MULTI-MODAL TREATMENT OF ADOLESCENT GIRLS WHO HAVE BEEN SEXUALLY ABUSED

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MULTI-MODAL TREATMENT OF ADOLESCENT GIRLS WHO HAVE BEEN SEXUALLY ABUSED

BY

LUVIA A. TREFTLIN

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

MASTER OF SOCIAL WORK

ABSTRACT

This practicum focused on a multi-modal approach to the treatment of child sexual abuse. A review of the literature describes the dynamics of abuse and includes the effects of child sexual abuse on the victims, factors which influence these effects, and treatment methodologies. Therapeutic interventions, including individual, group, and dyadic therapy with seven adolescents and their mothers is outlined. An ecological systemic approach was utilized in assessment and intervention with this population.

Observations of these adolescents during the course of treatment provided significant insight to the author into the importance of the victim's environmental support system. The therapist became a part of the client's system and, in most cases, was able to bolster emotional supports to the adolescent by involving her mother or guardian in the therapy process, and by facilitating communications between other formal and informal helpers. An adolescent's readiness to address treatment issues was affected by the adolescent's feelings of safety in her environment, as well as other developmental and situational considerations.

Multi-modal treatment appeared to be helpful to this population. Individual therapy assisted the adolescent to focus on her own needs and assisted in the development of insights related to her own strengths. Group therapy reduced stigmatization and provided a "family" type of supportive environment. Dyadic therapy with her mother strengthened emotional support and increased the likelihood of ongoing improved communications.

ACKNOWLEDGEMENTS

I would like to thank my parents, Margaret and Larry Johnston , who always gave me total love and acceptance. Without them as my models and inspiration I would not have had so much love to nurture me and to share with others. I wish you could come to my graduation, Daddy, you helped me all the way.

I would not have completed this program if it were not for my wise and loving husband and soul mate, Glenn. He pushed, pulled, challenged, taught me computer skills, fixed the printer, financed my classes, encouraged and loved me all the way. I do not know how to say how I feel, other than to say thank you and I love you. I would also like to thank my children, Kim, Carl, Jeff and Chris and my grandaughters Jenna and Carly, for all their patience and support. There were lots of times when I had to leave family activities to devote to my student responsibilities, and they never once complained.

I would like to recognize the patience, wisdom and encouragement of my advisor, Dr. Barry Trute, for all his input into my education at the University of Manitoba. He never gave up on me and helped me to believe in my abilities as a clinician and student. Dr. Laura Mills helped more than she realized with the adolescents' group. Walter Driedger who was director at the Clinic was also a great help during my practicum. I would also like to thank David Cherabin, the present director at the Elizabeth Hill Centre, for his willingness to come on board at the last hour and provide input into my practicum report and completion of my requirements for this degree.

DEDICATION

This practicum report is dedicated, with awe and thanks, to the adolescents who allowed me to come to know them and learn from them during our time together at the Community Resource Clinic.

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CHAPTER ONE

INTRODUCTION

For the last 20 years I have been directly involved in mandated child protection services in the District of Rainy River in northwestern Ontario. I had responsibilities as generalist practitioner and worked with children in care, permanent wards, families with situational or developmental difficulties and multi-problem families. This included work with individuals and their supporting network, including foster families and adoptive families. After many years as a front-line child protection worker, I wanted to increase my knowledge and skills in the treatment and prevention of child abuse. The agency for which I worked served four towns, 13 other smaller municipalities, 10 First Nations and the surrounding unorganized territories. Many of the families throughout the area were challenged by unemployment, low educational and job preparation skills, family violence, substance abuse, teenage pregnancies and they depended to a large extent on social assistance for their income.

In addition, I became aware of a large population of Aboriginal people who had experienced abuse as children living in local residential schools. This abuse was physical, sexual and cultural. Most of the residential students who experienced this abuse are now parents with children of their own. Inter-generational patterns of abuse were showing up in the caseloads for which I was responsible and in general information that was being provided by First Nations persons. I realized that there would be a greater need for skilled professionals to assist in the community as more disclosures of past abuse came to public awareness.

I noticed that there were families who experienced the effects of child abuse in all

socio-economic groups, both in northwestern Ontario and in the affluent parts of southern Ontario (where I had worked for several years). I came to understand that families which experienced child sexual abuse could best be helped by professionals who were informed, skilled, and who could work together with other community professionals as a team. After working with abused children and their families, I felt grateful for the opportunity for further study in an M.S.W. program and I wished to learn more about effective treatment for children and families. The lack of professional help for children in the area in which I lived prompted me to pursue studies in this field. I decided to develop a practicum around treatment for adolescents because there appeared to be a high rate of disclosure of abuse and a need for treatment for children in this age range.

Obtaining an M.S.W. degree had been one of my major goals for many years. In September of 1991 I began the course work for a master's degree in social work at the University of Manitoba with Dr. Barry Trute as my advisor. My practicum took place at the Community Resource Clinic (CRC) in Winnipeg, now renamed the Elizabeth Hill Counselling Centre in honour of the late Elizabeth Hill, one of the driving forces in the initiation and development of this counselling centre.

The clients with whom I worked during the practicum were largely selected from Child and Family Services of Central Winnipeg. This agency had identified a large number of children in their system who required treatment for sexual abuse. The Sexual Abuse Coordinator of Central Winnipeg Child and Family Services expressed concern that these victims were not receiving the time and attention they needed by the agency's overworked staff of social workers. The children with whom I worked were mainly adolescents (thirteen

to sixteen), or close to adolescence (eleven and twelve).

The plan of treatment for the clients I selected was a multi-modal plan which included individual therapy for the child, dyadic therapy for the child and mother together, and group treatment. Mothers were seen individually as required and I offered a group support format to the mothers who were interested.

I hoped that as a result of my work at the Community Resource Centre some children and their families would be assisted in their recovery from sexual abuse. I also hoped to educate them in the prevention further abuse. This practicum took place on a part-time basis from October, 1990 until June 28, 1991. Learning goals that I set for myself were:

1. to develop a comprehensive knowledge of the dynamics of child sexual abuse, including the causes, the effects on the child victims, and the family dynamics, including the inter-generational aspects;
2. to learn intervention skills through various therapeutic approaches: individual, group, and family;
3. to further expand my knowledge and skills in the utilization of family therapy as an effective approach in dealing with incest;
4. to develop a working knowledge of various instruments utilized in clinical practise to monitor and evaluate client progress;

As part of my practicum, Susan Maxwell, another M.S.W. student from the University of Manitoba, and I developed and implemented a psycho-educational group for girls who were sexually abused. Group participants were selected from our current caseloads and from referrals identified by the Child and Family Services of Central Winnipeg.

Chapter Two of this practicum report is a literature review that provides the knowledge base for the practicum. I have selected practitioners and researchers whose advice I found to be particularly relevant to the treatment of adolescent female victims of child abuse. Definitions of terms used in this report are included in Chapter Two as well as research information on the multi-modal methods of treatment, such as individual, group, and dyadic therapy with adolescents and their non-offending mothers.

Chapter Three describes methods and procedures followed in this practicum. Topics such as setting, supervision, client selection, time frames, treatment and evaluation methods are described. Chapter Four deals with a description of the adolescent psycho-educational group and specific case descriptions. The second half of Chapter Four includes a detailed description of four cases, and a more general description of three other cases with which I was involved. Included in the summaries of each of the four main cases is a description of each adolescent's presenting situation, a brief background of her family, assessment and goals of treatment, interventions that were utilized, measures, and a brief summary.

Chapter Five provides an evaluation of the practicum, an assessment of the attainment of my learning goals, and conclusions.

CHAPTER TWO

LITERATURE REVIEW

Introduction

This literature review considers various modes of treatment of adolescent girls who have been sexually abused. Special attention is given to intra familial abuse or incest because of the tremendous impact of this type of abuse on victims. The literature review begins with a presentation of definitions of child sexual abuse and a brief historical overview of this problem, followed by information on the frequency of child sexual abuse in Canada. The effects of child sexual abuse on the victim along with factors that influence these effects are discussed. A brief description of systems theory and the ecological approach to social work is given in addition to a consideration of the dynamics of the incestuous family system. Different conceptual models and approaches to the treatment of child sexual abuse are reviewed, including individual therapy, play therapy and group therapy. Dyad therapy with the victim and mother are also discussed. Characteristics of the therapist and his or her approach in dealing with the clients are then considered, followed by a brief summary.

Definitions

To avoid any misunderstanding there must be a clear definition of the basic terms utilized. The term "adolescence" is described in many ways. Generally, it is seen as the period of transition between childhood and adulthood. Douvan (1986) describes adolescence as beginning with rapid physical growth and developing sexual maturity and ending in the

achievement of adulthood with an adult identity with identified skills, talents and economic independence. In this literature review, "adolescent" refers to a person who is between the ages of twelve and nineteen.

One of the most clear and comprehensive definitions of child sexual abuse has been presented by Sgroi (1982):

> Child sexual abuse is a sexual act imposed on a child who lacks emotional, maturational, and cognitive development. The ability to lure a child into a sexual relationship is based upon the all-powerful and dominant position of the adult or older adolescent perpetrator, which is in sharp contrast to the child's age, dependency and subordinate position. Authority and power enable the perpetrator, implicitly or directly, to coerce the child into sexual compliance (p.9)

In this literature review, any references to child sexual abuse will fall under the definition of "contact sexual abuse" as defined by Russell (1983) and will not refer to non-contact sexual abuse. The latter would include behaviours such as, exhibitionism and sexual advances. It is unlikely that victims of non-contact sexual abuse would require extensive therapy.

Many sexually abused children are victims of people who are known or "trusted" by the child, often a family member. Sgroi (1982) defines incest as any sexual activity that occurs between a child and an older person who is in a parental or kinship role. She lists this sexual activity as including: nudity, disrobing, genital exposure, observation of the child, kissing, fondling, masturbation, fellatio, cunnilingus, digital penetration, penile penetration and "dry intercourse". In this literature review incest will refer to sexual contact between a female child or adolescent and her father or father-figure, such as her mother's partner.

Historical Perspective

Child sexual abuse is an age-old problem. In order to fully appreciate the seriousness and magnitude of the problem it must be viewed in an historical perspective (Rush, 1980). The abuse of children has occurred in many countries and many cultures over the centuries. In addition to being abused in their own homes, children have been raped, sold into prostitution and female children have been married to much older men (Rush, 1980). Although sexual relationships between close relatives have been taboo in most cultures for thousands of years, there have been rare exceptions. The royal families of Peru, Egypt and Japan used incest to maintain the purity of the royal line (Batten, 1983).

The problems of child sexual abuse have become a focus of attention in our society only recently. The feminist movement has been partly responsible for bringing the problem to a higher level of social awareness and has brought legal and educational aspects to bear on child sexual abuse (Parker & Parker, 1986). The feminist movement and resulting publicity have also empowered women to disclose sexual assault, including victimization as children, to public attention (Rush, 1980).

Extent of Child Sexual Abuse

The heightened awareness of child sexual abuse may be partially responsible for the perceived increase in frequency of abuse of children (MacFarlane & Waterman, 1986). More accurate statistical information is needed. It is difficult to determine the prevalence of child sexual abuse because of variations in definitions, differences in reporting procedures, and low rate of disclosure. The Badgley Report on Sexual Offences in Children (1988) provides data on the Canadian situation. Badgley found, in his study of Canadian adults, that one-half

of all females and one-third of all males were victims of "unwanted sexual acts". Three of every five sexually abused children were seriously threatened or physically coerced by their abusers. One in four perpetrators were family members or others who were in a position of trust; one half were friends or acquaintances of the victim's family. In 1993 it was reported that recent information indicated that at least 2.5 million women and more than one million men in Canada were child sexual abuse victims (Rogers, 1993).

Incest refers to sexual contact between family members. The most common type of incest is with a male perpetrator and a female victim and it is rarely a one-time event. Often the abuse begins while the child is prepubertal and may continue for several years (Justice & Justice, 1979; Finkelhor, 1979). It is estimated that incest occurs in five to ten percent of our population (Finkelhor, 1979; MacFarlane & Waterman, 1986). There are relatively few reports on the incidence of child sexual abuse by female perpetrators. Five large studies conducted in the United States and Europe (Herman & Hirshman, 1981) showed that 94.1% of incest was father-daughter, 2.6% was father-son, 2.8 % was mother-son and 0.5% was mother-daughter. Batten (1983) suggests that sibling incest is the most commonly occurring form of incest and it is under reported. The occurrence of sibling incest indicates families with a high degree of problems, including sexual disturbances, and sometimes resulting in offspring with congenital abnormalities. It is estimated to be less psychologically harmful to the participants than adult-child incest. Factors which contribute to sibling incest are a lack of parental supervision (Meiselman, 1978, in Batten, 1983), and the absence of a father (Weinberg 1955, in Batten, 1983). While all types of sexual abuse are under-reported, even less is known about this type of incest (Justice & Justice, 1979).

Effects of Child Sexual Abuse on the Victim

In order to effectively provide treatment to the victims of child sexual abuse, the therapist must have knowledge of the effects of abuse and the dynamics of the sexually abusive family. The negative effects of sexual abuse on individuals are great and may remain with victims throughout their adult lives.

Sgroi (1982) has summarized the range of possible effects of child sexual abuse:

- "damaged goods" syndrome,
- guilt,
- fear,
- depression,
- low self-esteem and poor social skills,
- repressed anger and hostility,
- impaired ability to trust,
- blurred role boundaries and role confusion,
- pseudo maturity coupled with failure to accomplish developmental tasks,
- and, (lack of) self mastery and control. (pg.109)

Sgroi states that all children who are sexually abused probably experience the first five effects, regardless of whether the perpetrator was known or unknown to them, while children who were abused by a family member are likely to experience the last five effects as well. According to Gelinas (1983), the long-term effects of child sexual abuse can also include overwhelming emotional states, including intense fear or anxiety, dissociative states, hallucinations, substance abuse, suicidal ideation and attempts. Meiselman (1979) reports relationship difficulties. Becker et al. (1983) report sexual dysfunction, and Herman and Hirschman (1981) report a sense of distance, isolation and negative self-image. Deblinger et al. (1989) cite symptoms of phobic and avoidant behaviours such as, affective numbing, nightmares, and repetitive, inappropriate sexual behaviours. These symptoms are described as being associated with Post Traumatic Stress Disorder (PTSD). PTSD has been reported

in child sexual abuse victims as well as in adults who experienced incest as children (Armsworth, 1984). Deblinger et al. (1989) group symptoms of PTSD into three categories:

(1) reexperiencing phenomena which includes: repetitive sexualized play, talk or behaviour; sexually abusive behaviour towards younger children and nightmares;

(2) avoidance/dissociative phenomena which refers to: loss of developmental achievements, decreased affect, depression, avoidant behaviour, loss of interest in normal activities, difficulty making friends; and

(3) symptoms of hyper-arousal which include hyper-vigilance or startle reactions, increased irritability, angry outbursts, increased aggressive behaviour, difficulties sleeping or eating.

Other symptoms described are noticeable weight loss or gain, difficulties in school, increased somatic complaints, suicidal ideation or behaviour, and immaturity.

Incest involves an extremely confusing set of dynamics for the child victim. Love, aggression and sexuality often become mixed together and distort the child's perceptions of her abusive parent. From a developmental perspective the child often views the world as dichotomous. The child cannot accommodate the notion of the abusive parent as being "good" and "bad" and since the hitherto trusted adult perpetrator is good, then she must be bad for this terrible thing to be happening (Courtois, 1988). The victim must find ways of integrating and accommodating the conflicting and confusing information (Summit, 1983). Victims may reject the information which their minds and bodies are providing and learn to disassociate from their bodies and reject their feelings as being fantasies; they may think they

are crazy. They may deny that anything has happened to them in the first place. The family is the primary socializing unit for individual family members. The reality that a child perceives within the family unit becomes the child's "map of reality". This map is used as a reference point for all information that is processed (Maddock, 1988). The feelings of craziness and confusion experienced by the victims may cause many children to recant the allegations they have made about the abuse they experienced (Summit, 1983).

The victim's map of reality is affected by the inability of the child to develop trust and by the confusing messages being given. The shared meanings which she has developed with her family become the rules by which she understands reality (Maddock, 1988). Each child must develop her own unique "map" in order to make sense of what is happening. She develops her own "personal theory", and no two people share exactly the same interpretation of common events. The paradigm which the victim develops to help her to deal with her abuse assists her to cope within the context of the family. However, that framework may put her into conflict with the larger societal environment outside the family (Maddock, 1988). The victim learns to suppress feelings and emotions as protection (Hall, 1978). According to Summit (1982), the child develops mechanisms which enable her to cope with the abuse and the resulting psychic trauma. These mechanisms may include "domestic martyrdom, splitting of reality, altered consciousness, hysterical phenomena, delinquency, sociopathy, projection of rage, even self-mutilation" (pg.64). Courtois (1988) describes how symptoms which develop to help the victim by numbing emotions eventually give rise to secondary problems such as depression, avoidance of intimacy, and difficulties with relationships. Psychological defences which are developed to assist the victim in dealing with

her abuse become maladaptive. According to Shapiro and Dominiak (1990), some of these defences can be denial, projection, acting out, splitting, displacement, distortion and regression.

Factors Which Influence the Affects of Child Sexual Abuse

According to Groth (1977), factors which affect the impact of child sexual abuse on the victim are: the length of the continuation of the abuse, the closeness in relationship of the offender to the victim (for example: father, step-father, uncle, brother, grandfather), the physical intrusiveness of the acts (if it was penetration or fondling), and if there was aggression. MacFarlane (1978), and Finkelhor and Brown (1986,1987), add the following influencing factors: if the child participates to some degree, the parents are non-supportive to the child upon disclosure, and the child is older and thus cognizant of the cultural taboos that have been violated. A younger child who has experienced non-violent sexual contact will be less traumatized than a pre-adolescent or adolescent who may associate sexuality with power, self-concept, love and fear (Larson & Maddock,1986). Adolescence is an especially challenging time for an individual; in addition to rapid physical growth there are major psychological changes. The task of individuation is paramount in adolescence, and is similar to the tasks of separation and individuation of early childhood (Crowder & Meyers Avis,1990). The adolescent develops new, stronger boundaries between herself and her parents, in order to establish her identity and define herself as an individual, separate from her parents. She requires greater privacy and freedom. Other important issues such as sexuality and peer relationships become demanding of the adolescent's time and mental energy. There are losses related to leaving childhood behind. The adolescent will have more

expectations and responsibilities placed on her. According to Karpel and Strauss (1983), trust issues become major considerations as parents and their adolescent children renegotiate rules and boundaries. When the normal developmental tasks are interrupted by crises such as sexual abuse, the child is hampered in achievement of these tasks, which become carried over into later functioning.

> "To a greater or lesser degree these disrupt normal emotional, cognitive and behavioral functioning unless and until they are addressed and healed. Sexually abused adolescents often are encountering the challenges of adolescence at the same time as negotiating earlier developmental tasks that have not yet been successfully completed" (Crowder & Myers Avis, 1990, p.30).

According to Gil (1991), and Steel and Alexander (1981), other important factors that influence the effect of sexual abuse on children are: previous emotional climate or level of family functioning, the child's psychosexual development, mental and emotional well-being of the child prior to the abuse, the degree of guilt the child feels, and the sex of the victim.

Systemic or institutional factors may provide further trauma to the victim and her family. At the time of disclosure, numerous professionals are drawn into the life of the family with good intentions, but they may have a collective impact of traumatizing the family as well as further traumatizing the victim (Trute et al., 1994). Trute et al. (1994) explain that the trauma associated with the involvement of professionals (for example, legal, medical, mental health, and child protective services) may result in more acute trauma to the victim than that which was caused by the sexual abuse itself. At the time of disclosure the family can be thrown into crisis (Trute et al., 1994). The victim who has disclosed abuse may or may not be believed, and she may be blamed for the family crisis. Many outside agencies and

professionals may become involved with the family which has worked hard to maintain rigid boundaries which had formerly excluded outsiders. Trute et al.(1994) go on to explain that this is an external threat to the continuity of the family structure as the family has known it. Conte (1984) described a number of variables which were associated with system induced trauma. He found that the greater the number of others who were involved with the child when the abuse was reported, the greater the trauma to the child. Even the involvement of friends and relatives of the family tended to make the experience of disclosure more difficult for the child. Greater trauma was induced in the child when the family members and friends did not focus on the child's needs and made negative comments about the abuse to the child. Conte (1984) also found that the larger the number of professional people involved with the child and family, the greater the trauma to the child. In addition, if the involvement of professionals was seen by the mother as being unhelpful, then their involvement produced greater trauma in the child. Conte (1984) and Maddock (1988) state that there is even greater trauma if the child is drawn into the court system and is required to testify against the perpetrator. The child needs to be protected from such external trauma (Rush, 1980; Trepper & Barrett, 1986). Conte (1984) states that it is important for clinicians to minimize any "systems induced trauma" while working with the victim. Elwell and Ephross (1987) suggest that only the most necessary professionals should be involved with the child and family, that parents should be counselled against giving negative interpretations to the child or allowing friends and relatives to make negative comments to the child. Parents and social workers should object to repeated interviews of the child by police, medical personnel and prosecutors, and social workers should advocate for children and their families.

All of these factors are important in evaluating the impact of the abuse on the victim. The most important overlying factor is the support and concern of the non-offending parent, who is usually the mother (Everson et al., 1989; MacFarlane & Waterman, 1986). In intrafamilial sexual abuse there may or may not be emotional support given to the child by the mother. In third party abuse where the perpetrator is a person from outside the family, there may be a great deal of emotional and environmental supports for the victim. If the child has a healthy attachment to a parent figure, she will have a secure base which will help her to better withstand the vicissitudes of life (Bowlby, 1988). The support of a parent or parents with whom the child is strongly attached will enable the child to be more resilient to the trauma of abuse and help in a better recovery.

An Ecological, Systemic Approach to Child Sexual Abuse

For over three decades the practice of social work has been advised by general systems theory and an ecological approach in working with individuals and their families. Germain (1968) wrote about the advantages of integrating the psychological and social perspectives and looking at the "person-in-environment". In using an ecological systems perspective one assesses and works with the adaptation and balance between organisms and their environments. Theories and terminology for this approach are borrowed from the science of ecology and general systems theory. This epistemology gives a fairly simplified framework with which to collect and arrange multiple data when analysing, understanding and setting goals for treatment with families and individuals (Hartman & Laird, 1983). Rather than look at the person from a purely psychological approach or a purely interactional

approach, one may combine these with the ecological systems approach. A circular, feed-back loop type of analysis is developed, rather than a linear view of the situation.

The development of ecological systems theory, according to Hartman and Laird (1983), was a combination of ideas and theories from contributors from many varied fields: Wiener (1948), a cybernetics specialist, and Reusch and Bateson (1951) contributed a great deal to the understanding of communication patterns which informed Jackson (1957;1965), Watzlawick (1967,1974), and Satir (1967) in the development of their work. Bateson, an anthropologist and leader in general systems theory, is seen by many as the father of family therapy. Bertalanffy (1950), founder of general systems theory, used scientific terms to describe systems and originated the term "solid steady state" to describe what Cannon (1932) called "homeostasis". These terms refer to the self-regulation of living systems to maintain coherence, order, or inner integrity. "Homeostasis", or "the moving steady state" was described by Miller (1975), in Hartman and Laird (1983), as "a range of stability within which the system moves" (p.66). Bertalanffy's term, "solid steady state" more aptly describes a constant, moving drive to maintain equilibrium. Some researchers suggest that intrafamilial child sexual abuse may be a "tension-releasing mechanism within the family, aimed at maintaining integrity..." (Batten, 1983, p.252). The incestuous family would be in a maladaptive solid steady state of equilibrium.

Hartman and Laird (1983) describe the basic components of a system. One of the basic tenets of systems theory is that a whole consists of interrelated and interdependent parts. In addition, the whole is greater than the sum of its parts and the parts are interrelated in such a way as to produce new qualities because of their interrelatedness. Each system has

its own frame of reference, which must be identified to assist in defining that system. Further principles of a system are; that a change in one part of a system affects every other part of the system and the system as a whole and that systems strive towards a balance of sorts (homeostasis or moving steady state).

By using an ecological systems perspective, one can focus on the level of adaptation (the "fit"), or maladaptation ("lack of fit"), between persons and their environment - that is, the interface between systems (Germain & Gitterman, 1980). Four guidelines that provide direction to the social worker in principles of practice are suggested by Hartman and Laird (1983). They are:

(1) Difficulties may be viewed as deficits in the environment, maladaptive strategies, faulty interrelations between systems, or disruptions in growth and development, instead of illness or problems within the individual.

(2) Problems are seen as the results of the relationships and interactions between many variables within the system. Rather than looking for a single cause and intervention, one can initiate changes and monitor them through feedback loops which indicate the systems' responses. Changes in the system can be identified through outcomes which can then be evaluated and which would inform further interventions.

(3) Life experience is fundamental to the utilization of the ecological approach in clinical applications. The life experiences of the client along with such natural helping systems as the family are critical considerations to affect change.

(4) If one part of a system is changed it has an impact on all other parts of the system. This is a basic component of systems theory. A minor change in one person's

behaviour or communication is capable of making changes in the whole family system. Because of this it is not always necessary to work with the entire family. Interventions with one family member may significantly change the entire family system.

Natural means are preferable to artificial or synthetic means of intervention (Hartman & Laird, 1983). The use of artificial interventions may produce iatrogenic and unknown effects. In addition, the least intervention necessary should be used. This is a good example of where "less is better". One other principle of systems theory, equifinality, informs us that a single effect can be produced by a variety of means. Awareness of this principle allows the social worker to utilize creativity and flexibility in seeking alternative interventions.

Two important concepts in understanding the organization of a family system are subsystems and boundaries. Eull (1982) describes subsystems as parts of the family that exist to perform specific functions. The major subsystems are the spousal, parental and sibling or child subsystem. The spousal subsystem refers to the organization of and functions of the spouses to each other; the parental subsystem refers to the organization and function of the couple in relation to their parenting responsibilities. Other subsystems have been described by Kantor and Lehr (1977) as the family unit subsystem which refers to the family system itself; the interpersonal subsystem which refers to the interactions between all individuals in the family, the personal subsystems which refers to the individuals themselves, and the extended family subsystem.

