative of mother "F's" desire to provide safety and security in her home but also of the challenges that this has presented for her autonomy and for family unity. The parents differed substantially on their view of the family environment in each of their homes, only being similar on the expressiveness subscale. These results provided an additional perspective to me as I began my intervention with this family.

Child "F" was described by her parents as being terribly traumatized by the sexual abuse, experiencing nightmares, sleeplessness, changes in affect, fear, worries, attachment issues and bedwetting. This young girl also expressed many troubling effects. She was able to frame these issues as being a result of the "bad guy" and the "bogeyman" who were sneaking up on her and creating these undesirable situations. The child was confident that she could take control of the "bogeyman" thus effecting change in some of the noted behaviours. The family as a whole was also experiencing varied reactions and responses, which included feelings of betrayal, shock, anger and guilt. It seemed to me that the relationship of the perpetrator to the child and family was a significant factor in the traumatic impact of the sexual abuse. This was explored specifically with the mother. It also came up with the child as a discussion of family loyalties and the loss of support from extended family such as cousins, aunts and uncles.

Often when discussing the abuse or when the child presented elements of the experiences, the parents were hearing the information for the first time. For example, the parents heard during one session that one of the ways that this

child demonstrated her protest of the abuse, at the time, was by biting her grandfather's hand and by screaming. This helped in emphasizing unique outcomes of the abuse that highlighted the inherent strengths of the child; strengths that would contribute to the healing process.

These parents were instrumental in directing the approach to sessions by suggesting that I meet with their daughter alone for part of the sessions because they felt it would be more helpful to the child and would be easier for me. I was extremely challenged at the beginning to ask and reframe questions that would elicit any form of a response. This changed when I met with child "F" alone. The parent's assessment proved to be accurate and highlights the knowledge and expertise of the parents in knowing their child.

The issue that seemed to be present was that the child was attempting to protect her parents from further upset and worries by refraining from full participation when together as a family in sessions. This was a common element seen in many of the other cases presented in this report. Being aware of a child's protective stance further contributes to support for a family based approach that promotes family cohesion and expressiveness in an effort to facilitate changes for the entire family unit. Seeing this child alone was beneficial for a time period because it was done within the context of family. If this occurred all the time, it would isolate the child's worries and progress, and limit any opportunity for a team approach within the family.

The use of the miracle question assisted in identifying life without the effects of the sexual abuse. The child was very expressive in showing me what

happiness would look like. Her parents could envision their daughter playing and smiling on a regular basis. A big shift came when the father openly stated that he was feeling better and recognized the impact his negative feelings and worries were having on his daughter's adjustment. Even up until the last session, I got a sense that this mother was still somewhat shadowed by her own victimization in recognizing shifts in affect and emotions of her daughter. I had offered to supplement the family-based service with an individual session with this mother, however, she chose not to proceed. An opportunity to reach out to the mother or having support via another resource may have contributed to more global changes in her family environment.

Overall, the process of intervention seemed to be effective at facilitating the beginning stages of a new chapter in this family's life. Using a metaphor, I would suggest that the rock has been dropped and the ripple effects are beginning to develop. The family realized that they possess the resources to support their child and the future development of preferred stories. I believe that there may be some setbacks for this family especially since the court process will interfere with their forward momentum. This was addressed in the last session, however, future planning was limited to a discussion on the phone with the mother because the family became extremely busy with summer time activities and did not make the final session.

Similarly, a post-test of the FES and CVFES was not completed but may have been helpful to get the family's self-perceived views after the eight sessions of therapy. Lastly, the family environments and dynamics have been dramatically

shifting over the last year for this family. I believe that this has been instrumental in creating new and varied meanings of family functioning and responses to everyday stressors as well as traumatic and crisis stressors.

Summary and Analysis of Family "G"

This case involved a single mother who was raising her 7 ½ (child "G") and 14-year-old (sibling "G") sons on her own. I found this case to be extremely challenging in the earliest stages because the information presented did not fall within the specific criteria of the FASA program and there was an outstanding custody pursuit that seemed to be dominating the mother's intent for seeking intervention for her son. Nonetheless, once I was able to hear the mother's worries and understand them separate from the custody issue, we were able to work jointly to establish goals for intervention.

The issue presented was that child "G" had recently begun to speak about recollections of a sexual violation that had occurred when he was 4 years old. The disclosure, however, was very unclear. With my new perspective I was able to gather information through the use of questions, which guided in goal formulation. Over the course of ten sessions, the mother, child "G" and myself worked toward creating a "story of the past" with a present and future that involved safety and family unity. As well, the 14-year-old sibling was involved in two sessions at the mother and child's request.

By providing an opportunity for both the mother and child to tell their story about the sexual violation, they felt heard and we were able to shift to examining the effects in the present. The past incident was named the "sexual harassment"

and it introduced several questions and some feelings of confusion and fear to child "G". Interestingly, with the use of the scaling question this child identified the effects as being most worrisome for his mother. Externalization was used as a way to discuss this matter as a relationship for the child and mother rather than being a defect with them.

This family was able to identify many strengths and resources that helped them to establish stability in the present despite family violence and breakdown in the past. Gender issues presented in many ways for this mother who had challenged patriarchal issues from her marriage, within her workplace and in society. She had internalized some of these beliefs and they were most apparent when she worried that her 7-½ year old son would epitomize such unacceptable values. We were able to discuss and explore the impact of gender for her, what she was now doing to stand up to it and how this was a model for her boys.

It seems that the intervention with this family opened up space for them to discuss matters among themselves and it propelled the mother into a new stage of confidence in addressing sensitive topics with her sons. The administration of the FES and CVFES to the mother and her 7-½ year old son corroborated the similarity with which both viewed their family. An incongruence standard score of 42 was recorded at the onset between the mother and the younger son. During the last session a mean family incongruence score of 48 was recorded and this included the 14-year-old son's scores on the FES. These results have to be regarded cautiously since there has been no information to support the comparison of results between the FES and the CVFES within one family. My

impressions of this family were similar to their responses. They scored similarly high on cohesion and expressiveness at both completions. The mother identified more control and organization than either of her sons at both stages, yet the differences were minimal.

The mother's qualitative feedback corroborates the findings on the standardized measures and my impressions. She stated that the process of therapy "brought us closer. It made us realize our strengths and weaknesses. It made us see how together we are as a family, how we work together". She also said that the process had been "very helpful". When asked what stood out the most for her, this mother wrote: "trust. Ability to rebuild inside each other and together as a family".

As a hard-working single parent and considering herself as working poor, this mother was committed to providing opportunities, values and beliefs to her sons and wanted to make sure the past would not interfere with this endeavour. Empowering her as the expert in her family was very effective. I supported my belief in this mother's strengths by sending her a letter, using the family's language, summarizing our work together and emphasizing the changes and alternative stories that were realized (Figure 4).

Summary and Analysis of Family "H"

The mother of a 9-year-old daughter contacted the FASA program at the insistence of the school and with indications that Child Protection Services would be notified if she did not access services from the FASA program. The plan developed by mother "H" and myself was to gather some basic information and

Figure 4. Letter sent to Mother “G” following therapeutic relationship.
(Names omitted from original.)

May 23, 2000

Dear Mother “G”:

I want to take a few minutes to summarize our work together. As I had mentioned we met a total of 10 times over the course of two months. I appreciated your openness and your determination to seek help for your son.

I recall that in our initial sessions you had identified that you want to make sure *your child* grows up to be “normal and healthy” despite his disclosure to you at the age of four that he was touched in an inappropriate sexual way. Although the exact details of the assault are unclear, it seems that over the course of therapy you and *your son* were able to put the information that you do know into a story of the past that will not continue to interfere in your lives.

Throughout our times together, you always demonstrated compassion and support for *your son* in a manner that is consistent with your beliefs as a parent. Both your sons are nice boys who show respect to one another and to you. It is this level of family support that continues to strengthen your family. I think it became clear that *your son* is a “normal and healthy” child who is playing baseball, likes video games, plays and argues with friends, likes going to spend time with his uncles and grandmother, and enjoys family outings, (even the ones to the hardware store). *Your son* is inquisitive and insightful as well.

At the onset, you had stated that you were quite hesitant to speak about sex and sexuality matters in front of your sons. This never seemed to create a barrier when it did come up. And even more courageous and remarkable is that you have taken time at home to speak with your sons with the help of written literature. As we mentioned in our last session it is this open communication in your family that will contribute to your sons learning about healthy sexuality matters rather than getting wrong information from friends or other unreliable sources.

Mother, I was struck by your commitment to stand up for what you believe in. This is evident as a parent since you identify your son’s safety as most important and you are taking measures to continue providing safety. As well, you described situations at work that demonstrate your protest of gender inequality. I hope your strengths and perseverance will continue to shine into the future and provide a balance for you if and when you experience other challenging situations. You have many good ideas and I appreciated learning from you and your family.

Best Wishes,
Paula Wickenden, BSW/RSW
Clinician, Families Affected by Sexual Assault Program

mutually understand how I would be most helpful. In this endeavour, a consent form permitted me to access information directly from the appropriate school personnel. The situation that was presented by this mother was that her daughter had been touched in a sexual way by an adolescent neighbour six years previous and that she had responded at the time by alerting police and speaking with her daughter openly. The school found out this information just before they began recommending that this child receive a service from the FASA program.

This case consisted of two meetings both involving the mother and child for varying parts. During these meetings the information gathered lead me to corroborate the mother's assessment that the sexual violation of the past was not impacting on the child nor the parent in the present. It seemed that school officials were operating under the socio-cultural belief and influence that sexual abuse inevitably has detrimental long-term effects for a child. Perhaps they were also grasping for any resource they could think of. This is a family that is challenged with many stressors and difficulties. When the school completed a more integrated approach and comprehensive assessment they determined that other forms of intervention were more appropriate. In this case, relational questions were significant in helping to understand the reason for referral and the issues in context.

Summary and Analysis of Family "I"

The identified child in this family was a 13-year-old female who had recently disclosed that a male cousin had sexually assaulted her when she was about 5 to 6 years old and he was an adolescent. This teenager, who disclosed

to a school counselor and to her stepmother, revealed very few details of the abuse. The identified goal by the teenager and her biological mother was to help the teenager to make a statement to the police. In an effort to elicit an understanding of how the effects of the sexual abuse had interfered in her life, I asked relational questions. The teenager felt that there were only a few minor worries, most of which pertained to the judicial process.

Mother "I" had very high expectations for her daughter and provided a clear message that she would not let this new information "control" nor "ruin" her daughter's life. Child "I" presented as a very confident teen with expected teenage social interactions and exceptional scholastic marks. I would suggest that mother "I" created an achievement and survival oriented belief system in response to her own childhood victimization issues. Unfortunately, the results of the FES for this family were deemed invalid because more than half of the questions were answered with both true and false, hence the scoring was extremely skewed. I appreciated and fully respected the meanings this family had developed but I did wonder how their verbal descriptions would translate on the FES.