Boundaries mark the distinctions between subsystems. Healthy, well-functioning families have clear distinctions between their subsystems. Boundaries may be too rigid or too blurred and easily crossed. Rigid boundaries do not recognize the growth and development

of children as they become older. Where boundaries are too easily crossed, children may assume a parenting role or be pulled into the spousal subsystem, as happens in incestuous families. According to many experts in the field of child sexual abuse, the family system in which incest occurs presents a major challenge to outside helpers. Intervention is needed in all subsystems of the family (Waterman, 1986; Sgroi, 1982; Giaretto, 1978; Trepper & Barrett, 1986; Larson & Maddock, 1986; Alexander, 1985).

Gathering of information about family systems is facilitated through the use of eco-maps as described by Hartman and Laird (1983). Eco-maps and genograms (Carter & McGoldrick, 1982) are useful in describing a family system within an ecological perspective. Using this paper-and-pencil technique, the individuals in a family system can be depicted in relationship to one another. The dynamics of energy exchange between the family members, between the environment and the family members and between subsets of family members can be illustrated clearly and simply. Stressors, conflicts and resources can be discovered as the eco-map or genogram is developed jointly by the social worker and the family or individual.

Dynamics of an Incestuous Family

In order to adequately provide an assessment and treatment plan for the incestuous family, the clinician must have a solid understanding of the dynamics of the incestuous family. According to Fishman (1986), the incestuous family presents the most rigid of boundaries. These families develop strong barriers which separate them from the outside world. In this closed family system members are discouraged from engaging in activities in the community. In many cases, the family may be physically isolated, just as they are isolated socially from the

community. Beavers (1976) stated that incestuous families are isolated, closed, energy - draining systems with "little vital interaction with the outside world", and with limited ability to adapt, to change, or to allow for growth of individual members.

In addition, boundaries and roles between family members are blurred. Children and parents may exchange roles. The boundaries between generations may be permeable (Larson & Maddock, 1986). There are great boundary disturbances in the areas between the family and the outside world, confused boundaries between generations and diffused boundaries between individuals (Maddock, 1989). There are also "intrapsychic boundary difficulties, particularly confusion of fantasy and reality" (p.134). Individuals need to develop defence mechanisms, such as denial and blocking out of feelings and thoughts. These mechanisms help the victim in dealing, or not dealing, with the shame, emotional pain, and confusion caused by the abuse and the family dysfunctions. The incestuous family often is enmeshed which restricts personal privacy, physically or mentally. Clothing is often shared among family members (Sgroi, 1982). There are often physical barriers missing which would give family members personal privacy. A curtain may serve as a door to a bathroom. Bedroom doors may not be present. These absences of physical barriers within the home are metaphorical representations of the boundary diffusion and enmeshments in the incestuous family. Communications are distorted and family members do not give each other clear messages about what is happening in the family. Things are said and events occur that are not recognized or discussed by family members. This is similar to what Bradshaw (1987) writes about dysfunctional families:

"... (they) deny feelings, perceptions, thoughts, wants and imaginings, especially the negative

ones like fear, loneliness, sadness, hurt, rejection and dependency needs" (p. 81). Members of the incestuous family often do not recognize or acknowledge interpersonal transactions which would be obvious in a healthy family. Imbalances of power contribute to the dysfunctional situation. Carter et al. (1986) describe the scenario of the patriarch who sets up a "primitive family order" and maintains authority by socially isolating the family. Herman (1981) attributes socialization in a patriarchal system as a factor in father-daughter incest. She states that the male supremacy learned and supported by our sexual division of labour reinforces the domination and power which fathers can have over their children, especially female children. The mother in the incestuous family sometimes comes from an incestuous family herself. In this situation, the incest is intergenerational and the dynamics of power imbalances may be seen as normal within the family. If the mother suspects abuse, and she is dependent on her partner economically and emotionally, she may deny that the abuse happened or that it will reoccur (Carter et al., 1986). She may feel powerless to do anything and may advise her daughter to say "no" to the perpetrator or to leave home. Cammaert (1988) states that, although the literature reports about mothers in incestuous families have been overly disparaging, it is not fully known if the characteristics reported about the mothers are a cause of the child's abuse or are a result of the excessive patriarchal family system. Cammaert (1988) describes the mother in incestuous families as having,

> " an extremely traditional view of women's role in marriage, believing that they should be passive, submissive, dependent, and compliant. This attitude results in the woman's having low self-esteem, depression, many pregnancies, and much incapacitating illness, often induced by the continuing stressful situation in which she lives. ....the power imbalance in the relationship completely nullifies any effective interventions attempts by the woman (p. 323)".

Therapeutic Considerations

Treatment must be predicated on a thorough assessment in order to develop the best therapeutic intervention for the family. Assessment of all family members is important, and should include family cohesion, adaptability, hierarchy and communication (Barrett et al., 1986). According to Larson and Maddock (1986), no one treatment method is sufficient to meet the needs of each offender and his family. A confrontational approach is more effective in some situations, while a supportive approach is needed in others. Assessment of the dynamics in the family, the type and extent of abuse, the effects on the victim, and the motivations of the offender are all important. Burgess, Holstrom and McCausland (1977) state that the therapist needs to assess the child in general and specific terms, and to use counselling techniques appropriate for children. They explain that the therapist needs to assess the child's "biopsychosocial assets and restrictions" (pg. 182). This gives the therapist a baseline of the child's development level. Assessment must also be made as to the child's normal response to stress, family supports to the child, the family's response to stress and the impact of the sexual assault on the child and family (Burgess et al., 1977). The safety of the victim must be primary. Sgroi (1982) states that the use of an authoritative, firm, consistent, yet supportive approach is the most effective way to deal with child sexual abuse.

The meaning and function of the incest must be understood. Larson and Maddock (1986) describe a typology of incestuous behaviour which is helpful in understanding the motivation of the perpetrator and in developing a treatment plan for the incestuous family. The four major functions served by incest are described as interpersonal exchange processes. They are: affectional process, erotic process, aggression process and the expression of rage.

In affection exchange incest situations, the adult has turned to the child for affection in an inappropriate way. This situation is encouraged by the lack of normal, healthy, nurturing parent-child interactions, where the child does not receive affection in the normal way from parents and relies on the "boyfriend" type of behaviour that she receives from her father for attention and love. This type of incest is usually revealed when the female adolescent wishes to begin normal peer boy-girl relationships and is prevented from doing so by her father, or when the father turns to a younger sibling of the victim for affection. Violence is seldom used in this type of incest. Members of this type of family may show some depression, anxiety and dependency needs. The victim may show symptoms of stress and social difficulties such as conflictive behaviour or isolation. In developing a plan of treatment for this type of incest, attention must be given to the strengths of the family. Outpatient treatment is usually effective in most of these families. Self-differentiation among family members needs to be encouraged as well as cooperation in meeting the needs of individual family members. Outside resources need to be used to help the family to expand their rigid boundaries with the community to include this new dimension. The focus for the offender needs to be on increasing self-esteem and personal identity issues.

In an erotic-exchange incest situation, the entire family has become eroticised. Larson and Maddock (1986) refer to this type of family as "pansexual", in which most behaviour becomes sexual and includes most family members, even the extended family. The family focuses all its activities including recreation, clothing, jokes, and language around sexual meaning. There is a lack of privacy and self-differentiation is not allowed. Sexually deviant behaviour may include voyeurism, exhibitionism and group sex, and child pornography may

be practised. Violence is not often used. Children are socialized into this pansexual milieu from infancy. The abuse sometimes becomes revealed when children of this type of family are discovered acting out sexually with other children in the neighbourhood or at school, or when one of the family members is caught abusing someone outside the family. Power and control are factors with the perpetrators. While the sexual behaviour in these families has come to be seen as "normal" by family members, victims may show troubled behaviour, such as eating disorders, self-mutilation and psychosis. A very direct treatment approach is required with these pansexual families. Larson and Maddock (1986) recommend physical separation of family members when the erotic behaviour has become entrenched in the family system. They recommend the use of group therapy or placement in a half-way house which de-emphasize sexual interactions. Group therapy for members of the family is recommended, including sexual addiction treatment for offenders. Finding other, more acceptable ways of interacting with individuals is recommended in addition to marital therapy which would include sex therapy. Family therapy with all family members may be used later, after family members have learned healthy intrapersonal and interpersonal boundaries, whereby they can allow for intimacy and nurturance in healthy ways.

In aggression-based incest families, sexualized anger is used to express frustration and disappointment about areas of the perpetrator's life. The victim may be a scapegoat for the perpetrator's misdirected hostility. The most vulnerable person in the family is chosen and the perpetrator may believe that his aggression towards the victim will punish the person with whom he is angry. When the target of the anger does not respond, often because she does not know of the offence, the perpetrator may feel even more frustrated, powerless and

angry. In this type of family there are rules against open communications and resolution of conflict. The incest is based on aggression as opposed to the two former affection and erotic based processes. Sex, coupled with aggression, contributes to psychopathology in the victims. Depression, suicidal ideation, self-mutilation and avoidance of conflict are symptoms which may be present in the victim. Treatment of the aggression-based family needs to include teaching anger and conflict resolution without involving sex. Inpatient treatment is recommended for offenders, and the victims often require the protection of foster care or some other safe environment. Family members may require treatment which includes dealing with shame and low self-esteem. Individual therapy may be required to address deficits and build enough ego strength to learn to enjoy intimate relationships. If individual and group treatment is successful, then family therapy is recommended which would help to build a "family identity" (Larson & Maddock, 1986, p.41). Building of trust, foregiveness, conflict resolution, and strengthening the family would be some of the goals of family therapy. The prognosis for this type of incestuous family is less favourable than the two affection types presented above.

In the rage-based incest families, the perpetrator is acting out long-standing rage and frustration, usually on the most helpless family member. Often the perpetrator is acting out his own unresolved childhood abuse. Some perpetrators show their rage while offending, while others act in a cold, emotionless way, rationalizing what they are doing. The family is often organized around the rage of the perpetrator, who exerts tremendous power within the family system. Prognosis for these families is poorest of all. The possibility of violence is always present. In-patient treatment is recommended by Larson and Maddock (1986) for

these offenders. Because the perpetrator is often acting out his own victimization, supportive therapy rather than confrontational therapy is recommended. According to Larson and Maddock (1986), this perpetrator will be overcome by his own shame and anxiety. He will shut down and become unavailable to outside helpers. This must be dealt with and the perpetrator must become able to deal with his own issues before he can be available to deal with his incestuous offences in a family therapy setting. Often in rage-based incestuous families, the family cannot be reconstituted. The mother in these families is often unable to provide for the care and nurturance of the children, who may be removed permanently from the parents. Larson and Maddock (1986) recommend that family therapy be given to these children in the context of their substitute caregivers, such as foster or adoptive families. The children will require help in learning new, healthy boundaries, unlike what they had learned in their family of origin.

In assessing the treatment needs of a family there are many variables to be considered. While incestuous families may have similarities, each family situation is unique. Orten and Rich (1988) describe a scale for assessment of incestuous families which is a concrete tool for assessing risk factors and treatment needs. Hoorwitz (1983) describes other factors to be considered when assessing and forming a treatment plan:

- was the abuse incidental or chronic;
- does it conform to the classic incest family structure or are there differences;
- was there violence or not;
- what is the age of the victim;
- what is the type of abuse activity;
- what is the degree of denial of the abuse by the family;
- other related problems such as alcoholism or poverty that the family may be experiencing.

Equally important to assess is the prospect of getting the various members of the incestuous family to accept treatment. Family members often have great loyalty to their family system, and to the maintenance of it, however faulty it may be. "Families develop a hierarchy of obligations, or a multi-generational balance sheet of merit and indebtedness which has tremendous impact on individual members, since any move toward differentiation may imply disloyalty" (p.80, Boszormenyi-Nagy and Spark, 1973; in Hartman & Laird, 1983). Victims may be seen as the most loyal in the family system as they worked hardest to keep the family together by putting up with the abuse (Lutz & Medway, 1984). However, they are often seen by themselves and other family members as the cause of the family being blown apart after disclosure.

An important factor in formulating a treatment plan for the family is the strong denial that will be encountered at all levels of the family system (Carter et al., 1986). Denial by the victim, by her mother and by other family members may be strong, but strongest of all is the denial by the perpetrator. In their description of therapy with the perpetrator, victim and family network, Barret and Trepper (1992), observe four stages of denial. The first stage is the denial that anything has happened at all. The second stage, denial of awareness, emerges when the first stage is broken down. The perpetrator may admit that the abuse happened, but will deny his awareness of it. He may plead drunkenness or blackout, or he may have no reason for his not remembering it. The mother may deny that it happened while she was at home, or that she was told of the abuse. The victim may say that she was sleeping or that she did not know what was happening to her. The third stage is the denial of responsibility; the perpetrator may say that he was seduced or that he was merely teaching the child about sex.

The mother or victim may take responsibility for the offenses, leaving the perpetrator with little or no blame. The mother may blame the victim, saying that the child should have said "no". Alcohol may be blamed, again attempting to take the responsibility away from the perpetrator. The final stage of denial to be dealt with is the denial of impact. After the family members have come to recognize and deal with the other forms of denial, they may still deny that the abuse was as serious as it was. They may state that it only happened for a short time, or it was only fondling, or they may minimize the abuse in some other way. Therapists for each member of the family must not allow these forms of denial to contribute to the dysfunctional situation.

There are various ways to break down the heavy denial of incestuous families. One such way is to involve the court system as an adjunct to therapy. Hoorwitz (1983) states that the family will not likely follow through with treatment unless the court has some power with the offender. It is reasonable that, since power imbalances were a major factor in the occurrence of abuse in the first place, it is a voice of power (the courts) that can help to move the offender towards recognition of his responsibility in the abuse. Treatment required as part of a probation order provides a stronger mandate (Bentovim,1986). Some therapists argue that the threat of criminal action is a helpful way to motivate offenders and families to accept treatment (Finkelhor, 1983), and that the court process can be empowering to the victim. There are many ways to approach treatment of members of incestuous families. The family may become more open to outsiders at the time of disclosure when they are in a state of crisis. Alexander (1985) states that when a family is in a crisis, there is a disruption of family rules and organization, allowing access to outsiders. On the other hand they may close off and

become unavailable for help, which could happen when the investigation of the abuse becomes lengthy and the family experiences "institutional trauma" (Trute et al., 1994, p.3).

Treatment Strategies

Sgroi (1982) describes three treatment phases as being (1) crisis intervention, (2) short-term therapy and (3) long-term therapy. Each stage is complicated and the therapist must be skilled and able to coordinate other resources available to the victim and her family. The child's physical and emotional needs are paramount; the crisis is even greater for the child if she has to be removed from her home. There may be pressure put on the child to recant her allegations and there may be other pressures put on the child and her support system. The child is not ready to get into the "nitty-gritty" of therapy at this time. She may be most helped by a therapist who is willing to help her to prepare for the likely interventions of community professionals such as the police and child welfare officials. This is an opportune time for the therapist to begin to build up the trust that will be necessary for direct therapeutic intervention.

Sgroi (1982) recommends short-term therapy for children for whom the abuse was not severe and who have a sufficient amount of support from their families and community. Issues which will likely need to be looked at during short-term therapy would be: "damaged goods" syndrome, fear, low self-esteem, guilt and depression. Long-term therapy is suggested for children who suffered from intrafamilial abuse and who do not receive sufficient support from parents or caregivers. Victims who experienced severe physical and emotional trauma will likely need long-term therapy which addresses all ten of the impact issues which were described previously.

Multi-modal Treatment

Multi-modal treatment is often prescribed because of the entrenched denial and severe family dysfunctioning that may have occurred over multiple generations (Carson et al., 1990; Giarretto, 1982; Herman, 1992; Orten & Rich, 1988; Sgroi, 1982). Studies show that many parents in incestuous families suffered from sexual abuse as children (Bander et al., 1981). Many women who were sexually abused as children marry men who are perpetrators (Sgroi, 1982). Individual and group therapy for the victim, perpetrator and non-offending parent are often recommended. Group therapy is recommended as being effective with non-victim family members. Marital and family therapy is often prescribed for the parents and the other family members where the plan is for the family to remain together or to be reunited. Giaretto (1982) developed a comprehensive program that provides treatment for the individual, in dyadic family subgroups, groups for victims, non-offending parents, perpetrators, non-victimized children of the family, and finally, when possible, family therapy.

Sheinberg, True and Frankel (1994) describe a multi-modal, recursive program that they utilize in the treatment of victims of child sexual abuse. The program consists of individual therapy, group therapy and family therapy. Each modality is referred to as "community", with a transfer of information from one "community" to another. The decision as to what information will be brought up in other therapy sessions is determined by the child in therapy. Their program is based on the concept that a person's consciousness is made up of different variations based on the context in which the person finds himself or herself. The sense of "I" differs for a child depending on the situation. The child has a different sense of self in the classroom, on the playground, at home, at the grandparent's and in Sunday school.

The child comes to understand a different sense of self in individual counselling, in group therapy and in family therapy. Through a "decision dialogue" (Sheinberg et al., 1994), the child determines what information surfacing from one therapy or "community" will be utilized in another. Through this process the child develops a sense of mastery over the process of therapy, which is empowering to the child. The child also learns that there are multiple truths that, although they may be contradictory, one does not have to rule out the other. Thus a child is able to accept her feelings when she says that she loves her father but hates what he did to her. Sheinberg et al, (1994) state that, using this approach, "The emphasis is on helping the child to consider and express multiple and often contradictory feelings, without feeling obligated to select one over the other" (Sheinberg et al., 1994, p.265).

Individual Therapy

Individual therapy is often utilized as the initial therapy process for a child sexual abuse victim. It can be a safe and constructive context for the telling of the child's personal trauma (de Young, & Corbin, 1994). Care must be taken by the therapist to ensure the child's sense of safety as they may have difficulty in learning to trust. Certain aspects of the therapeutic setting may be similar to the elements of the abusive relationship which the therapy is attempting to heal. When the victim experienced the abuse she may have felt trapped, used, confused and fearful (Weber, 1977; Justice & Justice, 1979; Forward & Buck, 1981). The therapeutic physical environment may be frightening at first to the child. Children may not feel safe in telling their stories when they have learned through experience not to trust, to tell, or to think that they have any power" (deYoung & Corbin, 1994).

Courtois (1988) and Sturkie (1992) state that there are similarities in the dynamics of abuse and of the therapist-child client relationships: (1) they are emotionally intense one-to-one relationships based on trust; (2) there is an imbalance of power between the dyadic pair; and (3) the confidentiality of the material could be interpreted by the child as secrecy. Herman (1992) emphasizes the importance of the establishment of safety as the first stage in the process of recovery. Knittle and Tauna (1980) state that a long period of time is required to build a trusting relationship as the child has learned to distrust authority figures and adults and may be afraid of being revictimized. Another difficulty cited in Knittle and Tuana (1980) for adolescents in individual therapy is that they may have built up strong defences and have difficulty believing that the therapist could possibly understand how they feel. The adolescent may have difficulty with a one-to-one therapeutic relationship and may not be able to overcome her feelings of guilt and shame resulting from the abuse.

Dawson (1984) states that children who have been sexually abused will need intensive treatment and suggests that treatment goals should include: reducing the child's strong sense of guilt resulting from participating in the abusive event, telling, family disruption, pleasurable physiological responses to the abuse, consequences to the offender and reactions in the community. Treatment should also help the victim recognize and deal with feelings of anger directed towards the perpetrator or others. According to Dawson (1982), the child's fears must be addressed in therapy and reduced by helping the child to identify the fears and deal with them. Therapy needs to assist the child to develop trust, enhanced self-esteem and assertiveness. Fears of permanent physical damage can be dealt with the help of a sensitive physician who is knowledgeable about the effects of abuse on child victims. Practical help

to the child who has to deal with court can be provided by the therapist; this will help to instill trust in the therapist at the same time. Sex education and appropriate sexuality is also suggested as a part of the child's treatment plan. Dawson (1982) emphasises that each child's needs are individual and different treatment goals need to be established unique to that child.

Wheeler and Berliner (1988) describe strategies for treating children who have been sexually abused. They make it clear that there is no particular theory or intervention that has been shown to be superior. They emphasize that the many, complex effects of child sexual abuse require multiple strategies. Their treatment recommendations focus on two main themes, which put simply, are that sexually abused children, as a result of their trauma, become caught up in intense feelings of anxiety and fear, and that through social learning processes, they have come to understand and act in certain patterns. They state that much of the abused children's symptoms are consistent with the diagnostic criteria for Post-Traumatic Stress Disorder, a subset of the anxiety disorders. These children experience "fear of being harmed, nightmares, phobias, regressive behaviour, and somatic complaints. Aggressive behaviour, anger, guilt and shame, sleep and eating disturbances, running away, truancy, and inappropriate sexual behaviour also occur with varying degrees of frequency" (Wheeler & Berliner, 1988, p.229). The child experiences difficulties when she represses and avoids the thoughts or events related to her anxiety. By avoiding her fears, the child never learns when the fears are unjustified or maladaptive. The repression also inhibits the child in coming to an understanding of what produces or maintains the anxieties or learns the language and new behaviours that will help to lessen the anxieties.

Wheeler and Berliner (1988) suggest treatment strategies to help the child to cope

with anxieties and fears and diminish denial and avoidance. Firstly, the child must be helped with the crisis of disclosure. Secondly, a stabilized baseline must be established and treatment can then begin and recovery or reduction in symptoms can then be measured. Verbal and non-verbal interventions can be introduced according to the child's age and developmental status. Play therapy is recommended and older children may be helped with a variety of interventions which include "talking, activities, therapeutic exercises or games, art therapy and play acting" (p.235). Adolescents may decide to have input into the type of therapy in which they are willing to engage. When the child is willing and able to talk about abuse-related issues, their anxieties will eventually become less. Wheeler and Berliner (1988) caution therapists to be sensitive to the needs of the children and pace the rate of therapy to match the child's readiness. They go on to describe various techniques to assist the child to deal with feelings of anger and grief. They suggest using various art forms to encourage children to understand and vent their feelings. Poetry, creating stories and songs and drawings are recommended. Helping children to develop management strategies for dealing with feelings are also described. Suggestions are geared to age and some are: scribbling a colour to describe the feeling on a paper and scrunching it and throwing it away; practising telling how they feel in a safe place; discussing the feelings in therapy; writing a letter to the offender, whether it is mailed or not; writing to the judge to tell how they feel; ceremonies that help to deal with grief such as a ritual to deal with memories or losses, or helping the child to plan to set aside a particular time to experience sadness. Older children can be helped to learn problem solving and relaxation exercises to cope with uncomfortable feelings, and rituals can be devised to help children to feel safe at times of the day or in situations when

they are usually uncomfortable or fearful.

Wheeler and Berliner (1988) give concrete suggestions as to how the child can be helped to deal with other aspects of their abuse, such as, altering attributions of responsibility for the abuse, explanations for the offender's behaviour, enhancing and regaining self-efficacy, sexual behaviour problems, and developing a set of beliefs which will help the child to put the abuse experience into perspective. Wheeler and Berliner (1988) give many helpful recommendations about treatment issues and approaches with sexually abused children. Their approach to the understanding of child sexual abuse is from the perspective of classically conditioned responses to trauma and learned behavioural responses. Their lack of a systems approach to treatment of this multi-dimensional problem appears to leave a huge gap regarding what is needed to help with the many other parts of the family system. However, their suggestions for working with the child victims gives much insight into helping children who are dealing with trauma.

Herman (1981) outlines the steps to recovery from trauma. The first step she emphasizes is the importance of having the victim regain a sense of safety. This is crucial and therapy should not be accelerated beyond the victim's own schedule of regaining a feeling of safety. The second step is for the victim to regain some sense of control over what is happening to them, a "direct unlearning of the lesson of helplessness that the trauma itself imparted" (Goleman, 1995 p. 210). Herman (1992) emphasizes the importance of the locus of control being within the victim. The unlearning of the trauma involves repetition of the incident with an opportunity to establish mastery over the traumatic incident, desensitization and mastery and finally re-entry into a normal social milieu. The third stage of overcoming

trauma, according to Herman (1992), is the active re-establishing of social connections. This may take a long while to establish. The memory of the trauma is never eradicated but the effect it has on the victim can be minimized.

Play Therapy

Children who have experienced trauma often have great difficulties in recognizing and verbalizing their feelings and understanding of the trauma and their resulting symptoms. Post traumatic play can provide a focus for therapeutic reconstruction for the child. While the child can be helped to work through her trauma through play, she will also need to be helped to verbalize her thoughts and feelings (Terr, 1985).

Gil (1991), in The Healing Power of Play, has provided a very complete review of play therapy from its historical beginnings through the various perspectives such as psychoanalysis and learning theory to techniques and practical information for the play therapist. Child therapy, which is often used interchangeably with play therapy has been a distinct type of work since 1909. Gil (1991) writes that Hug-Helmuth used play for children's therapy in 1920 for the diagnosis and treatment of childhood emotional problems. Schaefer (1980) found descriptions of play as "pleasurable", "intrinsically complete", "independent of external rewards" and "not occurring in novel and frightening situations". Schaefer further states that " one of the most firmly established principles of psychology is that play is a process of development". Gil (1991) cites the benefits of play as suggested by various practitioners:

- a mechanism for developing problem solving and competence skills (White, 1966);

- a process which allows children to "mentally digest" experiences and situations (Piaget, 1969);
- an "emotional laboratory" in which the child learns to cope with his/her environment (Erickson, 1963);
- play is a way that a child talks, with toys as his words (Ginot, 1961);
- and, a way to deal with behaviours and concerns through "playing it out" (Gil, 1991).

Play activity is the main therapeutic approach for children because it is a natural medium for self expression, it facilitates a child's communication, allows for a cathartic release of feelings, can be renewing and constructive, and provides the adult with a window with which to observe the child's world (Nickerson, 1973, in Gil, 1991). There have been many variations of play therapy depending on the practioners preferred approach. Anna Freud and Melanie Klein incorporated play into their psychoanalytical techniques (Gil, 1973). Structured therapy was a more goal-oriented play therapy starting in the late 1930s. Otto Rank and Carl Rogers developed relationship play therapy, and in the 1960's the behaviour therapists utilized the principles of learning theory. Group therapists incorporated play into sessions based on developmental stages of the child clients. Sand tray therapy, introduced by Dora Kalff (1980), is distinct from other types of play therapy because it is based on Jungian therapy which sees the sand tray as symbolic of the child's psyche (Gil, 1991). Play therapy helps children to overcome the effects of abuse and neglect and to promote healthy psychosocial development (Mann and McDermott, 1983). They observe that play is used by abused children more frequently than non-abused children to deal with inner feelings and fears. They describe four treatment stages that can be distinguished in play therapy:

- Phase I: Establishing rapport and learning how to play.
- Phase II: Regression and abreaction of the trauma.
- Phase III: The testing of real relationships, developing impulse control and self-esteem.
- Phase IV: Termination.

There are many vehicles that can be used in play therapy to facilitate the child's healing. Art is especially useful as an adjunct in assessment and therapy; it is sought out by children for the pure pleasure of the activity and it is relaxing to the child. It can aid in reducing tension in the therapeutic environment and in reducing resistance in dealing with issues which are difficult for the child. Through the use of art, children can relax and allow their creative forces to step in and facilitate them in uncovering repressed feelings. Drawing and painting, which is easier for children than direct verbal interaction, helps to build rapport between the therapist and child. Naitove (1982) states " the arts therapies are the purposeful use of media and techniques derived from the arts themselves and psychotherapy in order to help people to understand themselves, release tensions and anxieties, learn specific coping and communication skills, and facilitate the resolution of conflicts" (p.286)

Naitove (1981) comments on the use of a wide range of arts therapy and the benefits therein. Drama and poetry therapy are described as well as warm up activities for individuals and groups using these vehicles. Poetry therapy, including the use of journals and writing a group poem are suggested by Naitove (1981). Mazza et al. (1987) state that poetry as well as other written self expression can be used by adolescents to help them explore feelings. They go on to say, "For the abused child, poetry offers a channel to speak of feelings when

all other channels appear closed" (p. 87). They also state "The differential use of poetry in the treatment of abused children has promise as an ego-supportive technique that facilitates self-expression and fosters a sense of validation and control. In group modalities, the promise of poetry relates specifically to cohesion, universalization, and self-expression" (p.91). Mazza et al.(1987) also recommend the use of music and poetry as tools to encourage children who use auditory attending, and the use of graphic and plastic arts to encourage visual attenders.

Games are another mode of interacting with children and facilitating their healing. Nickerson and O'Laughlin (1983) suggest that games are a child's natural medium and help to reduce therapeutic resistance. Games are familiar to most children, make them feel relaxed and comfortable, and facilitate communication and expression. Playing games with children is a way for the therapist to understand the child better, while building trust and facilitating therapy. Games are, according to these authors, "fun, cathartic, emotion and energy engaging and releasing" (p.184). Gil (1991) provides a succinct summary of the dynamics of play therapy in the following quote:

> "... traumatized children retreat into secrecy to deal with a frightening event. The clinician must make the playroom a safe sanctuary where secrecy can be shared with a trusted other. If the child avoids the work, the therapist gently but steadfastly stimulates the child's attention, providing a variety of relevant props, stories or pictures. And once the material is being processed, the child requires assistance to feel his/her feelings, discharge them, and reorganize their perceptions of the abuse and what it means about who they were, who they are, and who they will be. Every opportunity to instill hope and a vision towards the future must be taken, so that the child feels less futile and more motivated towards growth. Every abused/traumatized child changes because of the trauma. The clinician's primary goal is to provide a reparative and corrective experience for the child"(pp.195-196).

Group Therapy

There is a consensus among researchers and practitioners that group therapy is the preferred therapy for treating adolescent girls. There are many reasons why group therapy may be so effective. DeYoung and Corbin (1994) provide the following points in support of group therapy for adolescent girls:

- Emotional needs can be met without the emotional intensity of individual therapy; and group therapy uses an egalitarian approach unlike the asymmetrical relationship between therapist and child in individual therapy.
- Having many group members gives opportunity for feedback and scrutiny from each other, and there is a reduction in the feeling of secrecy.
- Group therapy provides a peer-focused atmosphere in which the adolescents can share their experiences, feelings, and thoughts.
- The feelings of isolation, alienation, and being different that sexually abused children have are greatly reduced by their interaction with other children who feel the same way (Sturkie, 1983).
- Children can use the group as a surrogate healthy family for support during the critical months after disclosure.
- Children bond quickly in group therapy because of their shared experiences of abuse (Vander Kolk, 1986).
- The group setting provides a comfortable degree of anonymity which frees children to be more spontaneous about their emotions and memories.
- Group members can use others in the group to discuss their feelings, thoughts, experiences and memories, and test responses of peers.
- Group members can use the group as a safe place for expressing feelings and practising new behaviours. (p. 144).

Berliner and Ernst (1982) add that for some adolescents, the therapeutic group becomes or enhances basic family support. Administrative advantages to group therapy are that a greater

number of children are able to receive treatment in a practical and economical way, there can be continuity of group through co-therapists (if one therapist is unable to attend, the other can carry on without the group missing a session), and opportunities are provided for the training of other therapists (Kitchur & Bell, 1989).

Goals of Group Therapy

According to Berliner and Ernst (1982), the goals of group therapy are to offer a better understanding of the experience of the abuse and to develop a sense of mastery over it. They also state that the group should be fun for the participants. Kitchur and Bell (1989) suggest that goals of group therapy are to provide opportunities for victims to meet other victims and receive regular peer support and learn ego-enhancing skills which will reduce isolation and improve feelings about themselves. They also suggest that goals should be to enhance the development of trust for participants, to provide opportunities to model the therapists interactions with one another, to engage with the therapists in a safe adult relationship, to interact with peers in a supervised setting, to reduce "damaged goods" syndrome, to reduce role confusion, and to improve impaired abilities of self-mastery and control.

Therapists

Berliner and Ernst (1982) suggest that having co-therapists is most helpful and that one therapist could be the same gender as the offenders if this is not too frightening to the participants. The use of two therapists is also suggested by Kitchur and Bell (1989), but they recommend that the therapists are the same gender as the group participants. This is also

supported by Blick and Porter (1982) and Adams-Tucker and Adams (1984). Hazzard, King and Webb (1986) recommend two female co-therapists initially, with use of a male/female team for an advanced group. The latter also recommend that it is critical that the therapists have a strong, established, working relationship which can serve as a solid foundation for the development of group stability and trust.

Group Structure

Regarding group structure, Berliner and Ernst (1982) recommend that the leaders' style and functioning should be structured, but that the format should be loose-knit and unstructured with easy-entry of participants. Kitchur and Bell (1989), on the other hand, recommend that there need to be pre-determined themes which include why the abuse occurred, the meaning of the abuse, responsibility for the abuse, prevention of further abuse, body integrity, family, secrecy, friends, powerlessness, and court. Other researchers suggest that issues of individuation, depression, loss, self-destructiveness and suicide should be addressed in the format of the group (Hazzard et al., 1986; Knittle & Tuana, 1980; Lubell & Soong, 1982).

Size: Berliner and Ernst (1982) suggested a range of three to seven children in a group. Hazzard et al. (1986) worked with eleven girls in two consecutive groups; Kitchur and Bell (1989) worked with groups of ten to twelve girls. This latter size was also recommended by Carroza and Heirsteinir (1983), and Sturkie (1983).

Age and grouping: Berliner and Ernst (1982) suggest that group members should be at similar levels of social and personality development, with a range of two or three years as the best fit. They suggest that children who deny the assault or who are very

psychologically disturbed should not be included, and children who will see their offender again should be separated into a different group. They also suggest that children who are developmentally limited would do better if grouped with girls of similar intellectual capacity. Rape and incest victims share many similarities, according to these authors, but they suggest that incest victims usually require more intensive treatment of longer duration. Carozza and Heirsteinir (1983) have conducted treatment groups which included children who ranged from nine to seventeen years of age. Sturkie (1983) mixed children who were victims of intra-familial abuse with those who had experienced extra-familial abuse, and Hazzard et al. (1986) found that as a group size becomes smaller, it is more important to have a more homogeneous group. They suggested that children could range between eleven to sixteen and even eighteen years of age, but individual maturity was more important than chronological age. Kitchur and Bell (1989) worked with children who were eleven and twelve years of age.

Setting

Group therapy should take place in a neutral setting (Hazzard et al., 1986). According to Berliner and Ernst (1982), group therapy for adolescents should take place in a good sized room which is large enough for physical activities, but small enough for cohesion. The area should be in a setting where the group will not disturb others. These authors suggest the use of pillows on the floor, rather than chairs. Kitchur and Bell (1986) suggest that the setting should be in a comfortable and carpeted room.

Intake and Duration

Hazzard et al. (1986) recommend that groups can be open and receive new members as needed, while Berliner and Ernst (1982) prefer to conduct intake at regular intervals when

there are enough children to start a group. They recommend that groups should be time limited as this is more attractive to adolescents and provides for closure on the abuse experience. It is recommended that group treatment is effective for preadolescents for a period of six weeks to six months and for adolescents for one to two years (Berliner & MacQuivey, 1982; Blick & Porter, 1982). Hall (1978) and Sturkie (1983) recommend that groups continue for six to eight weeks with open intake, allowing new members to begin at any time. Hazzard et al. (1986) suggest that duration of treatment depends on needs of the adolescents as well as practical considerations such as availability of facilities, as well as planning the timing with other aspects of treatment of other parts of the family.

Transportation

Recommendations regarding transportation of group participants varied according to pragmatics. Some therapists arranged for the participant's caregiver to provide transportation, some arranged for car pooling and some used volunteer drivers. Kitchur and Bell (1989) arranged for group members to be transported by taxi although this was a factor which may have reduced the feelings of safety for some group members.

Parent Involvement

Parent involvement was recommended by most authors. Berliner and Ernst (1982) suggested that therapists meet with parents before the group begins to explain the format, structure and content of the group treatment, confidentiality, and to establish as system of communication between parents and therapists. Hazzard et al. (1986) recommended meeting with parents prior to beginning the group sessions to involve family members in the treatment plan and avoid family resentments, predict likely changes in their daughters' attitudes and

behaviours, to plan transportation, and to develop liaisons with other agencies. Kitchur and Bell (1989) held pre-group and post-group interviews with parents and their children. Use of parallel parent-child groups was also recommended (Damon & Waterman, 1986).

Format

The literature gives a variety of ideas for useful formats for group sessions. There are several common threads which appear about group treatment. One frequent suggestion was the use of a snack during the group sessions. Recommendations were made that the girls be given a snack either at the beginning of group or mid-way during the session. Girls can be encouraged to help in the serving of the snack as a way of increasing their self-esteem. Hazzard et al. (1986) states that the snack can be an important part in intervention with adolescent and pre-adolescent girls. A snack can be a symbol of nurturance to girls who are often emotionally needy, and it is helpful in promoting relationships and social skills among the girls. Most authors recommend use of a format which is similar each week. This gives the participants security in knowing what to expect each session. Kitchur and Bell (1986) describe their format as, starting with snack, circle-go-round with each participant telling about their week, then formal work on a selected topic, followed by a tension-relieving activity. They encouraged the girls to develop themes for group work. The weekly format described by Berliner and Ernst (1982) was the provision of a snack at the beginning of the session, and telling why they are there. Each child then takes a turn telling a positive event, followed by a discussion, mini-lecture or a demonstration, and ending with a group exercise or activity. Group sessions were usually held late afternoons (after school) or early evenings. Most authors recommended that sessions last no longer than one and one-quarter

to one and one-half hours.

Content

Suggested content of group therapy focused on themes related to the effects of sexual abuse on the victims. Hazzard et al. (1986) facilitated working on issues such as; emotional reactions of others to the abuse, personal emotional reactions, court testimony, family and inter-personal relationships, sexuality, self-esteem and self-assertion. Issues covered included acknowledgement of the assault, non-responsibility of the victim for the assault, recognizing and labelling feelings about abuse, developing a sense of affinity with other group members, and self protection for themselves in the future (Berliner & Ernst,1982; Kitchur & Bell, 1986).

Methodologies

Methodologies recommended for use in group therapy included discussion, art, guided imagery, film and book resources (Caroza & Heirsteinir, 1983), and non-verbal activities, films, guest speakers (Kitchur & Bell, 1989). The latter describe debriefing at the end of group sessions through the use of journals. Berliner and Ernst (1982) suggest use of art, drawing, role-playing, exercises, non-verbal and physical contacts, speeches, films, and demonstrations. Hazzard et al. (1986) recommended the use of "ice-breaker"games at the first group meeting and thereafter when a new member joined the group. They also recommended role-playing, reflection of feelings, art therapy and use of films as helpful methodologies. All of these authors included group discussions in their methodologies.

Evaluation

Therapists need to evaluate the success of their group in order to receive feedback on the effectiveness of their interventions and on changes that may be required for further group work. Ongoing feedback from group members can be given at each group session through the use of journals. Kitchur and Bell (1989) used Piers-Harris Children's Self-Concept (Piers, 1984) and Child Behaviour Checklist (Achenbach,T.M., & Edelbrock, C., 1983) to evaluate the children's progress. Regular attendance and lack of drop-outs in the group are measures of success according to Hall (1978), and improved school performance, involvement in peer activities and ability to discuss the abuse were measures of evaluating group effectiveness (Carozza & Heirsteinir, 1983). According to Kitchur and Bell (1989), the literature contains no recommended standardized outcome measures for pre-adolescents.

Family Therapy

Sgroi (1982) views family therapy as a very desirable modality for treatment . It is essential to be aware that family therapy which includes the victim and perpetrator should be initiated only after it has been carefully assessed that:

- the offender has acknowledged the offences and takes clear responsibility for them without putting the blame on anyone or anything else;
- the offender is accountable and some form of restitution is made;
- the perpetrator is aware of the dynamics leading to the offences and has learned to detect early warning signs or symptoms and has learned to deal with them in a positive way;
- and the offender has learned better ways of self expression, impulse management and need gratification (Gröth, 1977).

Server and Jantzen (1982) provide guidelines for reconstitution of the family which may also be used as guidelines for family treatment. These guidelines relate to the safety of the victim, acceptance of responsibility by the perpetrator, reassurance from all family members that the victim will be safe, and a safety plan for the victim. The non-offending parent must show that she is supportive and non-blaming to her daughter. Progress towards short-term and long-term treatment goals must be evident, and more appropriate roles and boundaries must be developed. Evidence of an improved marital relationship will also be an indicator that the family is ready for reconstitution.

Whether the family will be reconstituted or not, it is important to work with the non-offending parent and child victim. After disclosure, when the family is in crisis, effective treatment will need to address the immediate needs of the family. Work with the victim and mother can begin with support being given to both (Porter, Blick & Sgroi, 1982). Mother-daughter dyad therapy during all stages of treatment is recommended. Assessment of the mother's functioning within the family is essential. She needs to be empowered and assisted in accepting responsibility for the well-being of the children (Fredrickson, 1982). The mother needs to be strengthened in her parenting role and helped to ensure that her children will be safe. Assistance in the mother-child bonding is important in putting an end to the intergenerational pattern of abuse in their family (McDonough & Love, 1987). Treatment can run concurrently on an individual basis with the child, with the mother, and with the child and mother together. Group treatment for the child and mother can also take place at the same time or later. Treatment gains made with the child can be reinforced by the mother with the

coaching of the therapist (Wachtel, 1992).

The Therapist

Working with abused children and adolescents presents many challenges to the therapist. The therapist must be warm and yet authoritative, and must have honest, open and clear communications (Berliner & Ernst, 1982). They must be skilled in many therapeutic techniques and be comfortable in dealing with intense feelings, including their own feelings and those of the clients. They must also be at ease with open discussion of all issues related to human sexuality and have clear standards regarding sexual abuse. Herman (1992) suggests that therapists assist in the recovery, but are not agents of the recovery. The locus of control is within the victim. The therapist must maintain the roles of witness, consultant and ally. In working with the child victim it is necessary for the therapist to depart from the stance of moral neutrality. A position of firm solidarity must be established between the therapist and the client. Herman (1992) cautions that this does not mean that the victim can do no wrong. Instead, "it involves an understanding of the fundamental injustice of the traumatic experience, and a need for a resolution that restores some sense of justice (Herman, 1992, p.341). She also states that therapists cannot work in isolation and must have their own support systems in place. The work involves dealing with the trauma of others which can become contagious. This can create arenas of conflict with family members and professional colleagues, if the therapist is not understanding of the many, complicated dynamics in place. Hoorwitz (1983) states that the therapist must assume a coaching role in some occasions. Family members have to be helped to prepare for future stages of therapy. The therapist

coaches the family members on how to behave and what to say toward family members in subsequent family sessions. A therapist needs to display behaviours that can be modelled for the benefit of the victims in the group or for the individual child in a one-on-one therapy session.

Klein (1985) gives a detailed description of the therapists role in short-term groups; he describes a comprehensive, supportively oriented approach. He states that the therapist should:

1. quickly develop a relationship, engage the client, and encourage a therapeutic alliance through the use of "positive transference";
2. assess clients, carefully select and prepare them for the group and develop a contract with them with mutually agreed goals;
3. develop realistic, time-limited and achievable goals;
4. ensure that therapy focuses on the clients needs;
5. keep the interventions centered in the present and emphasize work on present difficulties;
6. work with conscious and pre-conscious client material;
7. promote client self-mastery and help them to develop their capacity for growth and positive coping mechanisms;
8. strengthen the client's healthier defences and avoid unnecessary anxiety and aggression;
9. assume teaching role with clients, giving advice and suggestions, showing new problem-solving methods, encouraging clients to identify and rehearse new behaviours in and out of group;
10. assist clients to identify their internal strengths as well as community and informal resources that they can utilize;
11. remember that because of time limitations of the group, it is difficult to work through issues entirely; the therapist should remain focused;

12. model new skills to clients and be available to allow the clients to role play these new skills;

13. respect and communicate that clients are responsible for their own rate of work;

14. communicate to clients that there is nothing magical or mystical about therapy.

Dawson (1984) suggests that therapists who are entering the family system at the critical time of disclosure remember the importance of remaining calm and in charge of his or her emotions, not only to allow the child to talk about the event, but to communicate to the child that what happened can be calmly faced and worked through. The importance of going slowly is stressed so that the child may feel competent and not rushed in telling about what happened. Reassurance and support to the child are stressed by Dawson, and he suggests that the child should be told what to expect along the way, and should not be given any promises that are not achievable.

To be an effective therapist it is necessary to communicate caring and genuine interest to the client. Fewster (1990) writes "In making recommendations to practitioners, the authors stess the importance of establishing a "personal" relationship with the client in which honest, caring, warmth and love can be nurtured and replace the soul-chilling encounters of abuse" (pg.vii).

Summary

To state that child sexual abuse has many negative effects on the child victim is a gross understatement of the situation. Some of the effects are relatively short-term in nature, and with help and support the children are able to go on with normal lives. Some sexual abuse, however, leaves deep scars on the victims and their lives are changed forever. Intrafamilial

child sexual abuse is especially damaging and involves family dynamics which are rigid and intergenerationally inculcated. Successful treatment of the child victim is almost impossible without professional intervention in the entire family system. A thorough knowledge and understanding of the dynamics of child sexual abuse, and the effects on the victims and family are necessary before meaningful intervention can take place.

Various methods of intervention have been discussed, among which are, individual therapy, play therapy, group therapy, and mother-child dyad therapy. Group therapy appears to be the most effective mode of treatment for adolescent girls. Recommendations from this survey of the literature include practical considerations in setting up a treatment program for this age group. There are many reasons why this mode is most beneficial, not least of which is the strong influence of peers at this age. Meeting with peers who have had similar experiences helps to remove the stigma and guilt that cannot be alleviated as effectively in individual therapy. Evaluation of various methods of treatment are not plentiful in the literature, but some suggestions for evaluation of treatment are given.

Finally, suggestions taken from the literature for the therapist's approach to treatment are given. As the therapist enters the client's system, he or she becomes a part of that system to some extent. The therapists, in addition to being knowledgeable and skilled in the dynamics of treatment, need to set up a support system for themselves, to ensure their ongoing effectiveness.

CHAPTER THREE

THE PRACTICUM: METHODS AND PROCEDURES

The Setting

During this practicum clients were seen at the Community Resource Clinic, now called the Elizabeth Hill Centre. The clinic was established by the Department of Psychology and the Faculty of Social Work at the University of Manitoba for the training of psychology and social work students. The clinic is located on the third floor of a building at 321 McDermot Avenue in the warehouse district in downtown Winnipeg. The Clinic takes up most of the third floor and is light, spacious and attractive but unpretentious. Since the time of my placement it has been renovated to include more offices and therapy rooms. In 1990 and 1991, during my placement, there was a large multi-purpose room in the centre of the facility surrounded by opaque glass walls. These outer glass walls of the multi-purpose room were bordered by a hall which formed a square around the multi-purpose conference room. Offices and therapy rooms were accessed from these halls. The clinic has a cozy, comfortable and modern appearance with hardwood floors and area rugs in the therapy rooms and attractive pictures and posters on the walls. There is a waiting area at the entrance of the clinic with a small table with crayons and activities for children, an area for the secretary and a storage room behind the reception area for client files and necessary forms and materials for students and clinicians. At the time of this practicum there were six therapy rooms, three of which were smaller and more suited for use with one or two clients and three of which were suitable for small group or family sessions. Video cameras and recording equipment were available

in all six therapy rooms. There were several small offices and one play therapy room around the periphery of the multi-purpose room as well. There was a one-way mirror adjoining one of the larger family therapy rooms for observation by students or supervisors. In the multi-purpose room there was a carpeted area with couches and chairs and another area with a long table that could be used for groups or for students to complete their paperwork. The ambiance at the clinic very professional with primary concern shown towards the attending families and children. There was an atmosphere of helpfulness and cooperation among the students and staff. Professor Walter Driedger was the Director of the clinic at the time and Audrey Schrivens was the secretary-receptionist. Both were very helpful to the students.

Supervision

The committee for this practicum initially consisted of Dr. Barry Trute, Dr. Laura Mills and Professor Walter Driedger. Dr. Trute was chairperson of the committee. All three committee members helped me immensely with their knowledge and insight. Biweekly supervision took place with Dr. Trute regarding case consultation, usually at the clinic, but sometimes at Dr. Trute's office at the university. Dr. Trute, in addition to being the chairperson for the practicum, was also my advisor and provided supervision to me on an ongoing basis whenever I needed it. Dr. Mills provided biweekly supervision to myself and to my co-therapist for the group, Susan Maxwell. Dr. Laura Mills is a clinical psychologist and is the Clinical Supervisor of group therapy at the Manitoba Adolescent Treatment Centre. She supervised and advised us regarding the group therapy aspect of our respective practicums. Dr. Mills assisted us in understanding of dynamics of groups and with particular

challenges we encountered with the group. Professor Walter Driedger was the Director of the CRC at the time. He provided supervision for individual cases on an ad hoc basis to myself in Dr. Trute's absence. He also provided supervision to Susan Maxwell and myself together as needed. By the time I was able to complete my practicum report, Professor Driedger had retired. I was very fortunate that David Charabin, who is now the Director of the Elizabeth Hill Centre, kindly agreed to become a member of my committee.

Supervision included review of taped individual therapy sessions and ongoing case assessment and planning. Individual and dyadic therapy sessions were taped but the group meetings were not taped.

Referral Process

Referrals were obtained from the Child and Family Services (CFS) of Central Winnipeg and from other referrals to the Community Resource Clinic, including Ma Mawi Wi Chi Itata. Guidelines for referrals for this practicum were:

(1) adolescent females, twelve to sixteen years of age, who had experienced sexual abuse,

(2) the abuser was a family member or trusted third party,

(3) the non-offending parent or foster parent would be willing to be involved in the treatment of the child,

(4) there would be no barriers to communication, such as language,

(5) the child was living in a safe place and was not living with the abuser, and,

(6) transportation for the child would be arranged by the agency or parent.

On January 11, 1991, a meeting was held with Janet Mirwaldt, abuse coordinator for CFS of Central Winnipeg, Dr. Barry Trute and Professor Walter Dreidger, Susan Maxwell and

myself. Specific children in need of treatment were presented and their suitability for group and for our individual practicums were discussed. From the children presented, some adolescent girls were selected as clients for Susan and myself. In order to obtain more referrals to fit within the parameters of my practicum, I asked Ms. Mirwaldt to request that her colleagues refer children requiring treatment who had recently disclosed sexual abuse. A follow-up letter was written to Ms. Mirwaldt outlining the guidelines for referrals. Subsequently, workers from Central Winnipeg Child and Family Services made referrals directly to me by phone and I would meet with them to discuss the children's treatment needs and their suitability for this practicum.

Treatment

A multi-modal approach was used and the adolescents were seen individually, with their mothers or foster mothers, and where appropriate, in group treatment. Written permission from the child's guardian was obtained during the intake interviews. Individual sessions occurred weekly, for the most part. The dyadic mother-daughter sessions were planned at intervals during treatment. Group therapy was not an option for three of the clients because they were uncomfortable with the idea of being in a group. One of these girls came to one group session and would not return. One girl came to two sessions but stated that she did not fit in with the group because she was sixteen and more mature than the other group members. A third adolescent expressed an interest in attending the group, but failed to attend. Family therapy including the entire family was not used, but family therapy techniques were utilized with mother/daughter dyads to strengthen the relationship between the victim and the non-offending parent. Family therapy was used with one family and

included the grandmother, her daughters, and granddaughter. Play therapy, which included art and drama, was implemented when it was deemed to be most appropriate. Several of the twelve-year-olds I saw during this practicum seemed to be more open and comfortable dealing with their issues in the play room using play therapy techniques.