Although I have worked under the premise that all the details or the history of the abuse experience do not need to be uncovered in therapy, I felt that perhaps I was not the most appropriate and helpful medium to achieve the goal (talking to police) for this teenager. Once some basic information was gathered and abuse specific awareness provided, this family was confident about their well-being despite this disclosure. I became stuck when I recognized that therapy

might not be necessary so by presenting my thoughts to this mother and child I opened up space for them to determine how to proceed. Child "I" had a supportive network of parents, stepparents and extended family that were identified as being central in her life. When asked in the final session who would be most helpful when she knew she was prepared to make a statement to the police, the child responded by saying "my parents, all four of my parents". This was a deliberate and bold message to her mother who had forbidden the biological father from being involved in therapy.

I had met with this teenager a total of six times but two of these meetings involved a peer dyad. This was an effort to bring two victims of CSA together to alleviate their insistent worries that they were the only children who had been subjected to this type of abuse. As well, for child "I" this peer meeting provided an opportunity for her to hear from another child about the process that occurs at the police station.

The relationship with the "I" family was mutually ended with an emphasis on the resources of the teenager and her parents, and with the clear differentiation that the individual/family healing process is separate and distinct from any police or court proceedings.

CHAPTER SIX

Summary of Practicum Experience

Discussion

Reflecting back on my expectations of this practicum experience, I had initially anticipated that I would provide an orderly and structured process of intervention to the families with whom I worked. After a few sessions and a number of setbacks in the therapeutic process I began to realize that my organization was clearly dependent on the family's pace and with their expertise leading the way. Thus, the cases that I have presented are true and accurate but they also represent the outcome or final stages of therapy; this is the time when all the pieces seemed to come together following a sometimes, erratic process. Presenting case studies only gives the reader a glimpse into the life of the case. "They do not adequately represent the disorderly process of therapy – the ups and downs of that adventure that we refer to as therapy. Thus, there is a simplicity reflected in these accounts that cannot be found in the work itself" (White, 1992, p.110). Every effort has been made to present the material in a manner that is respectful of the children and families who have had their lives changed by the introduction of sexual abuse.

The literature review has contributed to a further understanding of the theoretical orientations and practical applications of narrative and solution-focused therapy. Embracing the essence of these paradigms became the mainstay of being able to work within their parameters. Nonetheless, given that this was a professional development endeavour, paying attention to the multiple

processes going on was hard work. Making sure I was listening to the client, responding with NT and SFT based questions, presenting accurate information from the CSA literature and maintaining an effective process were all combined elements of the interventions.

In regards to the co-location of NT and SFT, I experienced this to be an effective collaboration of theory and practice. By incorporating the essence of each therapy, the family essentially received a more comprehensive service. To me, the word "solution" implies a finite goal whereas an alternative or preferred story connotes change and adaptation. de Shazer would probably dispute this definition as he describes solutions as continuous changes. Either way, when combined, the language used in sessions contributed to an interactive process of change toward client specific solution building and alternative stories. Families seemed to embrace the "language game" presented in therapy as well as the use of creativity and metaphors.

From a theoretical point-of-view the intent of SFT is to be simple and straightforward but by adding principles from another theory the process and outcome are less concentrated. Chang and Phillips (1993) likened SFT to a technical approach and NT to a more artistic approach, hence, using them collaboratively and skillfully can fill the gaps of their individual application. Incorporating the micro and macro perspectives and approaches of SFT and NT respectively also broadened the possibilities in working with these families. When one theory or premise within a theory did not fit a particular point in therapy, the other was appropriate.

In practice, the development of well-formed goals is the pivotal point and sometimes the trickiest part as the therapist directs problem talk to a more strength and solution oriented conversation. Setting clear goals with the client opens space for the changes to begin to take shape more quickly. I found that if I had not developed clear goals with the client or if I assumed any part of it, I experienced setbacks in my approach with the families. Often when seeking supervision the therapist I was reviewing with would begin their questions to me by asking, "what is the goal?". If I could not be clear with the case supervisor, then it became obvious that it was going to be difficult to ask appropriate questions to the client to facilitate the solution building process.

Uniqueness, as an inherent quality of each family, was evident and paramount throughout this process. Each family and their specific responses to this type of trauma taught me about individuality and respecting the social construction of reality as lived stories. This further highlighted much of the literature that speaks to SFT and NT being a process rather than a formula for working with client systems. This was clear to me, but became even more so as I progressed with cases and followed the journey most comfortable for the family.

I believe that questioning was an empowering process for the family to recognize their knowledge and skills that had become secondary to daily coping and functioning. Because I was sensitive to asking the "right" questions I did struggle at times to relax and pay attention to the direction that the client was giving me. I found that I would also get excited when I heard the strengths, resources, exceptions and unique outcomes for the family. I had to pay particular

attention to walking beside the family and not pulling them by a leash in the direction I wanted them to go in. I saw their potentials and was able to slowly and effectively draw attention to them as the beginning stages of change. The process was definitely a mutual and collaborative one.

Overall, I believe in the strength of using a family based approach. I applied my accumulated social work skills in providing family therapy. The provision of services within a family context required that I be alert and very much aware of interactions since this is the medium through which meanings are created and established from a person-in-environment perspective. Likewise, from my perspective, any combination of family that is helpful to address the identified issues should be included in therapy but not all family members must be present to call it 'family therapy'. This is consistent with SFT and NT.

Working with children individually for sessions, or parts of them, is an area that I would reconsider or be more clear about in the future. Although I always provided this variation within a family context, the rejoining of individual and family became more complex. I took the family's lead in facilitating therapy with variations of the family present. In the future I would ensure that a clear goal was established with the family about the structure of sessions as a way to remain collaborative and to increase effectiveness.