Treatment goals were developed specific to each adolescent after a thorough assessment was made. In the development of treatment goals I was mindful of the many effects of sexual abuse and corresponding treatment implications on the adolescent victims. Broad guidelines which assisted me were the traumogenic effects found in the works of Finkelhor and Browne (1985) which are, traumatic sexualization, betrayal, stigmatization and powerlessness. I was also advised by the treatment issues for victims of C.S.A. described by Porter, Blick and Sgroi (1982) and these were kept in mind while I was assessing the needs of each child. These are: "damaged goods" syndrome, guilt, fear, depression, low self esteem, poor social skills, repressed anger and hostility, impaired ability to trust, blurred role boundaries and role confusion, pseudo maturity with failure to accomplish developmental tasks and (problems with) self-mastery and control (p. 109). A more detailed discussion of the many effects of CSA was presented in Chapter Two of this report, and I considered these effects during assessment and development of treatment goals for each adolescent. Assessment of each adolescent's treatment needs was conducted within the framework of an ecological systems approach. The overall treatment goals for the adolescents to whom I provided service were:

1. to establish an environment of trust and safety for the adolescent to deal with her abuse;

2. to strengthen the adolescent's support system thereby reducing stress in her life and enabling her to more effectively deal with her issues;
3. to empower the adolescent by showing her respect as an individual and encouraging her to make positive choices;
4. to encourage and facilitate peer support among sexual abuse victims with the goal of reducing stigmatization and shame, developing trust and building appropriate social skills;
5. encourage the adolescent to be aware of her feelings and to learn to express them appropriately;
6. to encourage the development of positive self-esteem in the adolescent;
7. to help the adolescent to learn healthy interpersonal communications and problem solving skills;
8. to teach the adolescent about healthy sexuality and personal boundaries.

Time Frames

This practicum began in October, 1990, when I began to see one client who had been working with an MSW student who had completed her practicum and left the clinic. Other clients were added to the practicum in the spring of 1991, as appropriate referrals were made. Individual sessions were usually weekly, but were biweekly for one adolescent who travelled from outside Winnipeg. The sessions were planned for fifty-five minutes in duration. One pre-adolescent girl requested that she have longer sessions, so after discussion with her foster mother, this girl's weekly sessions were planned for one hour and a half.

Group Treatment

The adolescent group was a psychoeducational group. Planning for the adolescent group therapy began in January, 1991 and the group treatment began in April and ended in June, 1991. Twelve sessions were considered to be the ideal number, according to our research, but we planned for ten sessions because of our limited time. After the sessions began, we discovered that we would only be able to conduct eight sessions, because of a May holiday and the early start for school summer vacation. We would have been willing to extend the group into the school summer vacation, but a few of the participants had plans to attend early summer camp.

Sessions were held weekly on Mondays from 4:15 to 6:15 PM. The CRC was not open to other clients on this evening. We were advised from our research that group sessions should be held earlier in the week rather than later, so that the clients would have an opportunity to meet with their individual therapists prior to the weekend if a difficulty came up for them as a result of the group session. The first group sessions were held in one of the larger interview rooms. We thought that a room of this size would provide for feelings of safety and privacy for the participants. This room proved to be too small for the group and they had difficulties with sitting so close to each other and not having enough space in which to move around. After the second week the sessions were held in much larger multi-purpose room, which proved to be an ideal room for the group. The large table in the centre of the room provided a gathering place for snacks and group discussion. Participants could work on individual projects and still have a sense of privacy and it was easier to supervise the girls when they were all in the same room. The large room seemed to accommodate all the activity

and the girls appeared to enjoy the uniqueness of this large room with the variety of furniture and space in which to move around. We were able to tape the girls' work and flip chart paper to the walls of the room.

Weekly agenda for the group

The weekly agenda was developed after much careful planning and consideration of

(1) treatment needs for adolescent girls who had been sexually abused,

(2) their age range and levels of cognitive and emotional development, and

(3) the number of sessions we would be able to hold.

As co-therapists we had developed a list of topics which we believed would be important to our clients. In addition to our list, we also elicited a list of topics from the adolescents in the first group session. These needs as presented by the group participants were integrated with the treatment issues which we had already developed, and these became our guidelines for topics for the group sessions. Please refer to Appendix A for the topics covered in each week of the treatment program.

The group sessions were as informal and comfortable as possible but had sufficient structure to provide security and to ensure that the participants needs were met. The first session was an introductory session that provided the therapists with information from the girls to help organize the rest of the sessions. In addition to a list of treatment issues being developed, a list of group rules (Appendix B) were developed by the group members. We were flexible and willing to work with the group on issues that were important to them as they came up during group discussions, but there was an agenda (Appendix C) posted at each session for the participants to see. We also went over the agenda with the girls at the

beginning of each session. Depending on how the participants were responding to the topics the agenda would be adjusted accordingly. That could mean that we took longer on one topic than we had expected or it could mean that we would move quickly through a topic. To provide more structure we began and ended the sessions on time. Participation in the group was limited after the group had completed several sessions. As co-therapists, Susan Maxwell and I were careful to model appropriate attending behaviours and clear, direct communications with each other and with the girls.

We had a snack at the beginning of each session. The girls were encouraged to take part in the preparation and serving of the snack to each other and to the therapists. Snack time proved to be a natural way to bring the group together and it was a way of providing a form of nurturing and caring to the girls. Maslow (1962) delineates and describes a hierarchy of needs that shows the importance of satisfying the lower levels of physiological needs and safety needs before an individual can reach the higher levels of love, esteem and self-actualization.

Later in the snack period each participant shared one good thing and one bad thing that had happened to her in the last week (this was called "go 'round"). After the snack we used an icebreaker or a group building activity that took various forms. We then allowed time for any business issues to be discussed. This would lead into the specific topic for the week in which information would be generated for ensuing discussions and activities. This would usually take 20 to 30 minutes. We then utilized a relaxation technique or self-nurturing activity to wind down the session. At the end of the session each girl would spend time writing in her journal (Appendix D gives ideas for journalling). The journal was a vehicle

for the adolescents to comment on anything that they wished or to give some feedback on that week's session, or anything that they would like to have discussed. The journalling was not only a way for the girls to communicate privately with the facilitator, but was a way for the participants to integrate information from the session or to discuss any other issues they had. They were aware that Susan and I would later read their journals and make written responses to each entry before the next session took place.

Topics Covered

Because of the relatively few sessions we had with the girls the number of topics we dealt with were quite restricted. We spent several sessions dealing with information about sexual abuse and feelings that were associated with these traumatic events. We also covered such topics as offenders, non-offending parents, assertiveness skills, relationships with males, personal safety, values clarification and sex education. The first group session dealt with goals for the group and rules that would be followed by each group member to ensure effective communications and a meaningful treatment program. The last session included a small party that the girls had planned to celebrate their participation in the program. We wrote a collective poem and made cards with the poem which each person signed. Some of the adolescents planned to keep in touch with each other.

Assessment and Evaluation

Research for this practicum was qualitative and followed a single system design. Formal and informal assessment was used to determine the adolescents' needs and to develop an individualized treatment plan. Assessment instruments (also referred to as scales) were administered at the beginning of each client's involvement at the clinic to gain a better

understanding of the child's treatment needs and to facilitate development of individual treatment goals. "Self-report" scales were mainly used in evaluation as well as my professional assessment on a non formal basis. My assessment was based on a number of variables and included the use of an ecological perspective. This perspective allowed me to view the child within the context of her environment, including family, school and community. Developmental levels with incumbent needs, interpersonal and intra personal functioning, and basic personality were also factors which I considered in the assessment. The Achenbach Child Behaviour Checklist assisted greatly with this part of the assessment.

Self report scales and measures are the most frequently used in family therapy and show the client's perspective of their level of functioning (Trute et al. 1988). Measures were chosen that were quickly administrated, relevant to the treatment issues, and were not intrusive or off putting. Trute et al. (1988) cite Cromwell (1976) in offering advice in the selection of assessment and evaluation scales. They state that scales and measures,

> "should be consistent with the intervention paradigm employed in practice. They should be practical to applied settings (that is, be cost and time efficient, require minimal equipment or scoring routines, and be non-obtrusive to the clinical process). They should be sensitive to transactional change over time, They should have adequate generalizability (that is, be strong in their empirical reliability and validity). They should be appropriate to the family's life situation (that is, fit with the type of problem they present and be congruent with their social-cultural background)" (pp.9-10).

Data was also obtained through individual interviews with each client and the client's parent or guardian. Information which aided the assessment was obtained from the social worker who made the initial referral. In several cases the referring agency provided a copy of the Record of Disclosure and Child Abuse Committee minutes.

After an initial interview took place with each client, scales were then administered (usually during the second interview. The following scales were used:

Rosenberg Self-Esteem Questionnaire

Achenbach Behaviour Checklist (Child and Parent forms)

The following instruments were used at the beginning and end of the group to monitor the progress of the group and to provide an assessment at the end of the group:

Group Child Sexual Abuse Questionnaire

Impact of Event Scale

Rosenenberg Self-Esteem Questionnaire

Weekly consumer feedback- the group participants were encouraged to write their thoughts about the group process and content at the end of each session in their individual journals.

Consumer evaluation - a questionnaire for the adolescents at the end of the group.

I did not attempt to approach the use of measures or scales in the scientific way for which they were developed and I did not establish a baseline by which to compare pre-test and post-test measures. It was my belief that I could not establish adequate controls on the many variables which would be factors affecting any changes in the adolescents. I also believed that the short term nature of the interventions applied would not result in noticeable changes in standardized testing. I used the measures as ways to gather objective and subjective data from the adolescents and their mothers or guardians for my overall analysis of each participant..

Assessment of each adolescent's needs was necessary in order to develop goals for

treatment. There are three treatment phases, according to Sgroi (1981). The first phase is crisis intervention, then short-term therapy, followed by long-term therapy. Some of the adolescents were in the crisis phase when they became involved in treatment. These girls were not yet ready to become engaged in actual therapy around the sexual abuse. They were more in need of assistance in rallying their supports and in dealing with the necessary interventions of child welfare professionals. Long term therapy is usually suggested for children who have suffered from intrafamillial abuse and who do not receive the necessary supports from their family. Given the relatively short duration of my practicum, long term therapy was not possible, even though it would likely be needed by several of the adolescents with whom I became involved.

Short-term goals, according to Sgroi (1981), would likely be related to "damaged goods" syndrome, fear, low self-esteem, guilt and depression. Treatment for repressed anger and hostility, impaired ability to trust, blurred boundaries and role confusion, pseudo maturity, failure to accomplish developmental tasks and lack of self-mastery and control would be long term and would not be included in short-term goals. Regardless of whether a treatment issue requires a long or short-term strategy, treatment goals can be broken down into partial and instrumental goals (Nelson, 1981).

Partial goals can be part of a long-term goal or the accomplishment of some task that builds up the skills needed to achieve that goal. Other types of realistic goals that can be met are instrumental goals; these assist in the achievement of a long-term or end goal by an indirect means. For example, a change in one's perception of an event or her self-perception could help her towards a final goal. Nelson (1981) suggests that "The careful delineation of

interventions required in single-subject research can lead to the provision of more effective treatment by practitioners and can help practitioners generate research findings helpful to the profession" (pg.37). Nelson states that social workers utilize a wide range of theories from which to assess influencing variables which affect change. The range of theories utilized in the practicum, and represented in the literature review, come from the major fields of social work, psychology, sociology, education and health.

CHAPTER FOUR

THE CLINICAL EXPERIENCE

Selection of clients for this practicum was a process which began in early 1991. Referrals were sought from Winnipeg Child and Family Services. After an initial referral was received by telephone, I met personally with the referral agent. This was most often a social worker from Central Winnipeg Child and Family Services, but there were several referrals from a social worker from Ma Mawi Wi Chi Itata Centre. I was encouraged by Dr. Trute, my advisor, to choose only those referrals that would fit my guidelines so that my practicum could remain focused. I needed to keep my personal learning goals in mind and keep the practicum manageable.

Once I accepted a case, I gained as much information as possible from the child's social worker and other sources. This sometimes, but not always, included formal reports or case summaries from the referring worker. An intake interview, usually at the Community Resource Clinic, followed. This interview included the child, her mother or guardian, and sometimes the referring worker. In three cases, the intake interview was conducted in the client's home or foster home.

Assessment

Assessment of each client was both formal and non formal. A combination of scales was utilized to assess the child's self-esteem, impact of trauma, and the particular problems she was experiencing in her life at that time. Her support system and individual strengths

were assessed during the first few interviews. Instruments were utilized at the entry level to assist in the assessment of each adolescent's personal response to the abuse and to determine her level of functioning at home and in the community (including school). Soon after intake, usually during the second interview, the adolescent completed the Rosenberg Self-esteem Questionaire and the Impact of Event Scale. The adolescent completed the AchenbachYouth Self Report for Ages 11-18 in the next interview. Because the Achenbach Youth Self Report is a lengthy questionaire, I sometimes had the adolescent complete it during the course of two interviews, using just part of our time together on this scale. In a subsequent interview alone with the parent, the parent completed the Achenbach Child Behavior Checklist for ages 4-16. I assisted the adolescents and their mothers in completing these scales, and was careful not to influence their responses with prompts or suggestions. A brief description of the scales follows.

Rosenberg Self-esteem Questionaire

This scale is a self-report instrument to determine the self-acceptance component of self-esteem (Robinson and Shaver, 1973). There are ten items on the scale, five of which indicate high self-esteem and five which indicate low self-esteem. The "positive" and "negative" items are alternated and the questions are short and clear to reduce response set (the tendency of respondents to fall into a pattern of answers). This scale is easily administered as the client is only required to check off answers to the ten items. It can be completed in a few minutes, and is quickly scored. The Rosenberg Self-esteem Questionaire has face validity and directly measures self-esteem. It has been used extensively and has proven to be reliable.

Rosenberg (1965) suggested that a person with high self-esteem has a realistic outlook on his limitations, but anticipates success and accepts and respects himself. He also suggests that those with low self-esteem are dissatisfied with themselves, do not like themselves, and are lacking in self-respect. Responses are made on a four point Lickert Scale ranging from strongly agree to strongly disagree. There are several ways suggested to score this scale. The traditional method of scoring this scale (Robinson and Shaver, 1973) is to rate the responses as 1 or 0, regardless of whether the response was "agree" or "strongly agree". Moran and Eckenrode (1992) suggested ratings of 0, 1, 2 and 3 be given to the responses, which gives a possible range of 0 to 30. The higher the score, the better the self esteem. I used the latter method of scoring because it gave a wider range of scores by which to find comparisons between pre and post tests and between clients. I used this scale as a broad indicator of the adolescent's self-esteem.

Impact of Event Scale

This scale was developed by Horowitz, Wilner and Alvarez (1979), to measure the influences and stresses of a traumatic event on a person. The scale is comprised of fifteen questions to be answered on a four point Lickert scale, with responses ranging from "not at all", to "rarely", to "sometimes", to "often". Seven of the items on this scale measure intrusion and eight items measure avoidance. Intrusion included "unbidden thoughts and images, troubled dreams, strong pangs or waves of feelings, and repetitive behavior" (Horowitz, Wilner, & Alvarez, 1979, p.210). Avoidance included "ideational constriction, denial of the meanings and consequences of the event, blunted sensation, behavioral inhibition or counterphobic activity, and awareness of emotional numbness" (Horowitz, Wilner, &

Alvarez, 1979, p.210). The scale provides a subscore each for Intrusive and Avoidance reactions. It is suggested that each subscore be addressed separately and that it is not helpful to add the two subscores. Intrusive and avoidance reactions to stressful life events are related, but are not identical responses. Horowitz et al. (1979) stated that a person would often vacillate between avoidance and intrusion as a normal response to stress, but a high score in one subscale compared to a lower score in the other subscale could indicate pathology. As well, high scores for both subscales could indicate pathology. Both intrusion and avoidance may be healthy coping mechanisms. Avoidance is used to assist in coping with painful intrusive thoughts, but allowing the intrusive memories is also a way to process the meanings of the event.

The Impact of Event Scale is a good example of a scale that has validity, that is, it measures what you set out to measure. It has face validity which is an asset, but could also be a hindrance in some cases. For example, if a person badly wanted to receive counselling, she could easily answer the items to indicate a stronger response to the trauma. Likewise, she could create a lower score on the subscales. The benefit to me of this excellent face validity was that I could better understand each girl's thoughts about the event from her responses to the various items. This scale is tied to a theory of trauma and has been proven to be valid and reliable (Horowitz, Wilner and Alverez, 1979). While it was not specifically tested on adolescents, it is recommended that it would be appropriate for adolescents or children who are aware of their thought processes. It is recommended for use with victims of family violence, rape or accidents. This scale lends itself to tracking any changes in an abused victim over the time of treatment, as a baseline can be established at the beginning of treatment and

measured again at the completion of a phase of treatment.

Achenbach Child Behavior Checklist for Ages 4-16

This scale (Achenbach & Edelbrock, 1983) is a four page questionaire that can be quickly checked off by the child's parent or guardian. The first two pages include a general description of the child and information on his or her activities and school performance. The second two pages include 113 items to be checked off by the respondent as being "not true", " somewhat or sometimes true", or "very true or often true". Instead of giving diagnostic assumptions, this checklist provides actual descriptions of behavior. It provides comprehensive information about the child in her environment. Items that are included in the checklist show problematic areas in a child's social and emotional development. The items on the Achenbach Child Behavior Checklist (4-16) are organized in a similar fashion to the Youth Self Report and thus allow for cross-informant comparisons. The Checklist is comprehensive and covers a wide range of behaviors. It gives an ecological viewpoint of the child's behavior and assists the clinician in assessing the areas which are in need of intervention. Both the Achenbach Child Behavior Checklist and the Youth Self Report scales are reliable and valid checklists and they are grounded in extensive research.

Assisting the parent in completion of this questionaire not only gave a complete picture of how the child was functioning, but also gave me the opportunity to interact with the parent and provide support to that parent. In addition, it gave some insight into the dynamics between the parent and child, and gave the parent an opportunity to view the child in a more objective way and to understand how her child was functioning within a broad

range of possibilities.

Achenbach Youth Self-Report for ages 11-18

This questionaire (Achenbach & Edelbrock, 1983) is a four page checklist for adolescents to complete. The first two pages solicit information about the adolescent's interests, school and social interactions. The next two pages include 112 questions about attitudes and functioning. Most of the questions parallel those asked of the parent in the previously described Child Behaviour Checklist, but some are different. Because both checklists are similar I was able to compare the child's responses to those of her parent ("cross-informant comparisons") and discover if the child's self perception was realistic. The use of both of these checklists gave me a comprehensive picture of how the child was functioning within the family, school and community (interpersonal), and how the child was functioning at an intra personal level. Possible effects of the sexual abuse on the child's daily functioning could be seen, and target areas in need of intervention could be defined.

Psycho-educational Questionaire

This questionaire was used as one of the initial assessment tools in the adolescent's group. This was entitled "Things to Think About, Things to Learn" (Appendix E) and was adapted by Susan Maxwell and myself from a questionaire developed by Melanie Grace (1984). There were twenty-one statements relating to common beliefs or misunderstandings about sexual abuse by the general population. Respondents were asked to rate the statements as true or false. This questionaire helped to assess the adolescent's level of understanding of sexual abuse related issues and to pinpoint areas of need for the group participants. It

gave us a baseline by which to measure the adolescents' understanding and knowledge of the topic.

Nonformal Assessment

Nonformal assessment was derived from interviews and observations of the clients and was based on Finkelhor and Browne's (1984, 1988) framework of traumagenic dynamics and Sgroi's (1981) list of 10 effects of sexual abuse. Assessment of the child's support system composed of her caretakers, extended family system, counsellors and school was included in the nonformal assessment. The mother's support system or lack of it as well as the influences of the community on the family were also taken into consideration during the assessment. Assessment of the adolescent's treatment needs was a continuous process. As new needs appeared during the treatment process, goals were reassessed and addressed.

The Group

The practicum was a multi-modal approach to the treatment of adolescents who had been sexually abused. In addition to individual therapy and therapy with mother-daughter dyads, group intervention was also used. Group work was an important intervention with the adolescent victims of sexual abuse who were referred for treatment. Susan Maxwell, a fellow candidate in the MSW degree program at the University of Manitoba was the cotherapist. Together, we researched and shared our research with each other on group interventions. We developed the agenda and topics to be covered from information we obtained during our research of the literature. Some of the most helpful information was gained from Croll (1987), Crowder and Meyers-Avis (1990), Hazzard et al (1986), and

Berliner and Ernst (1982).

Our respective advisors, Dr. Barry Trute and Professor Walter Dreiger were very helpful in developing the group process. Dr. Laura Mills' advice was invaluable in planning the group and in the running of the group after it had started. From the information we obtained we were able to decide on the optimal time of the day to have sessions, the optimal time of the week, and ways to help provide the participants with a sense of safety and security. We chose to provide the group sessions immediately after school as they would have the rest of the evening to assimilate and deal with the information and feelings brought up at the group. An evening session would not have provided this time insulation. We chose to have the group sessions early in the week, so that the adolescents would have an opportunity to go over material from the group with their counsellors in their individual sessions during the rest of the week. Most of the girls walked or took the bus to the group sessions and we always drove them home.

The group was composed of seven adolescents ranging in age from 11 to 14. A place was kept for another adolescent but she decided not to participate. Five of the girls were on my caseload and two were working with Susan. One girl from my caseload came to the first session but did not participate further because she felt out of place as the only native girl in the group. One other girl from Susan's caseload came to the first session and then also dropped out. One other client of Susan's who had been invited decided that she did not want to participate. Another one of my clients decided to drop out after the third session. Two of the girls who dropped out were older than the girls who remained. The age difference may have been, in part, responsible for the older girls' dropping out. This was the first group

intervention experienced by any of the adolescents. The last few sessions were attended by four adolescents, three of whom were living in foster homes and one who lived with her mother.

The group sessions were held from 4:15 to 6:00 p.m. on Mondays from April to mid June. Our original and ideal plan was to hold twelve sessions. We were unable to begin the group as early in the month as planned, so we reduced the duration of the group to ten sessions. After the group began, we found that we had to drop two sessions because of scheduling difficulties around holidays and school break. In total, we were able to have eight sessions. The clinic was closed to other clients while our group sessions were being held. We planned to use an interview room for most of the group sessions, but we moved to the central meeting room of the clinic during the second session. It seemed that the adolescents found the smaller room too small and intimate, and were uncomfortable with this. The larger room met the needs of our group very well and the walls of textured glass provided a surface to attach pictures, charts and diagrams. There was a large table that we utilized for snacks and for persons who were working on individual assignments. The couch in the room was a convenient location for small groups to get together and discuss issues, and it provided a more relaxed place to sit. The larger space allowed for greater activity and for the adolescents to expend some energy without that becoming too hectic. It was helpful to be able to supervise small group work within the large room.

Careful planning went into the length of group sessions and in the weekly agenda. The group participants were encouraged to contribute to the agenda during the first session, and a list of topics in which they were interested was listed on a large flip chart sheet. We

were careful to do everything we could to help the participants to develop a sense of safety and security during the group sessions. Some of the techniques that we used were: to provide consistency in the length of sessions, posting the agenda each week, allowing no new participants without their consent once the group started, discussing confidentiality issues and confining individual's disclosures to within the group, and assuring the privacy of the clinic setting during group time.

Each session started with a snack. This provided a good way to bring the girls together as it provided an informal opportunity for the participants to join with each other (a good "ice breaker"). It allowed for some flexibility for clients who arrived late for the session. Sharing a snack was an opportunity to provide a form of nurturing to the girls. Participating in preparation of the snack helped to build their self-esteem and gave us opportunities to thank them for a job well done. The girls had some input as to what we would have for a snack, and in a small way, this gave them a sense of empowerment. The group sessions were held after school; the girls were hungry and they appreciated getting something to stave off their hunger. In a very practical way, the snack enabled the girls to be available to participate more freely in the group as one of their basic physiological needs was being met.

During the snack time we had a "Go Round" in which we heard from each person how their week had evolved. Each person talked about one good thing and one bad or not-so-good thing that happened to them since the last group session. The next item in the session was a group building exercise or an icebreaker. We utilized a variety of activities for this part. Next was a brief period that was devoted to the business issues of the group and

we then went into the most substantive part of the session which was the specific topic for the week. Information was presented and the adolescents had an opportunity to discuss the topic and ask questions. This main item on the agenda would last for about 20 to 30 minutes. If we showed part of a film, we would stop it for discussion at important parts. A relaxation period or a self-nurturing activity followed. This gave the girls a chance to relax and unwind after the main topic was discussed. This activity had an educational component and provided techniques of self-nurturing to the girls. It also improved their confidence in their own abilities (their self-efficacy) and enhanced their self-esteem. We hoped that these techniques would provide ongoing benefits long after the group was over. Having skills in self-nurturing could help them through other negative life events.

At the end of each session, the adolescents wrote in their journals. The journals remained at the clinic until the end of the group sessions. The girls knew that through the week Susan and I would read their entries and comment in the journals. The girls appeared to enjoy our written comments and looked forward each week to reading what we had written. The journals provided an opportunity for the girls to give their opinions and feelings in a safe way and to provide valuable feedback to the facilitators. They also provided opportunities for the facilitators to give positive affirmations to the adolescents. We did not want to give a questionaire to the girls after each group session, but we wanted to receive feedback from them. The girls were more frank in their journals than they were verbally within the group.

The topics that were covered in the group sessions were taken from models presented in the literature by other practitioners and clinicians, and from the participants themselves

(Appendix A). The first session was to get to know each other and to establish some ground rules (Appendix B) for the rest of the sessions. Three sessions were dedicated to sexual abuse and normal responses to it. Other topics that were included in the group sessions were personal safety, sex education, values clarification, perpetrators, and relationships with the opposite sex. Some sessions dealt with more than one major topic. The last session was planned by the girls and was a celebration of their participation in the group. Each session was intended to assist the participants in getting in touch with how they were feeling and how they could appropriately deal with these feelings, to obtain a better understanding of themselves and sexual abuse, to improve their coping skills and to increase their self-esteem.

Throughout the group sessions we attempted to provide as much reinforcement to them as we could, such as, smiling, nodding, using positive and affirming words, helping each girl to know that they were important to the group. We also set appropriate boundaries when necessary. For example, one of the girls brought a friend to join the group without discussing this with the leaders beforehand. Of course, we could not allow any child to receive treatment at the clinic without their parent's permission. In addition, we had an agreement with the girls in the group that we would not allow any newcomers into the group without discussing it beforehand with the group members. Notwithstanding the agreement one of the girls invited a friend to a session. When this happened, we expressed our appreciation to the group member who invited her friend because she thought so much of the group that she wanted to share it. However, we could not allow the newcomer to participate without prior consent of her parent and the group. We asked the new girl to sit in the waiting room and then at an appropriate time, the girl in the group took her home. She never did become a group member

because her mother did not consent. This proved to be an empowering experience for the girls because it showed them the cohesiveness and solidarity of the group. When there were difficulties with a girl's behaviour, we attempted to redirect them and set gentle but firm limits. We tried to let them know that what they had to say was important, but that everyone needed to have a chance to talk and give their point of view.