Prior to full-time participation in my graduate studies toward my Master in Social Work degree I had worked as a Supervisor of Social Programs in Cambridge Bay, Nunavut, Canada. I fulfilled both a clinical and supervisory role in a variety of social program areas, including Child Welfare, Mental Health and

counselling to individuals and families. The work involved prevention, intervention and ongoing support to children and families who had been affected by sexual abuse and many other forms of trauma. I believe this diverse work experience provided a solid professional foundation, including skills, knowledge and personal confidence, that was further enriched by the theory specific research and the training opportunity of this practicum.

The use of the FES and CVFES within this clinical practicum seemed to be helpful as an alternative source of eliciting information from each family member about their views of their family. I felt that I clearly regarded these standardized instruments with caution and as one of many ways that the clients were giving me information about their families. As well, I felt that these measures were utilized within the context of the theory of SFT and NT. There is limited data to support the use of the FES and CVFES in practice with the issue of child sexual abuse, which is viewed as a weakness and should be an area of further exploration.

Similar to the discussion by Durrant and Kowalski (1992) I believe it is important to recognize that there is no right way to address CSA. It is, however, examples like this practicum that emphasize that some children and families find common information and processes helpful while still respecting their individuality. As stated in the introduction, I believe that children's healing capacities are best nurtured within the family environment. In this regard, I would suggest that the FES and CVFES could be an appropriate clinical and evaluation

tool for future practice with this population and warrants further study to support this claim.

The strength and resources of individuals and of family was truly experienced with each of these families. In closing, I am wondering if it would be appropriate or even advantageous to analyze the family resilience literature as a missing link in this overall report? The following passage leads me to believe that an examination of family resilience, when faced with the sexual abuse of one of their children is appropriate and is correlated with some of the basic philosophies of SFT and NT:

Belief systems are at the core of all family functioning and are powerful forces in resilience. We cope with crisis and adversity by making meaning of our experience: linking it to a social world, to our cultural and religious beliefs, to our multigenerational past, and to our hopes and dreams for the future. How families view their problems and their options can make all the difference between coping and mastery or dysfunction and despair. (Walsh, 1998, p. 45)

Conclusion

The main goal of this practicum experience was to work with families to help alleviate the negative effects of extrafamilial child sexual abuse using a combination of solution-focused and narrative therapy within a family-based approach. As well, I aimed to develop a solid skill base using these theoretical orientations in family therapy.

The existing literature contributed to my learning endeavours and supported my clinical application of the knowledge and skills. This process has been helpful and it contributed to my academic and professional development. I increased my knowledge base about the effects of child sexual abuse through

the research and through the work with the families discussed in this report.

From the feedback received, the families experienced relief from the effects of the sexual abuse and they discovered hope, resourcefulness and happiness as possibility in their present and future stories. Thus, the learning goals were achieved and the families benefited by developing new meanings for themselves.

REFERENCES

Adams, J. F., Piercy, F. P., & Jurich, J. A. (1991). Effects of solution focused therapy's "formula first session task" on compliance and outcome in family therapy. Journal of Marital and Family Therapy, 17(3), 277-290.

Adams-Wescott, J., & Isenbart, D. (1996). The politics of recovery from child sexual abuse. Journal of Systemic Therapies, 15(1), 13-30.

Adams-Wescott, J., & Isenbart, D. (1990). Using rituals to empower family members who have experienced child sexual abuse. In M. Durrant, & C. White (Eds.), Ideas for therapy with sexual abuse (pp.36-63). Australia: Dulwich Centre Publications.

Andrews, J., Clark, D. K., & Baird, F. (1997). Therapeutic letter writing: Creating relational case notes. Family Journal, 5(2), 149-159.

Babins-Wagner, R. (1991). Development and evaluation of a family systems approach to the treatment of child sexual abuse. Journal of Child and Youth Care, special edition, 103-128.

Berg, I. K. (1994). A wolf in disguise is not a grandmother. Journal of Systemic Therapies, 13(1), 13-14.

Berg, I. K., & DeJong, P. (1996). Solution-building conversations: Co-constructing a sense of competence with clients. Families in Society: The Journal of Contemporary Human Services, 77(6), 376-391.

Berliner, L., & Saunders, B. E. (1996). Treating fear and anxiety in sexually abused children: Results of a controlled 2-year follow-up study. Child Maltreatment, 1(4), 294-310.

Besa, D. (1994). Evaluating narrative family therapy using single system research designs. Research on Social Work Practice, 4, 309-326.

Beyebach, M., & Rodriguez Morejon, A. (1999). Some thoughts on integration in solution-focused therapy. Journal of Systemic Therapies, 18(1), 24-42.

Beyebach, M., Rodriguez Sanchez, M. S., Arribas De Miguel, J., Herrero De Vega, M., Hernandez, C., & Rodriguez Morejon, A. (2000). Outcome of solution-focused therapy at a university family therapy center. Journal of Systemic Therapies, 19(1), 116-128.

Black, M., Dubowitz, H., & Harrington, D. (1994). Sexual abuse: Developmental differences in children's behavior and self-perception. Child Abuse & Neglect, 18, 85-95.

Brown, A., & Finkelhor, D. (1986). Initial and long-term effects: A review of the research. In D. Finkelhor (Ed.), A sourcebook on child sexual abuse (pp.143-179). California: Sage Publications.

Bubbenzer, D. L., & West, J. D. (1994). Michael White and the narrative perspective in therapy. Family Journal, 2(1), 71-84.

Canadian Association of Social Workers. (1994). Social Work Code of Ethics. Ottawa, Canada.

Chang, J., & Phillips, M. (1993). Michael White and Steve de Shazer: New directions in family therapy. In S. Gilligan & R. Price (Eds.), Therapeutic Conversations (pp.95-111). New York: W. W. Norton & Company.