One of the most helpful instructions that we received from Dr. Mills was to ensure that we encouraged interaction between the group members. She suggested that we did not want to provide "multiple individual therapy", but actual group therapy, and make the best use of the group dynamics. We gave control to the group whenever possible and tried to plan for activities to help get our points across, rather than engage in a lecture mode with them.

Summary

Research and preparation for the group treatment program took a great deal of time and cooperation between Susan, my fellow group facilitator and myself. I sincerely believe that I learned as much from the preparation and debriefing with Susan as I did during the group sessions. Each session was very different from the other. We planned the sessions carefully as we were aware that our time with the girls was limited and we wanted them to gain as much as possible from the experience. It felt like an overwhelming responsibility. However, we remained flexible and did not strictly adhere to our agenda for the day. We wanted to listen to the needs of the participants and work on their most important issues that they brought with them to the group sessions.

The group dynamics were fascinating as there were power struggles between several of the more insecure adolescents as they vied for control and attention. Leaders emerged, and

alliances formed between the various subgroups within the group. The group experience did not run long enough for the girls to gain a lot from their interpersonal relationships, but there were a few girls who planned to keep in touch with each other. Most of the time the girls in the group appeared to have fun, and we had hoped that this would be the case. Of course, there were difficult topics that we dealt with, but we tried to provide a balance, and have a tough, intense, session followed by a lighter activity.

We found it difficult to evaluate the success of the group. There are no standardized scales developed to measure the impact of group treatment for sexual abuse. We looked at our goals for the participants and decided that we would like to improve the adolescents' self efficacy, their self-esteem, lessen the trauma of their abuse, provide a vehicle for peer support, lessen their feelings of guilt, stigmatization and loneliness, and provide a supportive environment to them. We considered using the Piers-Harris Children's Self-concept Scale (Piers, 1984) for evaluation, but decided that it might be too long to administer to the group. We decided to use these measurements at the beginning and end of the group: Impact of Event Scale, the Rosenberg Self-esteem Questionaire, and a psycho-educational questionaire (Appendix E) which was geared to testing their general knowledge about sexual abuse. (A brief description of these scales are at the beginning of this chapter.) At the end of the group we also asked the girls to complete an evaluation about the group (Appendix F). Their weekly comments in their journals provided an ongoing, weekly source of feedback for us.

The results of the group evaluation were positive and are shown below:

1. The things that they found hardest about being in the group were - mostly, "nothing", but one mentioned a lack of cooperation by some of the girls, and one mentioned that it was

difficult to "talk about private parts".

2. The things that they liked best about the group were - the snacks, the emotional support they received, being with other girls, and the movies.

3. What they would have liked to do that we did not do were - to discuss more issues about sexual abuse and about their own personal experiences. One girls suggested that we could have had activities outside the clinic, such as going for a walk.

4. Regarding the number of weeks that the group ran - most suggested that the weekly sessions could have lasted for a longer time, such as two and a half hours, and some suggested that the sessions should have run for nine weeks or more.

5. Regarding their understanding more about sexual abuse than when the group first started - three girls answered "yes", and one girl said " I knew everything because my mom told me all of it when I was a little girl".

6. Would they recommend a group like this to their friends? - all answered "yes".

7. Regarding suggestions to the leaders for future groups - most responses had no recommendations, but one girl suggested some that there should have been more self disclosure by group members. Most responses were very positive about the group.

8. Regarding the setting (space, privacy, temperature, etc.) - all responses were positive about the clinic setting. They especially enjoyed the air conditioning and the physical space.

9. Regarding the time of the day that the group sessions were held - all responses were positive about the sessions being held after school.

10. Other comments or suggestions - there were no other comments except one girl voiced her thanks for being a part of the experience.

The individual results of the girl's pretests and post tests are given with the description of each case that follows. Means of the scales were calculated for several of the girls who attended the group, for whom a pre and post test was available. They are:

Rosenberg Self-esteem Questionaire:	T1	T2
Mean scores	21	21.5

Impact of Event Scale:	T1	T2
Avoidance mean scores	20.5	21
Intrusive mean scores	16	12.5

Sexual Abuse Awareness:	T1	T2
Mean score	17.6	19.6

The mean scores for these scales do not really give information on effects of group treatment. There were few subjects and many extraneous variables would need to be considered while the girls participated in the group. During the eight weeks that the group was run, one of the participants ran away from her group home, one was removed from her guardian's care and placed into a group home because of physical and emotional abuse, and one girl's perpetrator moved back into the family home. Mean scores remained relatively stable. However there was a slight decrease in Intrusive subscores and a slight increase in sexual abuse awareness. The decrease in the Intrusive subscore could indicate that the group participants had begun to "rebuild basic assumptions about themselves and the world: the belief in relative invulnerability, the conviction of mastery over the environment, and the view of the world as

meaningful and understandable" (Affleck, Tannen, & Gershman, 1985, p.655). The increased sexual abuse awareness could have occurred because of the educational component of the group, including our discussions and films. The best indicator that we had as to the success of the group was our observations of the adolescents' behaviour and any changes we saw, the comments and observations of the participants themselves, the interest shown at the group sessions, and their weekly attendance.

In terms of attendance, we began the group with seven participants, with the expectation that one more adolescent was going to join us the second session. This girl did not start, one dropped out after the first session (who really hadn't been eager to come in the first place), one of the older girls came sporadically and eventually did not return, and one ran away from home and left the group. We had four steady attenders. It may have been more advantageous to have girls who were more homogeneous in age and life situation, and it would have been much more helpful to have been able to run the group for a longer period.

Based on our observations of the girls, they appeared to get some positive returns for their time and energy that they put into their group attendance. Over the weeks, they arrived on time for the group, and they gradually became more able to talk about sensitive issues like feelings. They made comments that showed that they were gradually coming to the realization that sexual abuse happens to lots of children, and this seemed to reduce some of their feelings of stigmatization. The girls did not come to trust each other to the point that there was much self-disclosure in the group sessions. One of the things that seemed to break the ice regarding talking about sexual abuse at a more personal level was the viewing of the film "Something About Amelia". We showed part of it one week and part the following

week. After this film they did talk more openly about how they felt about their abuse. Creative activities and physical activities appeared to be most helpful to the participants in finding ways to express themselves. The sessions were after school where they had been sitting most of the day and in addition to that, there was some anxiety for them in coming to the group. While they seemed to look forward to the sessions, they were aware that in group we were dealing with a sensitive and personal subject areas. They had a high energy level as they approached the beginning of group sessions. The creative activities presented gave the girls opportunities to release that energy in a helpful way, and enabled them to be more open to new learning.

The Cases

The following section of this chapter is dedicated to a description of the cases with which I was involved during this practicum. Each case description is divided into: presenting situation, family background, assessment, goals of treatment and interventions. The names of the girls and their families have been changed to provide confidentiality. My basic approach was to begin each session with a check-in with the client(s) on how their week had been, and what they would like to discuss during our session. I had an agenda of my own which was focused on the particular client's needs as I had assessed them. My agenda was always secondary to the client's and I tried to follow along with what the client wanted, while keeping my assessment of what they required as a guide throughout our sessions. I used every opportunity possible to empower the client by providing choices in therapy, even in small ways such as what game they would like to play, choosing where they would like to sit,

and getting feedback from them on various things. I showed them unconditional acceptance.

One technique which I used with all the clients during my practicum was to develop genograms (Carter & McGoldrick, 1982) and ecomaps (Hartman & Laird, 1983) with them. The genogram is a family map, giving lineage of parents and children, dates of births, deaths, marriages, separations, divorces, and separations of children. Persons who are living together in the same household can be depicted by drawing circular lines enclosing that nuclear family unit. The ecomap was a picture of the client in their own unique environment. With the client in a centre circle of the page, all their supports and stressors were drawn around them, inside circles. Institutions and situations, such as school, health considerations, recreation, and church, etcetera, can be included. Lines were drawn between the client and all the "bubbles" on the page. The ecomap was a snapshot of the client's social environment and helped me in assessing client supports and stressors, and also helped the client to assess her own world. It was fun and empowering to the client. The adolescents and mothers with whom I worked found these charts interesting and self-revealing. The process of completing them assisted in the establishment of a therapeutic relationship as we had an opportunity to engage in a positive, rather non-threatening activity together. In addition, I gained a wealth of information about their lives, their families, support systems, and negative factors and stressors.

Almost all sessions were videotaped, after receiving permission from the child and her guardian. All interviews took place at the Community Resource Clinic, with the exception of two family interviews at Alana's home and several sessions at the park, with Susan. A verbal contract was developed with each girl during the intake interview which outlined our

expectations of each other and therapy.

Alana

Presenting Situation

Alana, almost fourteen, was referred in March, 1991, by an intake worker from Winnipeg Child and Family Services. I received the referral two months after Alana's disclosure. In mid-January, 1991, she had disclosed to her school counsellor that she had been raped New Years Eve by a 21 year old cousin in her home. Alana also disclosed that she had been fondled by this cousin since she was four years old. This cousin was seven years older than Alana. Alana also disclosed at this time that her aunt's boyfriend had fondled her buttocks and breasts over her clothes several times during the past year.

Alana had previously disclosed two separate incidents of sexual abuse that had happened to her in her neighbourhood. These incidents of fondling had occurred at two different neighbours' homes and had included Alana's younger sister and a friend of Alana's. Child and Family Services were involved in the previous incidents. Child and Family Services became involved once more following Alana's disclosure to her school counsellor about the recent abuse. Alana was examined by a doctor near the end of January 1991, charges were laid against Alana's cousin, the alleged perpetrator, and services were offered to Alana's family. The family was referred to "Families Affected by Sexual Assault" at the Children's Home of Winnipeg. According to the social worker from Child and Family Services, Alana's great grandmother (her guardian) was cooperative with the agency, but she

was disbelieving of Alana's allegations and was blaming and unsupportive to Alana. This great grandmother did not take advantage of any help that was offered to the family.

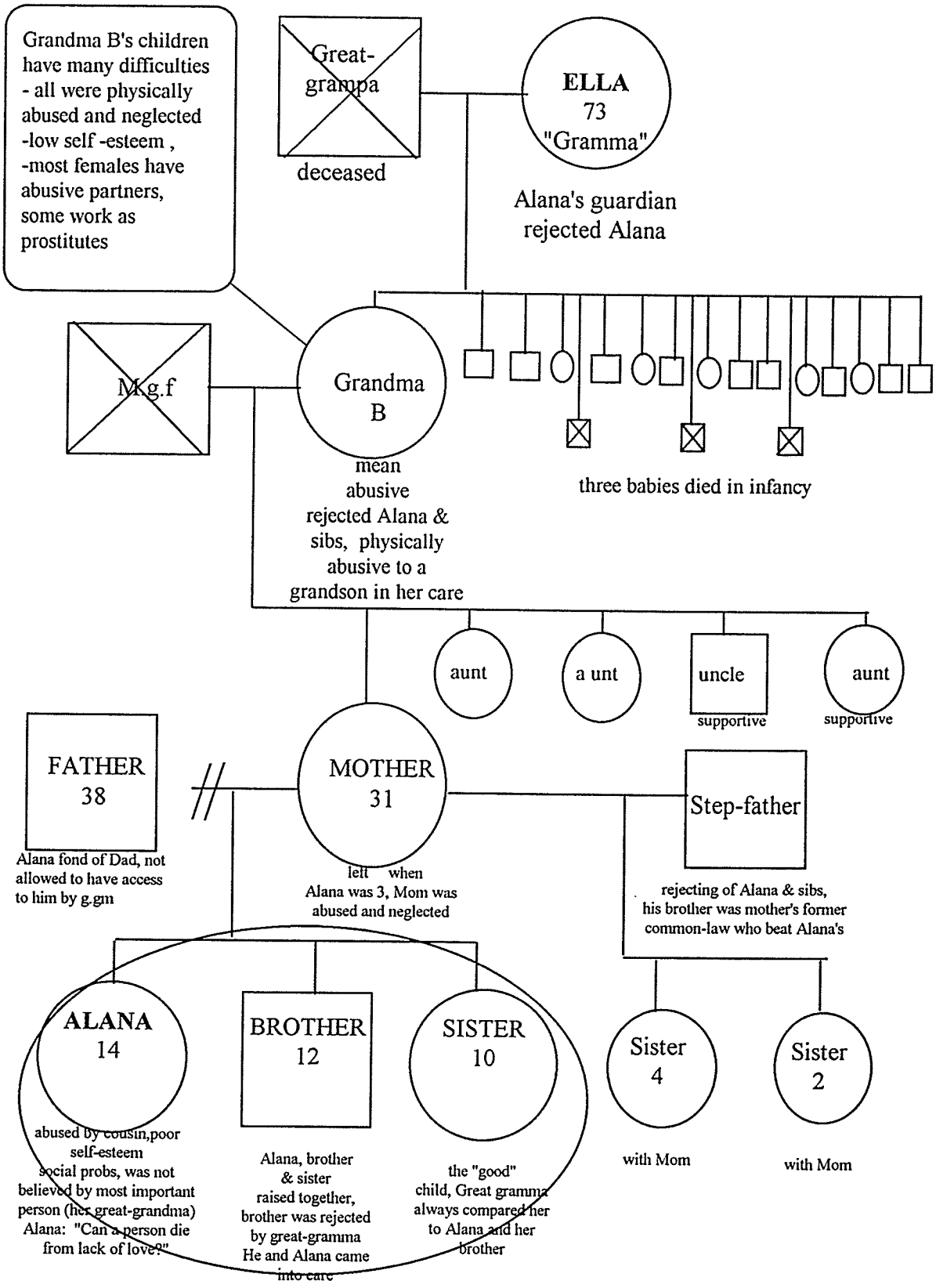
Family Background

Alana's family was well known in the Child and Family Services system for its past history of neglect and intergenerational physical and sexual abuse. Alana's mother had also been abused as a child and Child and Family Services and the school counsellor had been involved with her, as well as her brothers and sisters. Many of Alana's cousins were in the care of the agency and one young cousin had been sexually abused and murdered several years prior. The family members mostly lived in the inner city core area.

Alana, her eleven year old brother and ten year old sister, lived with their maternal great grandmother, Ella. They had been in Ella's custody since Alana was four years of age. "Gramma", as the children called her, was seventy-three years of age and had borne seventeen children, three of whom had died as babies. Ella, while she was the children's legal guardian, did not appear to take a great interest in the children's lives. She favoured Alana's younger sister over the other two children. Alana complained that her gramma never did any housework and expected the children to take care of the home, meals, and themselves. Alana complained that there was never any food in the house, or money for food, but her gramma often went to bingo games.

Alana was born when her mother was sixteen years of age. Alana's brother was born a year later and her sister was born the following year when their mother was nineteen. Their mother deserted them when Alana was three years of age. Alana's maternal grandmother was abusive to her children and grandchildren. According to the school counsellor, some of

ALANA'S GENOGRAM



Alana's aunts often came to school with bruises. The school counsellor described Alana's mother's family home as filthy, with five daughters living at home, three of whom each had three children. At least one of the maternal aunts was a prostitute.

When Alana was three years of age, her mother separated from their father who was physically abusive. She soon had another partner who, according to Alana, beat Alana's brother when he was two years of age. Their mother eventually left this man and was presently living with another common-law partner with whom she had two daughters who were four and two years of age. Alana felt rejected by her mother and resented her common-law partner because he was a brother of the man who had assaulted Alana's brother. Alana talked at times of going to live with her father or a married male cousin and his wife but neither option turned out to be viable. A genogram is included to further illustrate the family.

Assessment and Goals of Treatment

I saw Alana at the CRC almost weekly, from March 15 to June 27, 1991. In addition to individual sessions, Alana took part in the group sessions which were held during April to June. I also met with Alana and her social worker from Child and Family Services, once with Alana, her younger brother and sister and their great grandmother, and once with her great grandmother together with her youngest aunt. Any meetings with the great grandmother took place in their home. Dyad treatment with Alana and her great grandmother was not possible in this case because Alana's great grandmother saw Alana as a "liar and a trouble maker" and was not willing to engage in therapeutic sessions with Alana. She did meet with me, Alana and her siblings at the time of intake, and again after I had seen Alana

for several sessions. The purpose of this second meeting was to assess family needs and was to provide support to her and complete the Achenbach Child Behavior Checklist. I had hoped to develop rapport with her as well. The two Achenbach measures showed me that Alana was a well grounded adolescent who was fairly independent.

Alana was a very strong child in spite of all the difficulties she had experienced. She was well grounded in reality in terms of looking at her own behaviour and needs. Her responses on the Achenbach Checklist were consistent with those of her great grandmother's. Alana appeared to be cognisant of her requirements and the ability (or lack of ability) of her family and environment to meet these needs.

In respect to the last abusive event when she was raped by her cousin on New Year's Eve Alana stated that it was not her fault. She had tried to stop him but her cousin was bigger and stronger. Alana said she had screamed but no one heard her. Alana stated emphatically that she was not a "slut" as her grandmother believed, and that she is brave, pretty and intelligent. She did not like what happened because she knew it was wrong but he was too fat and heavy for her to push him away. Alana said she did not want to engage in sexual activities with older guys and that she does not do sexual things to little children. Alana said up until she was raped by him she simply liked the perpetrator as a cousin - no more and no less. She was able to recognize some anger towards her cousin, but was mostly confused about her feelings about him.

Alana completed the Achenbach Youth Self-Report for Ages 11 to 18. In it she indicated that she was average or better in running and playing baseball, football and soccer. Her hobbies were listed as volunteering, doing crafts and listening to music. Listening to

music was the most significant of the three. Alana played organized sports at school such as basketball, baseball and soccer. She indicated that she was good at babysitting, doing dishes, cleaning the house, making beds and cleaning yards. Alana reported having four or more friends whom she saw once or twice a week. She reported getting along with her siblings and other young people about the same as other children. Alana reported that getting along with her parents is not as good other children with their parents. She said she is better than other children at doing things by herself. Alana reported that she is average or above in all subjects but English. She had concerns with problems in algebra and with getting into fights at school.

Her behaviours were quite within the normal range for an adolescent and she was not the troublesome little "wretch" that she was described as by her great grandmother. In spite of her pseudo maturity, Alana desperately wanted to have the love of her great grandmother who she referred to as "Gramma". She saw her "Gramma" as cruel and withholding of love. The most helpful instruments in determining her feelings were the Achenbach Child Behaviour Checklist and Youth Checklist. Alana's aunt and great grandmother completed the parent form of this scale and Alana completed the youth's form.

The basic themes that emerged for Alana were:

Damaged goods syndrome - Alana constantly put herself down and had integrated the negative messages she was receiving from her gramma. After she was sexually assaulted by her cousin she was sure that she was inferior and damaged beyond help.

Guilt - Alana felt a great deal of guilt. She felt guilty for telling, guilty for causing trouble in the family and guilty for the sexual assault.

Fears - Alana experienced many fears. She lived in a multi-problem neighbourhood and had

no safety even in her own home where she had been abused over the years. She was not believed and protected by her own great grandmother. Her cousin had been raped and killed several years earlier at the age of three. Alana had been very close to that cousin, was traumatized by her death and had valid fears about her own personal safety.

Depression - Alana showed some depression. On the surface she appeared to be a happy, cheerful adolescent. Some of the signs of depression which Alana showed were, great difficulty concentrating in school, sleeping difficulties, and nightmares.

Poor self-esteem and poor social skills - Alana was getting into many fights at school and would be suspended if she got into another fight. Alana expressed anger, although she was very careful in expressing it.

Impaired ability to trust - Alana did not believe that there was anyone to whom she could turn. She was believed by some family members, but was not believed by many family members, including the most important person of all to Alana, her "Gramma". She did not trust her peers and was constantly in trouble with them. She talked about girls trying to beat her up.

Pseudo maturity and failure to meet developmental tasks - Alana had a great deal of responsibility at home and she worried about her siblings, and her cousins who were in the care of her maternal grandmother. On the outside, Alana was a very competent, independent adolescent. Underneath, which became exposed during therapy, Alana was a frightened child who wanted attention, protection and love from her "Gramma".

Interventions

Alana was cooperative in coming to the clinic on a regular basis for individual sessions. She

also was one of the more steady attenders in the group sessions, and attended every group session. She was open to talking about her ongoing difficulties of day to day living. These focused mainly on her troubles at school, at home and her low self-esteem.. She was getting into fights at school and was in danger of failing grade eight. Alana had no support from her great grandmother. Her main source of support was from the school counsellor, a few friends, and a few aunts who believed that she had been abused. Alana was getting into trouble with her "gramma" because of her disclosure of abuse, and all the "trouble" it caused for the family. She was also getting into trouble with her gramma because of what appeared to be normal, adolescent activities ("hanging around" with boys and girls her age, not doing all the housework, not coming home on time). It appeared that Alana's great grandmother may have provided adequate care to the children when they were little, but could not deal with their behaviour after they began to reach some normal developmental milestones in middle childhood and adolescence.

One strategy that helped in my work with Alana was the use of board games. I found games such as "Trouble" and "Checkers" to be the most helpful. Alana appeared to relish the individual attention she received in therapy while we played the games. Concentrating on the game at hand appeared to relieve some of Alana's tension and enabled her to talk more freely about her issues. Writing letters together was also was a way for Alana to deal with some of her fears and feelings about relatives who had betrayed her. The letters were not intended to be mailed, but Alana had that option, if she chose. Some of the areas in treatment on which we focused were, who in the family she could obtain support from and who believed her, learning more positive self-talk to replace the negative self-talk that she used. This

negative self-talk was a result of the guilt and shame that she felt for "allowing" the abuse to happen, and the very low self esteem from which she suffered. She had received many negative messages from her great grandmother over the years, and this had increased following the disclosure of abuse.

A large component of my work with Alana was crisis intervention. Since Alana had disclosed her abuse, her life had been thrown into turmoil. Part of my intervention was to liaise with her social workers from Child and Family Services and the school. There was a complementarity in our roles; assessment and clarifying individual tasks was an important piece of our communications. Together we identified physical and emotional supports to the family which could be implemented. The social worker from Child and Family Services obtained a parent aide to help the grandmother over the summer. Alana's family system was lacking in all areas and the task of finding positive role models and emotional supports from within her family system was challenging. Alana's membership in the adolescent group was very important to her as the group actually took the place of family for her on a temporary basis.

During the time Alana participated in treatment, her life was in crisis. She later disclosed physical abuse of her brother John by their great grandmother during our sessions. Subsequent to this, John and Alana were removed from their great grandmother's home and placed into foster care. John was placed in a foster home (which he loved because there was lots of food) and Alana was placed in a group home. I had hoped that Alana would feel that she was supported and believed after coming into care, but she continued to have difficulties and began to act out her frustrations. She needed to be shown that the staff in her group

home could provide her with some acceptance and security, unlike her gramma, who had "washed her hands of the troublemaker".

Assisting Alana in finding supports in her life and encouraging her to talk about her feelings and fears helped Alana to cope for the time being. She was in no way ready to deal with much of the sexual abuse that she had experienced. I believe that the most helpful thing for Alana was her participation in the group. She found it to be a place of safety and acceptance. Her self-esteem was improved slightly and she her feelings of isolation and stigmatization were lessened through her work in the group. The group served as a "family" while it was in existence.

Measures

Rosenberg Self-esteem Questionaire:

	T1	T2
Score	16	19

Alana completed the Rosenberg Self-esteem Questionaire on April 18, 1991 (T1) and again on June 21, 1991 (T2). Her first response to the statement that she was a person of worth, at least on an equal basis with others was to strongly agree. This response softened to just agree on the second completion. On both occasions she indicated that she agreed to having a number of good qualities, she strongly disagreed that she was inclined to feel like a failure, she strongly agreed that she was able to do things as well as most people, she disagreed that she did not have much to be proud of, she agreed that she felt useless sometimes. On the pretest Alana disagreed that she took a positive attitude toward herself. On the post test she felt better and said that she agreed with this score. In April Alana strongly disagreed that she

was satisfied with herself and in June that feeling had improved to where she agreed that she was satisfied with herself. On the T1 she indicated that she strongly agreed that she was no good at all and by June (T2), this feeling had ameliorated to where she agreed with the statement. In comparing the two Rosenberg Self-esteem Questionaires they show that she was unchanged in six of the ten items and showed improvement in four of the items. Alana's T1 score for this scale was 16 and her T2 score for this scale was 19. Alana showed an improved self-esteem over the five weeks that intervened between the completion of the same instrument.

Impact of Event Scale:

	T1	T2
Avoidance	18	-
Intrusive	24	-

Alana scored 24 on the Intrusive subscale of a possible 28 points, which would indicate that she was often bothered by thoughts about the abusive event. She said that she often thought about stressful life events when she did not mean to, she often had trouble falling asleep because of pictures or thoughts, she sometimes had waves of strong feelings about it, pictures about it sometimes popped into her head. This score helped me to see that Alana was having difficulties on a regular basis with thoughts, memories and feelings about the abuse which she experienced. Alana's score for Avoidance was 18, out of a possible 32 points. She said that she often tried not to think about it, she was often aware that she still had a lot of feelings about it but didn't deal with them. Alana scored less in the Avoidance subscore which showed me that she was not denying that she had been abused and was likely

to be willing to engage in therapy to deal with the affects of the abuse.

Sexual Abuse Awareness ("Things to Think About, Things to Learn"):

	T1	T2
Score	17	20

Alana completed a true/false instrument entitled "Things to Think About, Things to Learn" at the beginning and end of the psycho-educational group. This was a series of 21 true or false statements that gave a baseline for a person's knowledge about sexual abuse. Alana showed an excellent understanding of the basics surrounding sexual abuse. In the pretest she incorrectly agreed that most offenders stop abusing after they are caught; she disagreed that a child who is sexually abused may be more vulnerable to being abused again; she disagreed that a child who has been sexually abused may sometimes act out what happened to them with other children; and she disagreed that children who are abused sometimes think that they are ugly or look different than other children. She made only one incorrect response on the post test which was that she disagreed that a child who has been sexually abused is vulnerable to being abused again.

Summary

Alana was a feisty young lady who appeared to be quite cheerful on the exterior but she was experiencing a great deal of fear and pain. Alana was raped by a trusted third party who was her cousin. She also had experienced other forms of sexual abuse by several neighbours and another trusted third party who was her aunt's boyfriend who lived with the family.

Intervention with Alana consisted of crisis intervention as the referral came shortly

after she had disclosed her abuse to a school counsellor. There were several family factors involved that complicated Alana's treatment. Her family had been known to be very abusive. Alana had experienced physical abuse as a baby and had received a fractured skull. Her brother had been physically abused by her mother's common law partner who threatened to kill all the children. Their birth father had been violent to their mother and Alana's young three year old cousin was sexually assaulted and killed in the downtown area of Winnipeg. Alana had very few supports. Her great grandmother, who was her guardian, was verbally, emotionally and physically abusive to Alana, her brother and sister. Alana was betrayed by her cousin who sexually assaulted her and she felt doubly betrayed when her great grandmother did not believe her. In one therapy session when Alana was concerned about her rejection by her great grandmother she asked if a child could "die from lack of love". On another occasion as we developed a list of all the people who believed her, Alana said that the most important person of all did not believe her, her great grandmother.

Alana participated in individual and group therapy. In individual therapy I attempted to build up her self-esteem, help her to understand the dynamics of abuse, and bolster her environmental supports. During the course of treatment Alana came into care of Child and Family Services. I am not sure what impact this had on her treatment. In one sense, coming into care showed her that there were people who wanted to help her. Over time in care, with the support of her social workers, she may have come to realize a level of safety that would help her to address her abuse issues. Initially, her school counsellor was Alana's only source of emotional support. She had many stressors impacting on her during her treatment. There was the rejection by her family because of disclosure of abuse and also the stress of an

impending court case against the offender. In addition to that, she and her brother had been removed from their guardian's home and placed into foster care, causing more situational stress and requiring further adjustment.

Alana was open about her feelings and appeared to enjoy individual and group therapy. I believe she benefited from both types of therapy and they complimented each other. The main issues that Alana dealt with in therapy were the chaos in her life because of her disclosure, and her rejection by her great grandmother. The abuse itself had a severe impact on her, but it was secondary to the emotional abuse which she received from her great grandmother. There was intergenerational abuse and high denial in the family which, together with other factors, would indicate that Alana would require long term therapy.

Susan

Presenting Situation

Susan, almost thirteen years of age, was referred by a social worker at Ma Mawi Wi Chi Itata in late March 1996. The year before, in June, 1990, Susan disclosed to her school counsellor that she had been sexually abused by her uncle, who was married to her mother's sister. Eight months prior to this Susan had disclosed to her mother, Eadie, but her mother had ignored the disclosure. Susan said that the abuse began when she was six years old, started as fondling, and progressed to intercourse. The abuse was frequent and occurred when she stayed overnight at her aunt's and uncle's. Susan said she kept going to her aunt's and uncle's house because she wanted to play with her cousins who were about the same age as Susan, and were more like her sisters and brother. The uncle was convicted and was

sentenced to a six month jail term and three years probation. Susan was required to testify in court against her uncle.

Family Background

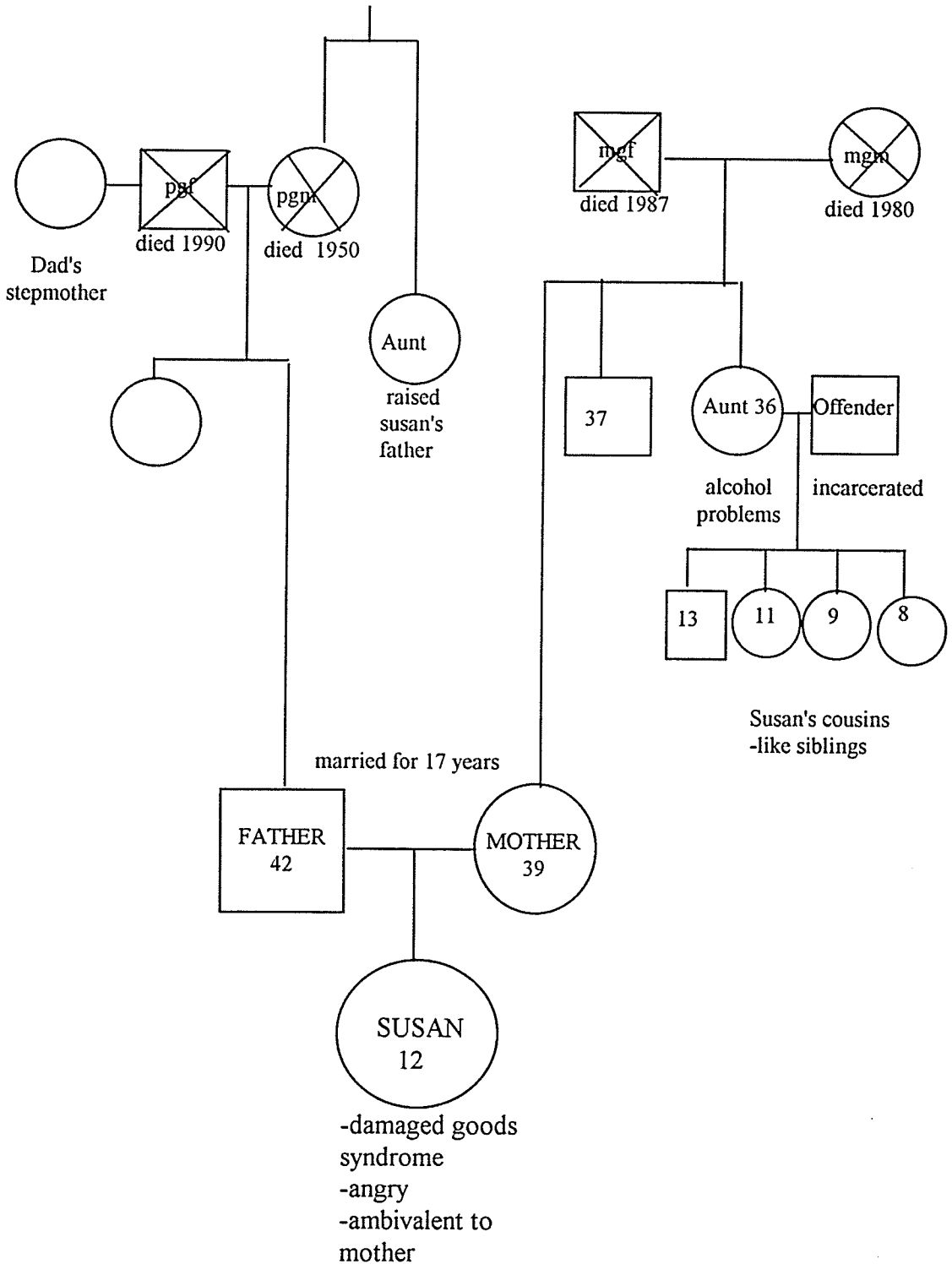
Susan's parents had moved to the city from their northern First Nations community shortly after their marriage. Susan was the only child of her parents, who had been married for 17 years. Her father worked in railroad construction and was away from home for six months of the year. It appeared that he was an absent parent even during the time that he was in the city. He abused alcohol at times, and spent a great deal of time away from the home even when he was not working, such as going to the library downtown and reading. Susan and her mother formed a subsystem in the family which appeared to be stronger than the marital subsystem. Susan's mother had worked as a homemaker for a local housing authority for 12 years.

Susan's mother expressed some sadness about not believing Susan when she first disclosed the abuse, but her main concern appeared to be for her nephew and two nieces who were now in foster care. The mother of these children, who was Eadie's sister, had been drinking heavily after the Susan's disclosure. Her husband had been removed from the home and the children placed into care of Child and Family Services.

Assessment and Goals of Treatment

One of Susan's main sources of emotional support appeared to be her school counsellor. Susan had a good relationship with this counsellor and was allowed to leave the classroom and go to her office whenever she needed to do this. Susan participated in a breakfast and lunch program at school, and was a crossing monitor. Susan had received awards for her

SUSAN'S GENOGRAM



services as a crossing monitor, and this was helpful to her frail self-esteem.

Susan began therapy at the clinic ten months after she had disclosed her abuse to the school counsellor. Therapy was short term rather than crisis intervention. Her worker from Ma Mawi Wi Chi Itata Centre helped the family at the crisis stage. Susan came to see me with her mother six times and by herself five times for a total of 11 sessions. The sessions were held from early April until late June of 1991. Susan was invited to the group sessions and attended one session. Susan lacked the confidence to come to group sessions. She did not refuse to come, but had several excuses such as headaches or other illness as reasons for not attending. During the group session that Susan attended, it was evident that she was very self conscious. She was an overweight child and was the only Native girl in the group. These two factors undoubtedly played a role in Susan's withdrawal from the group.

In the Achenbach Youth Self - Report Susan described herself as a Native girl who enjoys riding her bike and playing badminton. Her interests included reading, playing cards and just walking around with her friends. She stated that she spent more time reading than the average girl of her age. Susan did not belong to any organizations or clubs. She earned her spending money through babysitting, making lunch and feeding the cat. She had two to three close friends and saw them three or more times per week. Susan compared herself favourably to others of her age when she rated herself as about the same or better in terms of getting along with her cousins, other kids, parents and doing things by herself. She rated herself as average in her school subjects except for science and French where she was below average.

Susan had ambivalent feelings toward her mother. She stated the her mother was

supporting her in the present but could not understand why her mother did not believe her when Susan first disclosed the abuse. Susan stated that her mother is nice and recognized that her mother was angry at the offender. Understandably, Susan was having difficulty comprehending why her mother kept being friends with the perpetrator after she had disclosed the abuse.

Susan expressed her feelings about her uncle who had abused her. She knew that he had beat her aunt on a number of occasions and she was afraid that he would beat her also. Susan stated that she had liked her uncle before the abuse started but he had hurt her physically and now she was afraid of him, she hated him and wished he would never get out of jail.

Susan was very self conscious about her appearance because of being overweight. However, she appeared to have a positive perspective about herself as was disclosed on the Rosenberg Self-esteem Questionaire. She agreed that she is a person of worth with a number of good qualities, that she is able to do things as well as most people, that she has a positive attitude toward herself and in general she feels satisfied with herself. She did admit to wishing, strongly, for more respect for herself. Susan disagreed strongly with the statement that she is inclined to feel like a failure. She disagreed with the statement that she does not have much to be proud of. Susan disagreed that she feels useless at times and also disagreed that she thinks she is no good at all. Susan's total score on the Rosenberg Self-esteem Questionaire was 19. The highest possible is 30. I did not do a post test with Susan for this measure. I had planned to do post tests with her at our last meeting. Unfortunately, I had not seen Susan for several weeks prior to termination, and our last session was planned as a

picnic with her mother.

Susan did not trust men, and stated that her father is the only man she trusted. Susan described herself as being responsible, laid back and relaxed, friendly, kind, sharing, rather shy, softhearted and at times greedy. Her stated perceptions of herself were much more positive than what she showed by her behaviour. Susan often said derogatory things about herself and her abilities. She was self-conscious about her appearance and always wore bulky clothes, even when the weather was hot. Sometime in June, Susan tried to run into the traffic and was restrained by her friends. She was having a very difficult time dealing with the many issues which preoccupied her thinking. Susan was very quiet and shy and had difficulty in talking about the abuse she experienced by her uncle. Susan required long term therapy, but my intervention with her was short term. Short term treatment goals for Susan were to help boost her self esteem, to facilitate communications between Susan and her mother, to help her to identify her feelings about her mother and her abuser and verbalize these in helpful ways. I also wanted to help Susan to clarify and identify some of the issues that were providing the most angst to her and find some ongoing things that she could do for herself about them. Some of the issues that were identified for treatment were:

"Damaged goods" syndrome - Susan felt badly about her body image because of her problem with overweight. This exacerbated the problems that she was having about feeling dirty, unlovable, unwanted, damaged in a way that nobody would ever want to be her boyfriend or marry her some day. Susan felt stigmatized by the abuse and felt like everyone who saw her knew what had happened to her.

Poor social skills - Susan tended to isolate herself and had difficulty in expressing her needs.

She was shy and suffered from physical complaints as ways of dealing with things that she found difficult.

Betrayal - Susan felt betrayed by her uncle, who had been a trusted family member. She felt very betrayed by her mother, who was her main source of love and support. She was extremely jealous of the relationship which her mother had with her cousin Lee, although Susan and Lee were very close.

Repressed anger and hostility - Susan was angry with her uncle, and this was repressed to the degree that she had difficulty expressing her anger. She was angry and confused about her mother not listening when she first disclosed the abuse. Her mother continued to be friendly with Susan's abuser. Susan had difficulty expressing her anger about this to her mother.

Fears - Susan had many fears . She was afraid of her uncle, and was afraid that he would come and hurt her once he was released from jail. Susan knew he was a violent man. Susan's mother was planning to move into a larger house so that she could take in her sister's children who were in care. Susan had many fears about this move and was afraid that her father would not be able to find them when he came back to Winnipeg. She was afraid that her mother would give all her attention to her cousins once they moved into her home.

Guilt -Susan felt guilty for "letting" her uncle abuse her. She felt guilty about testifying in court and for him going to jail. She felt guilty for telling which ended the abuse, but which totally disrupted her aunt's family. She felt responsible for her cousins being in foster care.

Depression - Susan showed signs of depression which were more evident in her behaviour than what showed in the measurements she had completed. She attempted to jump in front

of traffic to hurt herself. This was a strong indication of the depression and hopelessness that Susan was experiencing.

Interventions

Establishing trust with Susan was one of the major challenges in therapy. Susan related well to me, but she appeared to be uncomfortable at the clinic and we sometimes walked over to a nearby park for our sessions. Susan may have been more comfortable in a Native setting (the present ambiance at the clinic, with Native posters and pictures would have made that setting more comfortable for her). She may have enjoyed participating in a group comprised of Native girls, if that were available. She was able to verbalize and work on her anger towards her uncle, but she had great difficulty in dealing with her anger and hostility toward her mother. Some of the things that we did in therapy involved identifying her confused feelings about her uncle, mother, father, and cousins she loved, but with whom she resented sharing her mother's attentions. Identifying feelings and putting negative feelings about her uncle "in a box" and "sending" them to him in jail was positive for Susan. She liked to sit on the floor and work on large flip chart paper. Because she had no confidence in drawing and felt inhibited by this, I participated in drawing with her. She became quite comfortable drawing with me after she saw my humble attempts. Susan enjoyed showing her mother things that we did and explaining these to her when we had joint sessions. Every other session included Susan's mother. I knew that our time together was of a short duration and anything that could be done to help communications between the mother and child would be helpful to Susan over the long term. I established a relaxed rapport with the mother and provided encouragement to her in parenting Susan and helping Susan with the aftereffects

of her abuse.

Susan became more comfortable at the clinic after we began to work together in the play therapy room. This had not been planned, but one afternoon Susan saw the play room as we passed by the open door. She became animated and said, "Wow, a person could go back in time here!". Following that discovery, we held all our sessions in the play room, even sessions which included her mother. We all sat on little chairs and worked at a little table and used whatever toys Susan wished to use. She was very excited about this room and it seemed to provide her with a sense of safety and security. It was small and cozy there. The themes that emerged in the playroom were the helplessness and powerlessness that she felt. It was much easier for Susan to work on her issues in this room, which was a safe haven for her. This safe place provided her with the opportunity to go back and experience some of the childhood that had been stolen from her by the abuse.

Summary

I was engaged in short term therapy with Susan, who had suffered very intrusive abuse over a span of six years. Her abuser was a trusted family member who was in jail at the time of her therapy. Susan was very angry but also fearful of her abuser. Her mother was her main source of emotional support, but Susan also felt betrayed by her mother because of her lack of response to Susan's disclosure. Other sources of help and encouragement were a school counsellor, a worker from the native agency who had assisted with the crisis intervention and a big sister from the Big Sister organization. Other factors which affected Susan's therapy were, the lack of involvement from her father who was away most of the time, and the fact that the family was going to be moving to a new home. A large part of the

guilt that Susan felt was because of the separation of her uncle's and aunt's family because of her disclosure of the abuse. Another complicating factor for Susan was the fact that she had participated in her uncle's trial, where she was required to testify against him and he received a jail sentence.

Susan's therapy included individual counselling and mother/daughter dyad therapy. Susan's mother attended therapy sessions with her on alternate weeks and with Susan attending by herself at other times. The mother/child therapy appeared to be the most helpful as their communications with each other became more open and clear. Susan was able to tell her mother about her fears and about her feelings which she had previously been unable to communicate.

Mary

Presenting Situation

Mary, eleven and a half years of age, was referred by Winnipeg Child and Family Services in February, 1991. She had recently disclosed abuse by her stepfather and he had been removed from the family home. Mary's disclosure of the incident came about two weeks before her referral to my practicum. The family was experiencing a crisis because of the disclosure. Mary had developed a "Gulf War neurosis" and had been coming to her mother at various times since this war began, confessing "sins" that she had committed. She was afraid of going to Hell. The omnipresence of the Gulf war on TV had made Mary fearful that the world was coming to an end and she would be faced with the consequences of all her "transgressions". Most of these "sins" were minor things that all children tend to do, such

as telling a little lie, or taking something that was not hers, or arguing with her younger brother.

Finally Mary disclosed that she and her stepfather had been playing a "bad game". She had difficulty telling about this, but had to get it off her conscience. The "game" had consisted of playing tag in the darkened bedroom and pulling pants off when a person was caught. Mary's younger brother Al was also involved in this incident. Social workers from Child and Family Services had interviewed both Mary and her younger brother separately at school. The abusive incident occurred in the evening when the step-father had both Mary and her younger brother in the master bedroom. The details of the event were vague because Mary did not want to talk about it and her brother said it was dark in the room and he had not seen anything. The incident had occurred when Mary was ten, about one and one half years prior to Mary's disclosure. Mary's mother took appropriate action and notified Winnipeg Child and Family Services. Social workers interviewed the children and other family members. Jake, the children's step father denied that he had done anything, but he was told to leave the home. Mary was very distraught about the whole situation and felt guilty about the aftermath of her disclosure. However, she felt better about her conscience and was not as fearful of Hell after disclosing.

Family Background

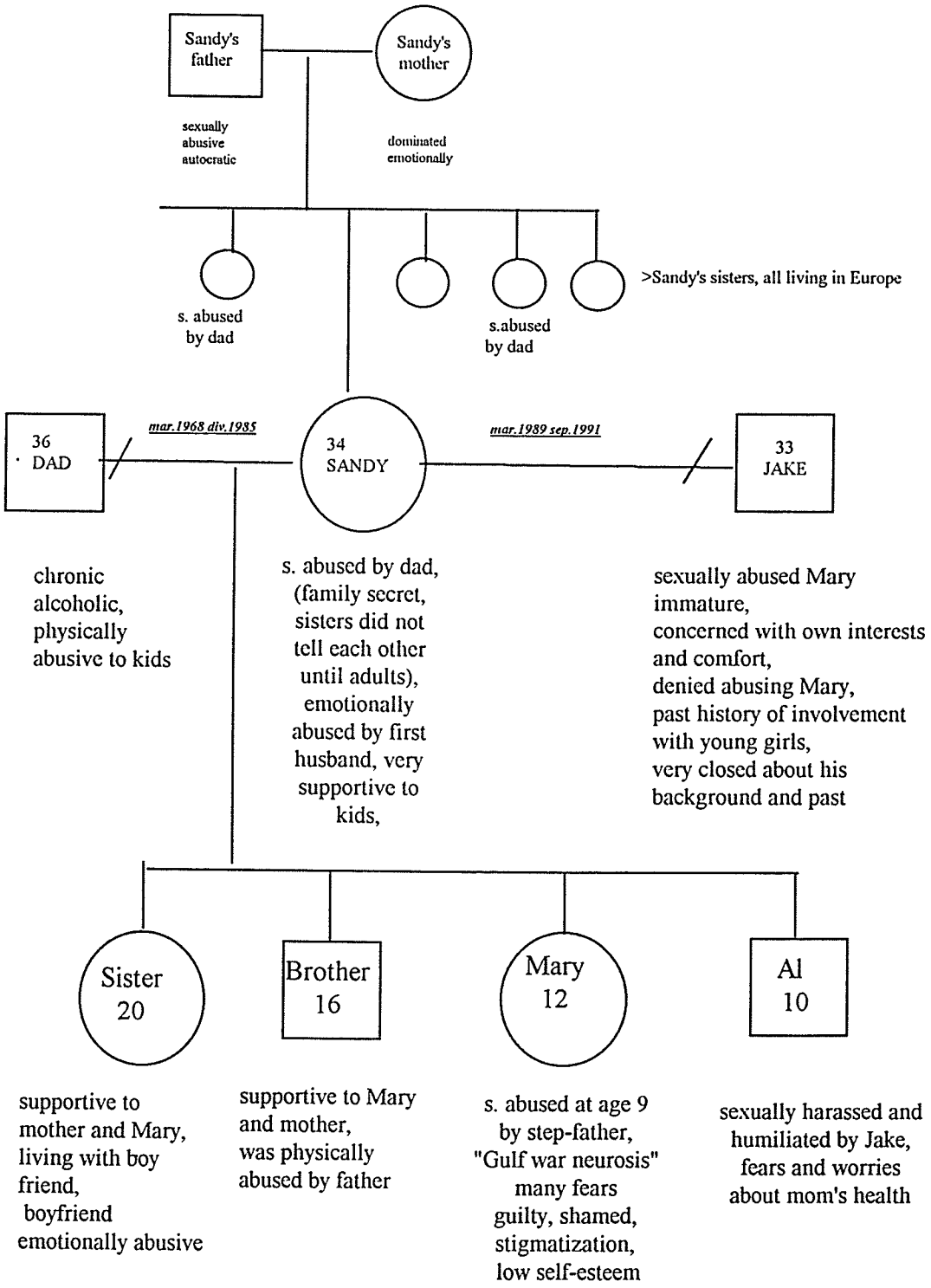
Mary lived with her mother, a seventeen year old brother and a younger brother of nine. She had a twenty year old sister who lived independently. Mary's parents came to Canada from Britain after their marriage and the birth of the two oldest children. Two more children were born after the family settled in Canada. The children's father was alcoholic and

physically abusive to the mother, oldest son and daughter. Mary's mother, Sandy, left her first husband and eventually divorced him. He maintained very little contact with his children and continued to abuse alcohol to the point that it affected his health and ability to work. He never assisted financially with the children and Sandy worked at several jobs to provide for the family. At the time of this practicum, Sandy worked in a clerical position in a medical setting.

Sandy's family of origin was abusive. Her father was dominating and he had sexually abused her and some of her sisters. She had also been sexually abused as a child by a minister. The family was very religious and the superior role of males over females was supported by the religious community and cultural traditions.

Sandy married her second husband Jake after a short courtship of six months. They had met through a dating service. Jake was handsome, attentive to Sandy, and he liked the children. He had many debts which he brought into the marriage with him. After several months problems began to surface. Jake showed self-centered, immature and childish behaviors. He lost interest in any sexual relationship with his wife and appeared disinterested in family life. He often spent money on things for himself which he did not need, like sports equipment, and left his bills unpaid. After Mary's disclosure, Jake was told to leave the home. He begged and pleaded to be allowed back into the home. This put great pressure on Sandy, who had come to feel responsible for taking care of Jake. Over the course of two years of marriage, Sandy had assumed payment of Jake's debts, had found him to be abusive to her children, and was financially and emotionally bankrupt. The financial bankruptcy was humiliating to Sandy because prior to this marriage she had worked at several jobs to support

MARY'S GENOGRAM



her children, had become debt free and purchased a house. She had to give up the house and receive "financial counselling" as a part of the bankruptcy requirements. In addition, Sandy eventually realized that this handsome, immature man she had married was more interested in her children and had likely married her because of his interest in her children. After the abuse of her children was disclosed, Sandy discovered that Jake had molested the sixteen year old daughter of a former common-law wife.

Jake continued to have contact with the family and Mary did not like being around Jake because she felt like "it" might happen again. Jake eventually was allowed to move back into the home and this presented an immense obstacle for Mary in her treatment. Sandy believed Mary and supported her, but she wanted to give Jake one more chance. Her religious background taught her that " love could conquer all". Having Jake back in the home put Mary into a state of intense confusion and stress.

Assessment and Goals of Treatment

On the Achenbach Child Behaviour Checklist for ages 4 - 16, Sandy described her daughter in the following way. She stated that Mary participates in baseball, swimming and biking and compares favourably to other children her age. Mary's favourite hobbies as perceived by her mother were singing, reading books and doing art work. Mary was above average in art and reading. And was busy with organized activities. She belonged to a community club, a dance club, a map club and a computer club. Mary did chores around the house. Some of them were raking the front lawn, keeping her room tidy; washing dishes, dusting and vacuuming.

Mary had two or three good friends who she saw once or twice a week. Mary got along with her brothers and sister and other children as well as other young people her age. Her mother believed that Mary obeyed her parents and got along well by herself better than other children her age. In school Mary was above average in English, math, French and geography. She was somewhat below average in writing and average in spelling and science.

Mary's mother presented as a competent, caring mother who was protective of her children. At the time of disclosure she told her husband to leave the house and was not sure if she would allow him to return, even if he received treatment. Sandy was very concerned about future abusive incidents when Mary became a teenager. Mary and her mother received strong support from the eldest son who offered to contribute financially to the household, although he was saving for university.

Mary and her brother were not in danger from their step-father even if he were to return home because the mother did not trust him, and she would not leave her husband alone with the two younger children. Sandy told me that she was seriously considering a permanent separation from her husband in the near future, and eventually she followed through with this plan.

When Mary was asked what the good things were about herself she replied that she was good looking with nice brown hair, she liked the colour and length of her hair. Mary liked getting along with boys. She stated that she was nice to people and had a good sense of humour. Mary considered herself talented. She liked to draw and was good at it. She had a good voice and enjoyed rap dancing. Mary said she was good at mathematics. She believed she had a great mother and she just likes being!

Mary's assessment of herself as reported in the Achenbach Youth Self-Report for Ages 11 to 18 was very similar to how she was described by her mother on the Achenbach Report for Parents. The one thing that was different was Mary's admission that she did not do well in her gym class. She believed she was having difficulty because she was not muscular.

Issues which Mary needed to address in treatment were:

Fears - Mary was afraid of going to hell for having been "bad". She was afraid that Jake would do things to her again, afraid of the family financial situation, afraid that her mother would get sick from trying so hard to earn enough money for the family on her own. She did not feel safe in the house that they had bought after her mother's marriage to Jake, and she often heard noises at night.