Child and Family Services. (1999). Department of Family Services: Annual report. Province of Manitoba.

Child and Family Services Act, The Queen's Printer for the Province of Manitoba (1999).

Cohen, J. B., Deblinger, E., Maedel, A. B., & Stauffer, L. B. (1999). Examining sex-related thoughts and feelings of sexually abused and nonabused children. Journal of Interpersonal Violence, 14(7), 701-712.

Cohen, J. A., & Mannarino, A. P. (1998). Intervention for sexually abused children: Initial treatment outcome findings. Child Maltreatment, 3(1), 17-27.

Combs, G., & Freedman, J. (1994). Narrative intentions. In M. F. Hoyt (Ed.), Constructive Therapies (67-91). New York: The Guilford Press.

Combs, G., & Freedman, J. (1998). Tellings and retellings. Journal of Marital and Family Therapy, 24(4), 405-408.

Coulehan, R., Friedlander, M., & Heatherington, L. (1998). Transforming narratives: A change event in constructivist family therapy. Family Process, 37, 17-33.

Crouch, J. L. (1999). Measuring Reaction to sexual trauma among children: Comparing the Children's Impact of Trauma Events Scale and the Trauma Symptom Checklist for Children. Child Maltreatment, 4(3), 255-264.

Davies, M. G. (1995). Parental distress and ability to cope following disclosure of extra-familial sexual abuse. Child Abuse & Neglect, *19*, 399-408.

de Shazer, S. (1985). Keys to solution in brief therapy. New York: W. W. Norton & Company.

de Shazer, S. (1988). Clues: Investigating solutions in brief therapy. New York: W. W. Norton & Company.

de Shazer, S. (1991). Putting differences to work. New York: W. W. Norton & Company.

de Shazer, S. (1993). Commentary: de Shazer & White: Vive la difference. In S. Gilligan & R. Price (Eds.), Therapeutic Conversations (pp.112-120). New York: W. W. Norton & Company.

de Shazer, S., & Berg, I. K. (1992). Doing therapy: A post-structural revision. Journal of Marital and Family Therapy, *18*(1), 71-81.

de Shazer, S., & Berg, I. K. (1997). 'What works?' Remarks on research aspects of solution-focused brief therapy. Journal of Family Therapy, *19*, 121-124.

de Shazer, S., Berg, I. K., Lipchik, E., Nunnally, E., Molnar, A., Gingerich, W., & Weiner-Davis, M. (1986). Brief therapy: Focused solution development. Family Process, *25*, 207-221.

de Shazer, S., & Molnar, A. (1984). Four useful interventions in brief family therapy. Journal of Marital and Family Therapy, *10*(3), 297-304.

Deblinger, E., & Heflin, A. H. (1996). Treating sexually abused children and their nonoffending parents: A cognitive behavioral approach. California: Sage Publications.

DeJong, P., & Berg, I. K. (1998). Interviewing for solutions. Pacific Grove, CA: Brooks/Cole Publishing Company.

DeJong, P., & Berg, I. K. (1998). Outcomes. In P. DeJong & I. K. Berg, Interviewing for solutions (pp.188-194). California: Brooks/Cole Publishing Company.

Dermer, S. B., Hemesath, C. W., & Russell, C. S. (1998). A feminist critique of solution-focused therapy. The American Journal of Family Therapy, *26*, 239-250.

Dickerson, V. C., & Zimmerman, J. L. (1996). Myths, misconceptions, and a word or two about politics. Journal of Systemic Therapies, 15(1), 79-88.

Dolan, Y. M. (1991). Resolving sexual abuse: Solution-focused therapy and Ericksonian hypnosis for adult survivors. New York: W. W. Norton.

Dolan, Y. (1994). Solution-focused therapy with a case of severe abuse. In M. Hoyt, (Ed.), Constructive Therapies (pp.276-294). New York: The Guilford Press.

Drewery, W., & Winslade, J. (1997). The theoretical story of narrative therapy. In G. Monk, J. Winslade, K. Crocket, & D. Epston (Eds.), Narrative therapy in practice: The archaeology of hope (pp. 32-52). San Fransisco: Jossey-Bass Publishers.

Durrant, M., & Kowalski, K. (1992). Overcoming the effects of sexual abuse: Developing a self-perception of competence. In M. Durrant, & C. White (Eds.), Ideas for therapy with sexual abuse (pp. 65-110). Australia: Dulwich Centre Publications.

Durrant, M., & White, C. (Eds.). (1992). Ideas for therapy with sexual abuse. Australia: Dulwich Centre Publications.

Dykes, M. A., & Neville, K. E. (2000). Taming trouble and other tales: Using externalized characters in solution-focused therapy. Journal of Systemic Therapies, 19(1), 74-81.

Epston, D., & White, M. (1992). Consulting your consultant: The documentation of alternative knowledges. In D. Epston & M. White (Eds.), Experience, contradiction, narrative, and imagination (pp. 11-26). South Australia: Dulwich Centre Publications.

Etchison, M., & Kleist, D. M. (2000). Review of narrative therapy: Research and utility. Family Journal, 8(1), 61-67.

Feiring, C., Taska, L., & Lewis, M. (1999). Age and gender differences in children's and adolescents' adaption to sexual abuse. Child Abuse & Neglect, 2, 115-128.

Finkelhor, D. (1986). A Sourcebook on Child Sexual Abuse. California: Sage Publications.

Finkelhor, D., & Browne, A. (1985). The traumatic impact of child sexual abuse: A conceptualization. American Journal of Orthopsychiatry, 55(4), 530-541.