Guilt - Mary felt guilty for "doing bad things with Jake", for telling, for not telling sooner, for the family being disrupted and having to be involved with Child and Family Services. Mary's heavy sense of guilt was disproportionate to the degree of abuse that she described.

Stigmatization - Mary felt that everyone knew what had happened to her. She was stressed out at school because of this stigmatization and because of all the thoughts and worries that constantly rushed through her mind. She often arrived home from school crying.

Low Self-esteem - Mary scored high on the Rosenberg Self-esteem Questionaire, but she felt badly about herself and constantly put herself down.

Intervention

I saw Mary alone for ten sessions, Mary and her mother for six sessions, mother by herself for three sessions and on one occasion I saw the mother and her husband, the

perpetrator. Mary, her mother and her younger brother came to see me for one session. These sessions were in addition to the group sessions in which Mary participated. Child and Family Services determined that Mary was safe at home even if her step-father were around. Her mother would not leave the two younger children home alone with the perpetrator and was in the process of terminating her relationship with him. However, the presence of Jake in the home brought any hopes of dealing with sexual abuse treatment issues to a grinding halt. Mary was so stressed by having this man around that she could only deal in therapy with bits and pieces of talking about her feelings and trying to find ways to feel safe.

After being in treatment for several months, Mary disclosed to me that she remembered more about the abuse by her stepfather. She said that her step -father had locked the bedroom door when the "game" began, had pulled down her swim suit and had touched her private parts. Al, Mary's brother, did not seem to be disturbed by the event. He saw it as a "silly game" and besides the lights were off and he really did not see anything happen. Mary's brother Al later told his mother that Jake had done more things to him. He said that Jake would poke him in the genitals with a hockey stick or other objects and constantly made derogatory comments about Al's "maleness" and belittled the size of his genitals, in addition to other put downs. After these disclosures, Sandy was more confident in insisting that Jake leave the home for good, and was not willing to consider having him back, even if he obtained treatment for his problems. This was a brave move for Sandy, because she feared that she be lonely as a single mother once more, and she would have less of a monthly income without Jake in the home. On the positive side, she knew that she had to support her children through the disclosures and in working through the abuse. Once Jake left the home for good,

therapy continued at a better pace, but it was only for a short time before the practicum was ended.

During the practicum I worked with Mary on improving her self-esteem. We attempted to bring the event out of the "closed closet" each week and discuss some of what happened. This part of the plan would be determined by Mary's comfort in discussing the abusive event. Concurrently, we would introduce the terminology of pertinent body parts to assist Mary in discussing the abuse. We also talked about Mary's self-esteem, the impact of the event, and the influence the event had on her functioning as an 11 year old girl.

Mary was a regular attender at the girls' group. She participated well and seemed to find the activities fun. She was verbal about her opinions. Being in the group helped Mary to deal with the guilt and stigmatization that she felt. She realized, after meeting the other girls, that nobody can tell that one had been abused by looking at them. Intervention with Mary and her mother was multi- modal. Mary was involved in individual treatment, she and her mother were involved in sessions together, and Mary was taking an active part in group treatment. A large part of my intervention with Mary was to indirectly bolster her environmental supports by providing encouragement to her mother. This enabled her mother to show more strength and energy in supporting her children through the crisis. A large portion of my work with this family was assisting them in dealing with the crisis of disclosure and ensuing events. The disclosure had come just weeks before the family was referred to the clinic and they were dealing with disruption of the marriage as well as Mary's abuse. After Mary disclosed more about her abuse to me in therapy, I assisted Mary, her brother, and her mother throughout the investigation which followed after this second disclosure.

Some of this assistance was practical, such as driving the children and their mother to the agency for interviews. The family needed assistance in dealing with the social workers and police, getting referrals to the school psychologist for the fall, and in many other little details that often became overwhelming to the family.

Measures

Rosenberg Self-esteem Questionaire:

	T1	T2
Score	26	24

On the Rosenberg Self-esteem Questionaire Mary agreed that she was at least on an equal footing with others. She also agreed that she does things at least as well as other people, that she is satisfied with herself. Mary strongly agreed that she has a number of good qualities and that she has a positive attitude toward herself. She disagreed that she does not have much to be proud of and she strongly disagreed that she is inclined to be a failure, that she could have more respect for herself, that she feels useless at times and that she thinks she is no good at all. Mary's assessment of herself on the Rosenberg Self-esteem Questionaire is not in agreement with a number of other assessments of herself. Her "war neurosis" and her strong sense of guilt about what she has done in the past are contrary to the results of the Rosenberg Self-esteem Questionaire. Mary's mother was with her when she completed the Rosenberg Self-esteem Questionaire and she believed that Mary was completing the report based on what we would like to hear. Her mother did not believe the results because Mary often came home from school crying and feeling badly about herself. Sandy's viewpoint of Mary's self-esteem was supported during therapy sessions. One time Mary drew a picture

of herself and described the girl in the picture as one who has a right to be worried about every single thing. The girl in the picture was described as feeling that she is a disgrace, that she does everything wrong and everything in her past is coming to get her. The girl felt that her conscience was "eating her up". The post test score of 24 was still fairly high, but was possibly moving closer to where Mary actually felt about herself. In comparing this score with statements that Mary made about herself, the Rosenberg Self-esteem questionaire did not appear to really reflect how Mary viewed herself.

Impact of Event Scale:

	T1	T2
Avoidance	24	26
Intrusive	16	17

On the Impact of Event Scale Mary indicated that she was deliberately blocking out thoughts about the abusive event. She responded as "often" avoiding letting herself get upset when she thought about the event. She often tried to remove it from memory and stayed away from reminders of the event. Mary tried not to talk about it or think about it. Mary said she sometimes had trouble falling asleep or staying asleep because of pictures or thoughts that came into her mind. She sometimes had waves of strong feelings about the event and pictures sometimes just popped into her mind. She was sometimes reminded of the abusive event by other things and sometimes was aware that she had a lot of feelings about her abuse but had not dealt with them. She admitted that sometimes her feelings were kind of numb. Mary's post test scores for both the Intrusive and Avoidance subscales were slightly higher than her pretest scores. Mary's subscores for Avoidance, at 24 and 26 (out of a possible 32) could

possibly have indicated that she was not wanting to deal with her feelings about the abuse. Her Intrusive subscores were 16 and 17, out of a possible 28. The fact that both post test subscores were slightly higher may be accounted for by the great turmoil in which the family found themselves because of the offender being allowed back into the home and then forced to leave again. Mary went through a great deal of anxiety when this man was living back in the house again. It was a relief when he left the second time, but there was also a great deal of anxiety because of the many adjustments which their mother was forced to make because of this decision.

Sexual Abuse Awareness ("Things to Think About, Things to Learn"):

	T1	T2
Score	18	19

Mary completed this measurement at the beginning of the girls group and again at the termination of the group. Out of a possible 21 answers, Mary got 18 correct on the pretest and 19 correct on the post test. Both times she agreed that most offenders stop sexually abusing children after they are caught, and she disagreed that children sometimes act out what happened to them with other children. On the pretest Mary stated that most abusers are strangers, but she changed her response on the post test to a correct response.

Summary

Mary, who disclosed her abuse to her mother out of fears precipitated by the Gulf War, actually had the least intrusive incident of sexual abuse of all of the clients. However, she was greatly affected by it. Intervention consisted of crisis intervention with the mother and short

term therapy with Mary. Mary participated in individual, group and dyadic therapy with her mother. I believe that Mary benefited greatly from each form of therapy, especially the group therapy.

There were many factors that affected the rate of progress for Mary in therapy. Part way through therapy the offender, who was her stepfather, was allowed to come back into the family and this was very upsetting for Mary. It placed her into a further crisis and she did not have the emotional energy to deal with aspects of her abuse in therapy. She was more concerned with what was going to happen to her and to her family. She was concerned about her stepfather re-offending and she felt uncomfortable around him and very angry that he was in the home once more. I felt frustrated and powerless to help her because of her situation at home. At times the focus of our work together was her personal safety in the home. After her stepfather left the home a second time, and Mary truly believed that he was not coming back, there was a noticeable difference in Mary's readiness to progress with her therapy. This highlighted to me the importance of the establishment of safety as explained by Herman (1992) as the prerequisite to treatment for sexual abuse.

Lena

Presenting Situation

Lena, twelve years of age, was referred in January, 1991, by Child and Family Services. She was living in a specialized foster home with a single foster mother named Cheri and her four year old son Garth. The foster home was in a downtown part of Winnipeg, close to the Community Resource Clinic. Cheri was very supportive and helpful to Lena. Cheri

had received training from Child and Family Services to prepare her to assist Lena with issues related to her abuse. Lena had many disturbing symptoms resulting from the abuse that she had experienced, such as nightmares, sleepwalking, and many attention seeking behaviours. Lena had a thirteen year old sister named Kim, a ten year old brother named Stan, and a five year old sister named Cindy. All four children were permanent wards of the Child and Family Services. They had come into the care of Winnipeg Child and Family Services in 1989 when the family home was "raided" by police and social workers. The three girls had originally been placed in a receiving home together, but Lena was assessed as having special needs and was placed in a foster home by herself. Kim and Cindy were placed together with a foster family and their brother Stan was placed in a group home and assigned a special worker who provided close supervision.

Child and Family Services were asked to investigate the situation after young Stan was found engaging in sexual encounters with younger children in the neighbourhood. Upon investigation, Stan was assessed to have been badly abused over a long period of time. He had been sodomized to the extent that medical evidence was readily secured. The apprehension of the other children was traumatic to them. When the police and social workers "raided" the home, the children were scantily clad in nightwear and appeared to have been the "entertainment" of the parents and their friends who were having a party. The children were forcibly removed and Lena remembered biting one of the police officers. The children were very loyal to their mother and fearful of social workers. They were careful about what they told the police and social workers and disclosures were not easily obtained. Eventually the children disclosed many incidents of sexual abuse by their father, step-father,

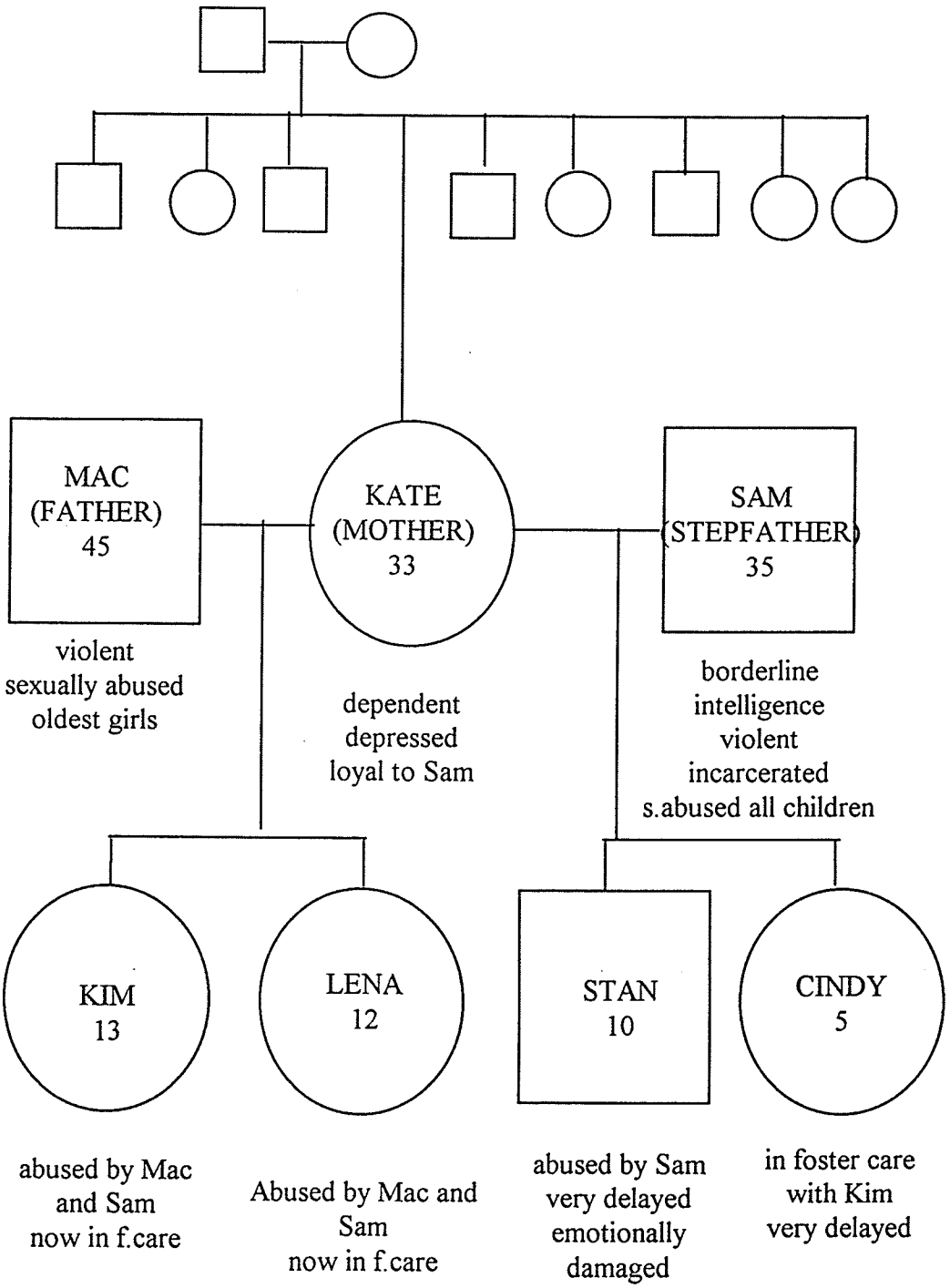
and friends of their parents. Ritualized abuse was strongly suspected, and sexual abuse by their mother was suspected. Lena disclosed that she was sexually, emotionally and physically abused, over a long span of time, by her biological father and stepfather. The most frequent abuser was her stepfather, Sam. The children had witnessed each other being abused and had seen their mother physically assaulted by Sam and by her former husband Mac, and had witnessed adult sexual activity.

Family Background

The family was a multi-problem family in which there was drug and alcohol abuse. Their home was the "drop-in" site for friends who had a similar lifestyle. Lena and her sister Kim had the same birth father. Their parents had married when their mother was eighteen years of age. This marriage lasted for nine years, six of which the husband spent in a penal institution following convictions for manslaughter and possession of drugs and weapons. Lena's father beat their mother while Lena and her sister were forced to watch. He made them say that their mother is a "dirty whore". He made their mother sign over the custody of the children to him and forced her to leave at gunpoint.

It was believed that he was sexually abusive to Lena and Kim. Not too long after Lena's mother left their father, she began to live with Sam and eventually married him. Sam was assessed as being of borderline intelligence. He had been sexually abused as a child and was raised in a youth facility. He had been in difficulty as a child for chronic fire-setting. He was heavily involved in drugs and alcohol and was often in trouble with the law because of violent, dangerous behaviour. He was the biological father of the two youngest children, Stan and Cindy. The children disclosed that they had witnessed stabbings, slaying of animals, sexual

LENA'S GENOGRAM



abuse of their siblings and sexual acts between adults.

Kate, Lena's mother, grew up in a family of nine children in which all the children had to fend for themselves. Their mother was alcoholic, and there were three different fathers for the nine children. Kate was described in a psychological assessment as "sad, emotionally distant from the world, emotionally colourless and constricted". While the children appeared to be fiercely loyal to their mother, they were resentful that she remained married to Sam, whom they feared and who had abused them so badly. Lena told me that she had lived with an aunt until she was five years old. When the family was assessed by a clinical psychologist, he reported that Kim and Lena had received some degree of adequate parenting, but the two younger children, Stan and Cindy, had not received any adequate parenting. The two youngest children were developmentally delayed because of their deprived environment. It is possible that the two oldest children had formed a healthy attachment to their mother and had some of their needs met while their father was incarcerated. In the second marriage, however, the children experienced a more deprived and abusive environment and the youngest children were not able to have any of their needs met.

Assessment and Goals of Treatment

Lena told me that she felt like "just a toy" and that was she very unhappy. She said that sometimes she wished she were dead. Lena had been assesses by a clinical psychologist as being "dysphoric". When she had first come into care she had stapled her feet and hands with a stapler. She had a scar where she had driven a nail into her hand. On one occasion

when she was going to hurt herself, her sister Kim had "knocked her out" to stop her. Lena felt very guilty about not being available to take care of her little sister Cindy, since they lived in different foster homes. Lena was a sad girl who presented as being "rough and tough" to the rest of the world. She was accident prone and was always getting hurt. She had been sexually abused by her birth father, her step father and possibly others, and had witnessed violence and sex by adults. During several therapy sessions, Lena inferred that she had been sexually abused by her mother, but her fierce loyalty to her mother prevented her from telling more. Lena had a strong dislike for men and in play therapy showed that she believed that all men are lazy opportunists who take advantage of people. On one occasion Lena told me that both her fathers were "devils".

Lena completed the Auchenbauch Youth Self-report for ages 11 - 18. In the report Lena listed roller skating, baseball, basketball and karate as sports that interested her. She stated that she believed that she did as well as other children her age in these sports. Her hobbies and activities were listed as karate, reading and drawing. Lena believed she did better than average in reading and drawing. She did not belong to any organized clubs. Lena had chores to do at home which included making her bed, cleaning her room and cleaning the bathroom. She had four or more close friends and saw them once or twice per week. Lena believed that she got along with her siblings better than others of her age, that she got along with other children in an average way, and that she got along with her parents better than other children. She showed great loyalty to her mother. Lena also reported that she did things by herself better than other children. She reported being average in mathematics, French and music, and above average in English, reading and social studies.

Issues which Lena needed to address in treatment were:

Fears - Lena had many fears and most of these were grounded in reality. She was terrified of her stepfather getting out of jail and killing her for disclosing her abuse by him. Lena had seen a great deal of violence. Her father had once stabbed a police dog during a robbery and there were disclosures by the children of animals in the neighbourhood being killed by her stepfather. Lena was also terrified of his many friends whom she sometimes saw around the neighbourhood. She had difficulties whenever her class went on a field trip, even to the local swimming pool, as she was afraid of meeting one of these people. Lena often had horrible night terrors; when she first came into care, she sometimes had as many as eight per night.

Depression - Lena had been diagnosed as having dysphoria. She sometimes presented with a flat affect and she could see no hope for her future. She was an unhappy girl who covered up her feelings by acting tough and trying to boss others around.

Poor social skills - Lena had difficulty engaging with peers and she sometimes got into fights. She appeared to be a lonely girl who did not have many friends.

Repressed anger and hostility - Lena had a great deal of anger but was often reluctant to express it. Some of her anger towards her stepfather was generalized to all men. She stated in therapy that men are "pigs, stupid, fags, gays, bums". She claimed to have once tried to kill her stepfather by putting soy sauce on his food. He was allergic to this and she hoped it would kill him. Her foster mother reported that Lena had killed her gerbils for no reason and she would not trust Lena to be alone with her young son.

Impaired ability to trust - Lena needed a great deal of time with somebody before they could win over her trust. Once this was gained, Lena was loyal to a fault. Getting her to give you a chance was the difficulty. Basically, Lena did not trust anyone except for her foster mother.

Problems with self-mastery and control - because of all the horrendous things that had been done to her, and the fact that she had no decision making ability in her life, Lena had developed an external locus of control. She felt that she had no control in her life, so she constantly attempted to engage others in control issues, such as insisting that the group should have broccoli for a snack, when she was the only person who wanted it. She tried to take over discussions in the group and sabotage the group process, especially if the topic was a difficult one for her.

Powerlessness - Lena was very much into engaging in power struggles when she had the opportunity. She felt very powerless in many areas of her life, especially when it came to her biological family. She had no decision making power regarding visits with her mother and siblings. She tried to "boss" others around as a way of getting some of her power back. The powerlessness over her own abuse, and the abuse of her mother and siblings, were issues with which Lena had to contend since she was a young child.

Interventions

Lena and her siblings had come into care one year prior to my involvement. Lena was not in need of crisis therapy at this time. The crisis of coming into care in such a traumatic way had been largely dealt with by her social workers and foster mother. Because of the severity of her abuse, Lena was in need of long term therapy. However, the length of my

practicum dictated that the therapy which I provided to Lena was short term therapy. Beginning in March, 1991, until the end of June, 1991, I saw Lena 11 times by herself and once together with her foster mother. I saw her foster mother once by herself and on two occasions I met with the social workers who were assigned to Lena by Child and Family Services. Initially the sessions with Lena were scheduled for one hour, but Lena requested that we extend the time for a further half hour. After consulting with her foster mother we were able to extend the time as Lena requested. Lena and I began our sessions together in the regular interview rooms at the clinic. After Lena discovered that there was a play therapy room, she requested that she be allowed to receive therapy in that setting. I was able to arrange this, but this room was only available for a one hour period, rather than the one and a half hour which we had been spending at the clinic. We made arrangements whereby I would see Lena in the play therapy room for one hour and then we would resume our session for a further half hour in a regular interview room. The last half hour became valuable debriefing times for Lena. There were a few occasions when we were not able to schedule the play therapy room, in which case we would hold the entire session in a regular interview room. By that time our sessions together had taken on the form of play therapy, and this continued, even when we used a regular interview room. In the interview room we did not have the play items, but Lena chose to use drama at these times. We imagined props or used whatever was in the interview room. Before we began to use the play therapy room, Lena and I used games, drawing and talking as ways to connect and begin to deal with her issues. Lena was fairly flat in affect and reluctant to volunteer much in our sessions. She had been

involved in many interviews with social workers and police over the past year. In the play room Lena became a different person. She was creative, animated, and eager to develop plays and act them out. I was assigned roles which I obediently carried out, except when the role was that of an abuser. I did not want the playing out of a negative role to interfere with the relationship which Lena and I were beginning to develop. If Lena did need a "bad guy", I consented but was careful that there were no situations devised which would take away the trust that Lena had come to have with me. Lena often played the role of a policewoman or a very capable woman who rescued and helped people. I believe that she was working through some of her issues of powerlessness and loss of control with these dramas. Lena had been taught to hate "cops". I saw it as a positive when she assumed the role of a good, strong policewoman. Lena also liked to draw pictures and write poetry in the play therapy room. Often her pictures were of her family, sometimes pretty, happy butterflies and rainbows, and occasionally sinister drawings with the devil, lots of stars, and blood. She showed me a story that she had written at school once which was a horror story about children in a haunted house. In the story there was blood all over, and one of the children had his head cut off. One day Lena drew pictures and wrote a poem to accompany them. One picture was a chalice of blood with the words "Devil's Cup" written on it. To accompany the picture, Lena wrote "Blood is like a drink that the devil gives you to drink". Below that Lena drew a picture of a tree with tears falling down from it and spears of lightning coming from the sky towards the tree. Above that she wrote "Pain is like a soft spot that can't be touched". Two other poems that Lena wrote expressed some of her true feelings, much

unlike the tough, uncaring girl that she tried to present to the world. Her poems were:

"Running like a long gazelle,
Feeling like the wild, wild wind.
Passing houses, passing people
All are blurs to me."

"Rain gently kissing spring's new flowers
washing out the city grime
Tears of all the children
wishing they had never hurt."

Lena could describe her pain with pictures and poetry but otherwise could not verbalize it. A great part of my work with Lena focused on helping her to identify her feelings and needs and to learn how to communicate these to significant others. For example, Lena was often in trouble with her foster mother. Lena was a difficult child to care for, no doubt, and she was constantly testing limits with her foster mother. Eventually, Lena was able to compose a letter to her foster mother and communicate some of her concerns to her. Her foster mother was very responsive to this, and it helped them to begin to have better communications. Lena also learned that it is better to find ways to communicate her needs than to act out and get into trouble.

Lena attended the psycho-educational group for girls. She was an avid group member and arrived early for every group session and helped with preparation of the snack and cleanup after the group was finished. Lena missed the last group session, and this was because she was upset about the termination of the group. She had a difficult time with

goodbyes. Lena gained a great deal from her attendance in the group. She was not always cooperative, and competed with the other girls for attention, but she was relieved to see that other, normal adolescents had, like her, been sexually abused. She seemed relieved to see that there were others like her who showed no outward signs of stigmatization.

Measures

Rosenberg Self-esteem Questionaire:

	T1	T2
Score	23	24

Lena completed the Rosenberg Self-esteem Questionaire. Out of a possible total of 30, which would indicate exceptionally high self-esteem, Lena scored 23, well above the mid point of 15. In this ten point questionaire Lena strongly agreed that she was a person of worth, that she was able to do things as well as other people, and that she had a positive attitude toward herself. She agreed to having a number of good qualities, and that she could have more respect for herself. Lena disagreed that she certainly felt useless at times. She strongly disagreed that she was inclined to feel like a failure, that she did not have much to be proud of and that at times she thought she was no good at all. Lena's post test score was 24, one point higher than the pretest. I was puzzled that Lena showed such high self esteem on this measure. It may be that the abuse that she experienced was not as intrusive to her self-esteem as it would be to many children. The abuse was a part of the family norms, in the same way that stealing and telling lies were normal behaviour in that family system. As well,

Lena may have not been prepared to openly report the self doubts that she showed in her therapy sessions on this measure.

Impact of Event Scale:

	T1	T2
Avoidance	23	16
Intrusive	8	8

Lena also completed the Impact of Event Scale. She indicated that she often tried to remove the abusive incidents from memory, and that she stayed away from reminders of the event. Lena reported that she sometimes felt as if it had not happened or that the event was not real. All other responses were at the "rarely" or "not at all levels". At the initial stage of treatment, Lena's pretest score for the Avoidance subscale was 23 of a possible total of 32. Her pretest score for the Intrusiveness subscale was 8 out of a possible 28. This could be interpreted that Lena was not bothered very often with thoughts or memories intruding on her conscious awareness. I am not sure of the reasons for this, as the abuse that she suffered was very severe and lasted for most of her young life. Either Lena had very strong denial with accompanying defences, or her family norms were such that the abuse did not have as much of an impact on her as it would have on a child who was raised in a family which had more normal boundaries and roles.

Sexual Abuse Awareness ("Things to Think About, Things to Learn"):

	T1	T2
Score	18	20

As part of the group treatment, Lena and the other girls in the group completed a

true/false questionaire entitled "Things to Think About, Things to Learn (see Appendix E).