Finkelhor, D., & Browne, A. (1986). Initial and long-term effects: A conceptual framework. In D. Finkelhor (Ed.), A sourcebook on child sexual abuse. (pp. 180-198). California: Sage Publications.

Fischer, D. G., & McDonald, W. L. (1998). Characteristics of intrafamilial and extrafamilial child sexual abuse. Child Abuse & Neglect, 22(9), 915-929.

Fish, V. (1993). Poststructuralism in family therapy: Interrogating the narrative/conversational mode. Journal of Marital and Family Therapy, 19(3), 221-232.

Franklin, C., Corcoran, J., Nowicki, J., & Streeter, C. (1997). Using client self-anchored scales to measure outcomes in solution-focused therapy. Journal of Systemic Therapies, 16(3), 246-265.

Freedman, J., & Combs, G. (1996). Narrative therapy: The social construction of preferred realities. New York: W. W. Norton.

Freeman, J., Epston, D., & Lobovits, D. (1997). Playful approaches to serious problems: Narrative therapy with children and their families. New York: W. W. Norton.

Friedrich, W. N. (1993). Sexual victimization and sexual behavior in children: A review of the recent literature. Child Abuse & Neglect, 17, 59-66.

Genuis, M., Thomlison, B., & Bagley, C. (1991). Male victims of child sexual abuse: A brief overview of pertinent findings. Journal of Child and Youth Care, special issue, 1-6.

Gil, E. (1991). The healing power of play. New York: The Guilford Press.

Gil, E., & Johnson, T. C. (1993). Sexualized children: Assessment and treatment of sexualized children and children who molest. Rockville: Launch Press.

Giliberti, C. (1994). Seeking a just response to child sexual abuse: Bill C-15 and after. Justice research notes (no. 7). Ottawa: Department of Justice.

Gladding, S. T. (1998). Solution-focused and narrative family therapies. In S. T. Gladding, Family therapy: History, theory, and practice (4th ed.). New York: Prentice-Hall Inc.

Haaken, J., & Lamb, S. (2000). The politics of child sexual abuse research. Society, 37(4), 7-15.

Hall, D. K., Mathews, F., & Pearce, J. (1998). Factors associated with sexual behavior problems in young sexually abused children. Child Abuse & Neglect, 22(10), 1045-1063.

Hewitt, S. K. (1999). Assessing allegations of sexual abuse in preschool children: Understanding small voices. California: Sage Publications.

Jinich, S., & Litrownik, A. J. (1999). Coping with sexual abuse: Development and evaluation of a videotape intervention for nonoffending parents. Child Abuse & Neglect, 23(2), 175-190.

Johnston, S. M. (1997). The use of art and play therapy with victims of sexual abuse: A review of the literature. Family Therapy, 24(2), 101-113.

Johnson, T. C. (1999). Understanding your child's sexual behaviour: What's natural and healthy. California: New Harbinger Publications, Inc.

Kendall-Tackett, K. A., Williams, L. M., & Finkelhor, D. (1993). Impact of sexual abuse on children: A review and synthesis of recent empirical studies. Psychological Bulletin, 113, 164-180.

King, E. (1998). Role of affect and emotional context in solution-focused therapy. Journal of Systemic Therapies, 17(2), 51-63.

Laing, L., & Kamsler, A. (1990). Putting an end to secrecy: Therapy with mothers and children following disclosure of child sexual assault. In M. Durrant, & C. White (Eds.), Ideas for therapy with sexual abuse (pp.159-181). Australia: Dulwich Centre Publications.

Lanktree, C. B., & Briere, J. (1995). Outcome of therapy for sexually abused children: A repeated measures study. Child Abuse & Neglect, 19(9), 1145-1155.

Lerner, G. (1996). Narrative child family therapy. Family Process, 35, 423-440.

Ligenzinska, M., Firestone, P., Manion, I. G., McIntyre, J., Ensom, R., & Wells, G. (1996). Children's emotional and behavioral reactions following the disclosure of extrafamilial sexual abuse: Initial effects. Child Abuse & Neglect, 20(2), 111-125.

Lipchik, E. (1994). The rush to be brief. Networker, 35-39.

MacFarlane, K. (1986). Helping parents cope with extrafamilial molestation. In K. MacFarlane & J. Waterman (Eds.), Sexual abuse of young children: Evaluation and treatment (pp. 299-311). New York: The Guilford Press.

Manion, I., Firestone, P., Cloutier, P., Ligenzinska, M., McIntyre, J., & Ensom, R. (1998). Child extrafamilial sexual abuse: Predicting parent and child functioning. Child Abuse & Neglect, 22(12), 1285-1304.

Manitoba Family Services. (1995). Child protection and child abuse: Protocols for social workers. Winnipeg, Manitoba: Government Services.

Massat, C. R., & Lundy, M. (1998). "Reporting costs" to nonoffending parents in cases of intrafamilial child sexual abuse. Child Welfare, 77(4), 371-389.

McCourt, J., & Peel, J. C. F. (1998). The effects of child sexual abuse on the protecting parent(s): Identifying a counselling response for secondary victims. Counselling Psychology Quarterly, 11(3), 283-300.

Miller, G., & de Shazer, S. (1998). Have you heard the latest rumor about ...? Solution-focused therapy as a rumor. Family Process, 37(3), 363-377.

Miller-Perrin, C. L. (1998). Sexually abused children's perceptions of sexual abuse: An exploratory analysis and comparison across ages. Journal of Child Sexual Abuse, 7(1), 1-22.

Minuchin, S. (1998). Where is the family in narrative family therapy? Journal of Marital and Family Therapy, 24(4), 397-403.

Minuchin, S. (1999). Retelling, reimagining, and re-searching: A continuing conversation. Journal of Marital and Family Therapy, 25(1), 9-14.

Monk, G. (1996). Narrative approaches to therapy: The "fourth wave" in family therapy. Guidance & Counselling, 11(2), 41-48.

Monk, G. (1997). How narrative therapy works. In G. Monk, J. Winslade, K. Crocket, & D. Epston (Eds.), Narrative therapy in practice: The archaeology of hope (pp. 3-31). San Fransisco: Jossey-Bass Publishers.

Monk, G., Winslade, J., Crocket, K., & Epston, D. (Eds.). (1997). Narrative therapy in practice: The archaeology of hope. San Fransisco: Jossey-Bass Publishers.

Moos, R. H. (1974). FES item booklet. Family Environment Scale (Form R). California: Consulting Psychologists Press, Inc.

Moos, R. H., & Moos, B. S. (1994). Family Environment Scale Manual: Development, Applications, Research (3rd ed.). California: Consulting Psychologists Press, Inc.

Nau, D. S., & Shilts, L. (2000). When to use the miracle question: Clues from a qualitative study of four SFBT practitioners. Journal of Systemic Therapies, 19(1), 129-135.

Nichols, M. P., & Schwartz, R. C. (1998). Family therapy: Concepts and methods (4th ed.). Boston: Allyn & Bacon.

Nylund, D., & Corsiglia, V. (1994). Becoming solution-focused forced in brief therapy: Remembering something important we already knew. Journal of Systemic Therapies, 13(1), 5-12.

O'Hanlon, B. (1994). The promise of narrative: The third wave. The Family Therapy Networker, Nov/Dec, 19-29.

O'Hanlon, B., & Bertolino, B. (1998). Even from a broken web: Brief, respectful solution-oriented therapy for sexual abuse and trauma. New York: John Wiley & Sons, Inc.

Parry, T. A. (1998). Reasons of the heart: The narrative construction of emotions. Journal of Systemic Therapies, 17(2), 65-79.

Parry, A., & Doan, R. E. (1994). Story re-visions: Narrative therapy in the postmodern world. New York: The Guilford Press.

Peters, S. D., Wyatt, G. E., & Finkelhor, D. (1986). In D. Finkelhor (Ed.), A sourcebook on child sexual abuse (pp. 15-59). California: Sage Publications.

Pino, C. J., Simons, N., & Slawinowski, M. J. (1984). Children's Version of the Family Environment Scale manual. East Aurora, NY: Slosson Educational Publications, Inc.

Rasmussen, L. A., & Cunningham, C. (1995). Focused play therapy and non-directive play therapy: Can they be integrated? Journal of Child Sexual Abuse, 4(1), 1-18.

Ray, K. C., & Jackson, J. L. (1997). Family environment and childhood sexual victimization: A test of the buffering hypothesis. Journal of Interpersonal Violence, 12(1), 3-17.

Ray, K. C., Jackson, J. L., & Townsley, R. M. (1991). Family environments of victims of intrafamilial and extrafamilial child sexual abuse. Journal of Family Violence, 6(4), 365-374.

Redekop, F. (1995). The "problem" of Michael White and Michael Foucault. Journal of Marital and Family Therapy, 21(3), 309-318.

Regehr, C. (1990). Parental responses to extrafamilial child sexual assault. Child Abuse & Neglect, 14, 113-120.

Reichert, D., & Frankel, H. (1993). Integrating family assessment into social work practice. Research on Social Work Practice, 3(3), 243-257.

Reuterlov, H., Lofgren, T., Nordstrom, K., Ternstrom, A., & Miller, S. D. (2000). What is better? A preliminary investigation of between-session change. Journal of Systemic Therapies, 19(1), 111-115.

Rind, B., Tromovitch, P., and Bauserman, R. (1998). A meta-analytic examination of assumed properties of child sexual abuse using college samples. Psychological Bulletin, 124, 22-53.

Roberts, J. V. (1994). Criminal justice processing of sexual assault cases: Canadian centre for justice statistics. Ottawa: Minister of Industry.

Robertson, J. R. (1984). Sexual offences against children: The Badgley report. Ottawa: Minister of Supply and Services.

Schwartz, R. C. (1999). Narrative therapy expands and contracts family therapy's horizons. Journal of Marital and Family Therapy, 25(2), 263-267.

Selekman, M. D. (1997). Solution-focused therapy with children. New York: The Guilford Press.

Semmler, P. L., & Williams, C. B. (2000). Narrative therapy: A storied context for multicultural counseling. Journal of Multicultural Counseling & Development, 28(1), 51-61.

Shilts, L., & Reiter, M. D. (2000). Integrating externalization and scaling questions: Using "visual" scaling to amplify children's voices. Journal of Systemic Therapies, 19(1), 82-89.

Stalker, C. A., Levene, J. E., & Coady, N. F. (1999). Solution-focused brief therapy – one model fits all? Families in Society: The Journal of Contemporary Human Services, 80(5), 468-477.

St. James-O'Connor, T., Meakes, E., Pickering, M., & Schuman, M. (1997). On the right track: Client experience of narrative therapy. Contemporary Family Therapy: An International Journal 19(4), 479-495.

Statistics Canada. (1999). Family violence in Canada: A statistical profile. Ottawa: Minister of Industry.

Swanston, H. Y., & Tebbutt, J. S. (1997). Sexually abused children 5 years after presentation: A case-control study. Pediatrics, *100*(4), 600-609.

Tingus, K. D., Heger, A. H., Foy, D. W., & Leskin, G. A. (1996). Factors associated with entry into therapy in children evaluated for sexual abuse. Child Abuse & Neglect, *20*(1), 63-68.

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

Tomm, K. (1998). A question of perspective. Journal of Marital and Family Therapy, *24*(4), 409-413.

Tremblay, C., Hebert, M., & Piche, C. (1999). Coping strategies and social support as mediators of consequences in child sexual abuse victims. Child Abuse & Neglect, *23*(9), 929-945.

Van Scoyk, S., Gray, J., & Jones, D. P. H. (1988). A theoretical framework for evaluation and treatment of the victims of child sexual assault by a nonfamily member. Family Process, *27*(1), 105-113.

Walsh, F. (1998). Strengthening family resilience. New York: The Guilford Press.

Walter, J. L., & Peller, J. E. (1992). Becoming solution-focused in brief therapy. New York: Brunner/Mazel Publishers.

Weingarten, K. (1998). The small and the ordinary: The daily practice of a postmodern narrative therapy. Family Process, *37*, 3-15.

Wells, M. (1990). Canada's law on child sexual abuse: A handbook. Ottawa: Minister of Supply and Services Canada.

Wells, R. D., McCann, J., Adams, J., Voris, J., & Ensign, J. (1995). Emotional, behavioral, and physical symptoms reported by parents of sexually abused, nonabused, and allegedly abused prepubescent females. Child Abuse & Neglect, *19*(2), 155-163.

West, J. D. (1998). Insoo Kim Berg and solution-focused therapy. Family Journal, *6*(3), 346-355.

Weston, H. E., Boxer, P., & Heatherington, L. (1998). Children's attributions about family arguments: Implications for family therapy. Family Process, *37*, 35-49.

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

White, M. (1992). Deconstruction and therapy. In D. Epston & M. White (Eds.), Experience, contradiction, narrative, and imagination (pp. 109-151). South Australia: Dulwich Centre Publications.

White, M. (1993). Commentary: The histories of the present. In S. Gilligan & R. Price (Eds.), Therapeutic conversations (pp.121-132). New York: W. W. Norton & Company.

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

Wieland, S. (1997). Hearing the internal trauma: Working with children and adolescents who have been sexually abused. California: Sage Publications.

Williams, M., & Hudson, J. (1991). Evaluable models of child sexual abuse treatment programs. Journal of Child and Youth Care, special edition, 7-21.

Witkin, S. L. (1999). Constructing our future. Social Work, 44(1), 5-9.

Zimmerman, J. L., & Dickerson, V. C. (1994). Using a narrative metaphor: Implications for theory and clinical practice. Family Process, 33, 233-245.

Zimmerman, J. L., & Dickerson, V. C. (1996). If problems talked: Narrative therapy in action. New York: The Guilford Press.

APPENDIX A

Sample Questions from Family Environment Scale (FES)

Cohesion Subscale

1. Family members really help and support one another.

Expressiveness Subscale

12. We say anything we want to around home.

Conflict Subscale

23. Family members sometimes get so angry they throw things.

Independence Subscale

34. We come and go as we want to in our family.

Achievement Orientation Subscale

45. We always strive to do things just a little better the next time.

Intellectual-Cultural Orientation Subscale

56. Someone in our family plays a musical instrument

Active-Recreational Orientation Subscale

67. Family members sometimes attend courses or take lessons for some hobby or interest (outside school).

Moral-Religious Emphasis Subscale

78. The Bible is a very important book in our home.

Organization Subscale

89. Dishes are usually done immediately after eating.

Control Subscale

80. Rules are pretty inflexible in our household.

APPENDIX B

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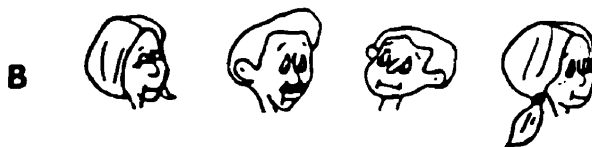
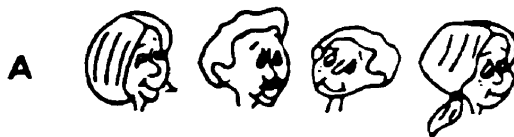
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APPENDIX C

**Sample Questions from
Children's Version of Family Environment Scale (CVFES)**

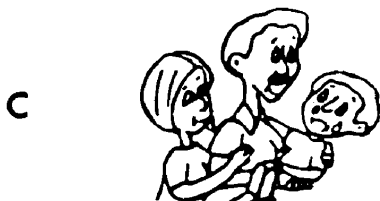
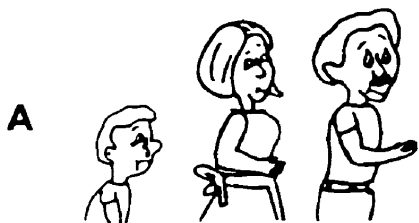
Cohesion Subscale

3. Which picture looks like your family?



Conflict Subscale

4. Which picture looks like your family when someone feels badly?



APPENDIX D

Feedback Questionnaire

I would appreciate your feedback and comments about the service that you received while attending therapy at the Families Affected by Sexual Assault (FASA) Program at New Directions for Children, Youth & Families. This will be useful to know what was helpful to you.

1. How helpful has it been for you and your family member(s) to come to therapy?

___ 1. Not at all helpful ___ 2. A little bit helpful ___ 3. Very helpful

Please explain or provide comments if you wish:

2. How has your therapist helped you the most? What have you thought or noticed that stands out for you about the service provided by your therapist?
3. How do you think therapy has helped your family?
4. What has been least helpful about coming to therapy?
5. Is there any suggestions that you would like to make in regards to things that you would have liked to seen done differently or changes that the therapist can make for other families coming here for service?