The instrument had 21 statements relating to commonly held beliefs about child sexual abuse. In the pretest, one of the questions that Lena got wrong was that she agreed with the statement that most offenders are mentally ill or retarded. This is an understandable belief for Lena, as her stepfather was assessed as borderline intelligence. Lena showed a good basic understanding of the dynamics of child sexual abuse because she had only one incorrect statement out of the 21. In both the pretest and post test she disagreed that children who have been abused sometimes think that they are ugly or look different than other children.

Summary

Lena, who came from a very chaotic and abusive family, participated in individual and group therapy. Lena's abuse was very intrusive and ongoing for most of her life. However, she did not show as much trauma from the abuse as what she experienced from being separated f rom her mother and her siblings. Arrangements were rarely made for visits between Lena and her sisters or brother. She was not allowed visits with her mother because the mother was trying to get the children to recant and told them that their stepfather would be killed in jail thus putting the children under more stress. Her foster placement was tenuous as she exhibited some behaviour problems that made parenting her difficult.

Lena appeared to have a very high level of denial as was shown by the Impact of Event Scale. It was my observation that Lena progressed very well in individual therapy. She appeared to gain a great deal from group therapy but she may not have been ready for a group as she was very disruptive in the group, and a challenge to the facilitators. Lena did best when in the play therapy room where she controlled the environment and worked on issues

of abuse and helplessness through her play.

Other Cases

There were several other adolescents who were referred to me during this practicum. I did not see these girls on a regular basis, but I learned a great deal from each of them. The following is a brief description of my involvement with them.

Kim

Lena's older sister Kim was referred to me at the same time as Lena. Kim was not interested in coming to the clinic to see anybody for therapy, nor was she interested in attending the group sessions. She was living with a middle class foster family who had several children of their own. Kim desperately wished to be a "normal" child and was trying to integrate herself into this home and community. She had a high denial of any problems, although the social worker had expressed concerns about Kim having suicidal ideation. Kim reluctantly agreed to come into the clinic to please her foster parents and social worker.

I saw Kim on two occasions and talked to her social workers from Child and Family Services during the intake procedure. Kim had been the parentified child in the family because she was the oldest and most responsible. Kim was a very angry teenager, especially toward her mother because her mother was aligned with the perpetrator. After the second session with me Kim decided that she did not want to come back to the clinic. The reasons that she gave for not wanting to engage in therapy were that she did not need any help, and she did not like me asking her questions about suicide (I had checked out her intentions as part of a risk assessment during the initial interview). Kim had a high level of denial about

her biological family and did not want to be reminded about them. It was my impression that Kim was afraid of having to reveal information about herself or her family. After all, Kim's experience with social workers up until now was that they had separated her from her mother and siblings. She had experienced hours of interviews with social workers and police about her family, and now she was being encouraged to have therapy when she did not wish to be reminded about her past.

During our second interview I did an ecomap and a genogram with Kim. In hindsight, I believe that this was too early to engage Kim in talking about her biological family. I may have stirred up feelings about her mother which caused her difficulty. She was feeling angry towards her mother and experiencing a great deal of guilt about this anger. One thing that might have helped Kim to engage in treatment would have been the development of a treatment contract together which would consist only of issues that Kim wanted to address. An important thing I learned from Kim is that everyone needs to have a certain level of readiness before they can make a commitment to therapy.

Tina

Tina, a fourteen year old Native girl was referred to me by Child and Family Services in April, 1991. Tina was an only child and lived with her mother. One year prior to her referral to

the clinic, Tina was locked in a room by two men, aged nineteen and twenty-one, and raped by one of them. Another recent, stressful event in Tina's life was the loss of her maternal grandmother, who passed away at Christmas. Tina had been very close to her. Tina had

many fears, especially of her two abusers, who lived in the neighbourhood. She was expected to testify against them in court in the future. In addition to being fearful, Tina was very confused about her feelings. She showed signs of depression, and had a flat affect, as if her spirit were broken. Tina was involved in some Satanic worship and talked to her school counsellor of becoming an SC (Satan's Chic), in the months to come. Her school counsellor described behaviours which she thought were indicative of an altered state, suggestive of a multiple personality disorder. She said that Tina's eyes would flit back and then her mood would be quite different.

I saw Tina four times, and once with her mother at intake. Her mother was invited to attend a mother's group with several other mothers of abuse victims, but she did not come. In early June of 1991 Tina attempted suicide by slashing her wrists and was hospitalized for an assessment. I was involved in the discharge meeting at the hospital, and it was agreed that Tina would receive follow up services at the hospital as an out patient. My practicum was coming to an end and Tina required long term therapy.

My work with Tina mainly focused on Tina's safety, facilitating communications between Tina and her mother, and providing emotional support to them. I attempted to assist Tina in identifying and labelling some of her confused feelings, and in the expression of anger which she identified towards her assailants . I helped her to establish plans of safety for when she encountered her abusers in the neighbourhood. Tina was unwilling to engage in therapy and she had come to the clinic at the urging of her social worker and mother. Tina may have been a good candidate for a therapeutic group composed of Native girls, if such a group were available. She related well to her peers and they were very important to her. Therapy with

peers may have provided the ambiance that would have helped Tina to engage in therapy. In retrospect, it may have been more helpful to Tina if we did not focus on the abuse and spent our time in therapy joining with her on issues that would be safer for her to discuss. Tina was a candidate for long term therapy, which she hopefully received from the Health Sciences Centre.

Bonnie

Bonnie was a sixteen year old Native girl who had been sexually abused by her paternal grandfather, who was her guardian. I never was able to engage Bonnie in therapy, but I learned a great deal from this case as I was required to take an entirely different approach in my attempts to provide help to Bonnie. Bonnie refused therapy and I was requested by her grandmother and aunt to continue to work with the other women in the family. When Bonnie was a small child her grandfather had sexually abused her over a period of time. The family was not aware of this until Bonnie disclosed to her aunt after Bonnie had come into the care of Child and Family Services.

Bonnie's family moved to Winnipeg in 1980 from a First Nations community in northern Manitoba after Bonnie's grandfather developed a brain tumour and required extensive medical attention. He died in 1983. Bonnie and her two younger brothers were cared for by their maternal grandparents because their parents were unable to care for them due to alcoholism. Bonnie and her brothers were treated as the younger siblings in this family rather than as niece and nephews. Frances had fourteen children, including six daughters and eight sons. All her children now lived in Winnipeg. Bonnie and her brothers are the

children of Frances' oldest son.

Bonnie's grandmother, Frances, cared for her three grandchildren until she could no longer control them. They were constantly truant from school and would not come home at night. In 1987 Frances suffered a nervous breakdown, was hospitalized, and the children were taken into care by Child and Family Services. The children were in different foster homes. Bonnie had a severe solvent abuse problem and ran away often. The family was angry with Child and Family Services for failing to provide protection and treatment for Bonnie. Agnes, one of Bonnie's aunts, was the spearhead in trying to get help for Bonnie.

When the children were young and the family lived in their northern community, the grandfather became violent when he used alcohol. When this happened, Frances would take the children to hide in the bush so that they would be safe. There had never been any indication that the grandfather was sexually abusive to anyone until Bonnie made her disclosure.

When I first received this referral from Child and Family Services, I saw Bonnie once in her foster home by herself and then with her foster mother. Bonnie said that she wanted to come to the clinic, but she never kept any appointments. Eventually, she ran away from her foster home and was living on the street. Agnes requested family therapy for all the women in the family because she said they were all suffering and needed to work some things out. We agreed that if I started working with the family that perhaps Bonnie would get interested and begin to get involved, or that Bonnie could be helped in an indirect way through her family. This is an example of equifinality which means that a single effect can be produced by a variety of means. I met with Bonnie's grandmother (Frances) at her house,

with Frances and Agnes twice at the clinic, and with Frances and all her daughters twice in her home.

Other than Agnes, the other women in the family were reluctant to discuss their father's abusive treatment of Bonnie. Frances believed Bonnie when she disclosed that her grandfather had abused her, but nobody could understand why it had occurred. She had no idea of what happened or why her husband would have treated their granddaughter in such a way. Frances was very supportive of Bonnie who called her frequently and came over to see her. Frances was obviously the most important person in Bonnie's life.

The focus of family therapy with the women was to help them to lift the load off Bonnie by "breaking the silence" about the abuse in the family and to let Bonnie know they wanted to help her. The women found it difficult to talk about their father's abuse of Bonnie. Most of them were still in a state of shock about the disclosure. None of them had been abused by their father and they felt great loyalty to him. Some of the women began to discuss some of their own abuses for the first time. One aunt planned to write a letter to Bonnie, one planned to tell Bonnie about her own abuse, and another was going to spend more time with her. One of the reasons for having Bonnie's aunts tell her about their own abuse was to help Bonnie to talk about what had happened to her and help her to get on the road to recovery. Bonnie was in the house when the last session was held with the women. She was invited to take part but she did not attend directly. She served coffee to her aunts and grandmother during the session. When I was at Frances' home, I was acutely aware of the portrait of Frances' husband which hung high above those in the room. It seemed to me to be a

metaphor for what was happening. Even after his death, his memory had a great deal of power over the family, and his daughters and wife had a great deal of loyalty to him. They found it most difficult to acknowledge that Bonnie had been abused, even though they did not disbelieve it.

In addition to meeting with the women in the family Bonnie's youngest uncle was encouraged to take part as he was already close to Bonnie. He could take on the role of "big brother" for her. During one family meeting he was in the house but not in the same room with us.

The family decided that a primary issue for Bonnie was her use of inhalants. They believed that it was very important that Bonnie receive treatment for this debilitating habit. They tried to persuade Child and Family Services to obtain treatment for Bonnie, but this did not happen. Bonnie later was placed in a youth centre as she had been picked up while engaging in prostitution downtown. Her family recommended to Bonnie's parole officer that the court place Bonnie in a treatment centre for the abuse of inhalants.

Members of this family expressed a great deal of caring and concern towards each other, and especially towards Bonnie. It was my impression that the family came to believe that they could not rely on outside agencies to "fix" the children. They came to see that the family, working together, had more strength and power to influence the children than they had formerly realized.

Summary of Cases

All but one adolescent described above had been sexually abused by a family member. Lena, Mary and Kim had been abused by stepfathers. Alana was abused by a cousin, Susan by her uncle, and Bonnie by her grandfather who was her guardian. Tina was the only adolescent with whom I worked who had been sexually assaulted by a third party, who was a young man in the neighbourhood. The intrusiveness of the abuse varied from case to case, but I was not able to see a direct correlation between the intrusiveness of the abuse and the effects of abuse on the child. All suffered from most of the effects of abuse which were described by Sgroi (1982). Most noticeable effects were low self-esteem, fears, guilt, poor social skills, and depression. The severity of impact of the abuse on each girl varied. It was surprising that Mary, the girl who had suffered the least intrusive abuse, showed the greatest impact, according to the Impact of Event scale, and according to her descriptions of her feelings. Contrary to this, Lena, one of the girls who had suffered the most intrusive, chronic abuse did not show as severe an impact according to her description of her feelings and the results of scales. Factors other than severity of abuse must be taken into account to explain this. One explanation could be that Lena was in a state of denial about her abuse, which assisted her in dealing with it at the time. Lena had many symptoms of post traumatic stress syndrome. She may have had a strong defence built up to enable her to cope with her life on a daily basis.

The following matrix describes at a glance many factors which were described by Hoorwitz (1983) as important in formulating a treatment plan. This matrix is helpful in looking back over the cases which I have described, as it summarizes many of the issues

which impacted on the adolescent during her treatment.

A SUMMARY OF FACTORS WHICH INFLUENCED TREATMENT

Factors	Alana	Susan	Mary	Lena	Kim	Tina	Bonnie
Was abuse incidental?	Yes	No	Yes	No	No	Yes	No
Was abuse chronic?	No	Yes	No	Yes	Yes	No	Yes
Was abuse violent?	Yes	Yes	No	Yes	Yes	Yes	No
Age at time of abuse	14	6-12	9	3-11	3-12	13	5-9
Type of abuse	Rape	All	Fondling	All	All	Rape	All
Did family deny abuse?	Yes	Yes	No	Yes	Yes	No	No
Intergenerational abuse?	Yes	Yes	Yes	Yes	Yes	Yes	Yes
Was child supported?	No	Yes	Yes	No	No	Yes	Yes
Court involved in court?	Poss.	Yes	No	Yes	Yes	Poss.	No
Perpetrator incarcerated?	No	Yes	No	Yes	Yes	No	No
Child in contact with perp?	No	No	Yes	No	No	Yes	No
Child's feelings of safety	Low	Med.	Med	Low	Low	Low	Low
Level of family problems	High	Low	Med	High	High	Low	Med

Multi-modal treatment was attempted with all the adolescents in my practicum. For the adolescents who were able to participate in two or three of the modes, there was a

resonance between the different modes which enhanced the effects of therapy for the clients. The resulting synergy provided a more in depth treatment for those adolescents. The following chart illustrates the mode of treatment that each adolescent received:

MULTI-MODAL TREATMENT MATRIX

NAME	TYPE OF TREATMENT			
	Individual	**Group**	**Dyadic**	**Family**
Alana	X	X	--	--
Susan	X	--	X	--
Mary	X	X	X	--
Lena	X	X	--	--
Kim	X	--	--	--
Tina	X	--	X	--
Bonnie	--	--	--	X

Alana did not receive dyadic therapy with her great grandmother, but I had several sessions with them. Lena's foster mother was too busy to be available, but I coached Lena in letter writing to her foster mother to facilitate communications between them. Multi-modal treatment, in which the child could transfer learning from one mode to another, was the most helpful to the adolescents with whom I worked. It provided them with added empowerment and emotional support and enabled them to get a clearer sense of the meaning the abuse had for them.

Individual therapy provided a safe context in which the adolescent could deal with her abuse and with other factors which were impinging on her world at the time. These issues

varied from week to week, but mainly focused on stresses at home and at school. In individual therapy the adolescent was able to improve her self-esteem and sense of empowerment. As we built a relationship together, her ability to trust others became greater. This enabled her to reach out to others and begin to develop other relationships in her environment. In individual therapy the adolescent could look forward to a weekly session with an interested and caring professional who set aside the time just for her, to deal with what the adolescent saw as important on that particular day.

Individual therapy may be difficult for some adolescents. The girl may have difficulty in a one-to-one relationship with the therapist as she may have learned through her abuse not to trust. She may have built up strong defences and may not be able to overcome her feelings of guilt and shame. One issue to be cautious about in individual therapy is that the therapist must ensure that the adolescent has control of the situation and feels safe. Individual therapy in some ways could be seen as threatening to the adolescent, if she is not assured of her safety at all times in the therapeutic environment. Individual therapy for sexual abuse should not be attempted if the adolescent is not in a place of safety or does not feel safe. Having to deal with abuse issues without safety can exacerbate the adolescent's stress and cause more problems for her.

Group therapy was probably the most helpful of all modes to the adolescents who took part in the group treatment. Through interactions with their peers they were able to experience a reduction in stigmatization and develop better social skills. Their guilt, shame and depression were lowered by meeting with other adolescents who had experienced similar life events and who were coping with similar difficulties. Because of the importance of

peers in adolescence, the group experience provided benefits which were much greater and longer lasting than what could have been realized in individual therapy alone.

The amount of time and organization required to develop the group, arrange facilities and transportation, and select appropriate candidates who would be compatible in age and treatment needs, was one drawback to group therapy. Another difficulty with group treatment was that some adolescents did not feel like they fit in with the others, and some were more needy and attention seeking, which distracted the others. It was sometimes difficult to develop group dynamics when the group was not homogeneous, especially when the group was small. It may not have been helpful for some girls to be placed into a group of more mature, experienced and "street-wise" girls, who were exhibiting acting out behaviour, such as running away from home. Another difficulty in facilitating a group is the need for the availability of two group leaders. It may be possible for one leader to run a group, but it is more helpful to the participants to have two leaders.

The benefits of dyadic therapy between the adolescent and her mother were great. This mode was empowering to both the adolescents and their mothers. In dyadic therapy the adolescent was able to discuss issues that were brought up in individual therapy, with which she may not have otherwise felt comfortable discussing with her mother. In working with the mother and adolescent together, I could assist in building up ongoing safety for the adolescent. The adolescent found that she could turn to a trusted family member, not only regarding the abuse, but for other needs as well. Communications were facilitated and the improved communications provided additional safety to the adolescent. Another benefit was the development of trust between the adolescent and myself as her therapist. The adolescent

saw that she was consulted and listened to about issues that she wanted to discuss with her mother.

Dyadic therapy could not be attempted without the cooperation of the adolescent's mother. One drawback to dyadic therapy was the extra time and organization required to see each of the pair separately as well as seeing them together. Another difficulty that I became aware of was the possibility for the development of loyalty issues. In most cases the therapist needs to keep an unbiased stance with family members. However, when a child has been abused, it sometimes becomes necessary to advocate for the child. I had to be mindful in dyadic therapy that each party felt like she had been heard and understood.

Family therapy was used in only one case. Family therapy cannot be attempted in child sexual abuse when the abuser is a family member unless a multitude of tasks have been completed beforehand and the adolescent is safe and has reached a point in her own therapy where this is beneficial.

CHAPTER FIVE

SUMMARY OF LEARNING GOALS

I was very grateful for the opportunity which this practicum provided for me to learn more about the dynamics and treatment of child sexual abuse. I chose a multi-modal approach to treatment because I wanted to learn about the different approaches and I also hoped that a many faceted approach in working with an abused adolescent would present more opportunities for healing to the clients. Whether I worked individually with the adolescent, with the girl and her mother, or with several adolescents in a group format, I was overwhelmed not only by the opportunities for learning but also by the tremendous responsibility to the clients to whom I was providing service. The adolescents and their families had experienced a great deal of pain, and I hoped that any interventions attempted would be helpful to them.

After having experienced many years in the child welfare field I believed that I had attained an adequate skill level for some of the competencies required for this practicum. There were other skills which were just being developed and I was at the beginning of the learning curve for skills required in family therapy. Every session with the adolescents was different and challenging for me.

My learning goals were:

1. To develop a comprehensive knowledge of the dynamics of child sexual abuse including the causes, the effects on the child victims, and the family dynamics, including the intergenerational aspects.

2. To learn intervention skills through various therapeutic approaches: individual, group, and family.

3. To further expand my knowledge and skills in the utilization of family therapy as an effective approach in dealing with incest.

4. To develop a working knowledge of various instruments utilized in clinical practice to monitor and evaluate client progress.

My first learning goal was realized through a search of the literature which taught me a great deal about the dynamics and treatment of child sexual abuse. I learned that child sexual abuse is very widespread, and although it now receives more pubic attention, it has always been a serious problem in our society. Child sexual abuse occurs in all socio-economic groups but is more prevalent in families where there are extra stresses such as poverty and drug and alcohol problems. Sexual abuse of children is often intergenerational and persons who grew up in families where there was sexual abuse, lack of privacy, power imbalances, and exposure to sexual activity and inappropriate sexual relationships were more likely to sexually abuse a child. The literature describes a wide range of effects of child sexual abuse on the victims. I discovered through the practicum experience that the effects of sexual abuse are as intense and far reaching as is described in the literature.

The adolescents with whom I worked in this practicum showed evidence of a wide range of effects as were described by Sgroi (1982). They were: damaged goods (syndrome), extensive guilt and fear, depression and low self-esteem. Some of the girls had poor social skills and some suffered from repressed anger and hostility. Some of them had an impaired ability to trust, especially the ones who had experienced severe abuse. Blurred role

boundaries and role confusion, and pseudo maturity with failure to achieve developmental tasks were observed in the girls from severely dysfunctional families. Some adolescents appeared on the surface to be very capable and overly responsible, and yet had the same fears and emotional needs as children younger than themselves. Their abuse had interrupted achievement of their developmental tasks. Some of the adolescents also showed problems with self-mastery and control. Crisis intervention was required by some of the girls and their families, especially those who had recently disclosed their sexual abuse. Others were ready for short term therapy and almost all would require long term therapy.

Specific behaviours that the girls mentioned in completion of the Achenbach Youth Self-report measure showed that they experienced anxiety and depression. Items that the girls rated with the strongest response, ("most of the time"), were "I sleep less than most kids", " I am suspicious", "I store things I don't need", " I have trouble concentrating, " I daydream a lot". Mothers and guardians of these girls gave a strong response which indicated their children were having trouble with the following items: arguing, daydreaming, biting their fingernails being secretive and keeping things to themselves, being unhappy, sad or depressed. The mothers also rated the following behaviours as occurring "very often": lack of concentration, demanding a lot of attention, not getting along with other youngsters, lying or cheating, nervous, high strong and tense, overeating, stubborn sullen or irritable. Most of the girls reported having difficulty sleeping or having nightmares, several were having difficulties with food, either overeating or possibly purging after meals.

The clients with whom I worked taught me that, while the intrusiveness of the sexual abuse influenced the impact on the child, family norms and values were also influential on the

child's perception of the abuse and of herself. In families where abuse was the norm and was all pervasive, specific incidents of abuse did not appear to have the same impact on children as did less serious abuse to a child where this was not the norm for her family. Some adolescents developed greater defence mechanism such as denial, which helped them to cope.

The second learning goal, that of learning intervention skills through the various therapeutic approaches, was achieved. Through the use of the multi-modal approaches to treatment I learned a variety of interventions with victims of child sexual abuse. The use of dyadic therapy with the adolescent and her mother improved and facilitated communications between them and provided benefits on an ongoing basis. The girl's mother, in most cases, was her main source of emotional support and strength. Anything which could improve their bonding and communications was helpful to the adolescent. With dyadic counselling the parent had the opportunity to hear from her child about her the pain and all the other feelings and fears that she was experiencing. The child also heard from her mother about how she felt about her child being abused. If the girl and her parent can practice these skills in therapy with the coaching of the therapist, then they are more able to continue this improved level of communications at home. Dyadic therapy is conducted in a safe environment where the mother and child can work on issues without the interruptions that occur at home. This mode of therapy also helps to ensure the child's safety. The child can tell her mother about her fears and they can discuss and work out safety plans. The mother, in this way, can better understand and thus reassure and protect her daughter. In dyadic therapy the therapist can assist the mother and child to work out ways of having the child's needs met. The child can learn to tell her mother what she needs. For example, if she is feeling sad or scared she can

learn how to ask her mother for time to talk, or ask for a hug. If she is feeling angry, she can learn to express this, as well. This helps the child to learn to identify her needs and feelings for life long benefits. It goes without saying that dyadic counselling is not possible if the parent is unwilling or unavailable to attend sessions with the child. Dyadic counselling could be used with a supportive father or other person who is significant to the child. The various forms of therapy provided opportunities to exchange information between others in the different modes of therapy. A recursive feedback loop was in action, and the adolescent was encouraged to give input as to which issues she wanted to have brought up in sessions with her parent or the group. Being consulted in this way, and listened to, was empowering to her, and helped to offset the feelings of powerlessness resulting from the abuse.

Whether the mode was individual, dyadic, or group therapy, there were many methods which I learned to employ to influence, modify or mitigate effects of abuse. In the first session with the client I assisted her in identifying issues to be addressed during the course of therapy. We discussed instrumental issues, such as the length of therapy, expectations we each would have, and we developed a verbal contract. I looked for positive aspects and strengths in the adolescent and parent that we would be able to build upon in therapy. I let the girl and her mother know what to expect from me and from therapy. I attempted to enhance their self-esteem in every way that I could, including adding my observations of their strengths to their own observations of their strengths. Positive reframing and teaching positive self-talk helped the girls to cope with the many negative messages that they received from their environment. Learning to recognize, identify, and accept their feelings helped to provide empowerment and stress reduction. Learning to

clarify their feelings when various things happened provided them with a better awareness of themselves. I worked with the clients on techniques to deal with feelings and fears such as putting the shame and guilt concerning the abuse into a box and "sending them to their abuser", or writing letters to various parties. Using pictures of the various "feeling" faces helped the clients identify their various feelings. Teaching relaxation techniques to the girls was beneficial to them. In dealing with fears we sometimes drew pictures of what the fear looked like and externalized it in this way and encouraged the adolescent to talk about it. We made stories together of successes in overcoming fears and stories which would empower the adolescent. I taught the adolescents techniques to help them cope and to minimize the power of memories. For example, I taught them to picture themselves in a movie theatre and picturing the memory as if it were a movie on the screen and manipulating that image by making it small and far away in the mind's eye. Changing any image and making it look different was helpful.

I helped clients to set up boundaries and to learn about healthy boundaries and roles that would be more helpful to them, for example, "who is the adult and who is the kid", "whose job is that", "what is the adults's job and what is the child's job". Together we developed practical plans to help them to feel more safe.

Facilitating communications between mother and daughter was very helpful. For example, "what can _____ do to let you know _____?"; " What would be a sign to show you _____?"; "What would you do if _____ ?". I used debriefing techniques (" What would you do differently if you could?"). We talked about the telling of the abuse and why it is necessary and how difficult it is to tell. In individual therapy with the girls we processed

things that had come up in the group.

Providing an environment of safety and confidentiality to the adolescent was most important. Providing the adolescent with a safe and confidential place in the clinic produced an atmosphere that helped her to identify and process some of her issues. The adolescents knew that what we talked about stayed in the counselling room except if there was a danger to them, in which case that would be discussed with the girl and her guardian. Using the multi-modal approach I clarified with the adolescent hat issues she wished to discuss with her mother and what she wanted to process privately from the group discussions. I assured the adolescents that they did not have to talk about anything they did not want to discuss. This provided empowerment to them during therapy. Summarizing and providing feedback to the client, active listening whereby I would repeat what the client had said to ensure that I understood, encouraged more dialogue. Labelling abusive behaviour as abuse was helpful, especially where the girl had grown up in an abusive family where such behaviours were seen as normal. Teaching assertiveness skills to the adolescent, and encouraging her to look at things from different perspectives was also beneficial.

One of the most helpful techniques in therapy with the adolescents was to teach them about the basic dynamics of abuse. I utilized Finkelhor's (1986) model for this. This model suggests four aspects about the dynamics of abusers. Firstly, the offender has the desire or wants to abuse the child. Secondly, the child is simply available to the offender. Thirdly, the offender has no internal controls that stop him from abusing the victim. Lastly, there are no external controls to prevent the abuse from happening, for example, there is no other adult around to prevent the abuse from happening. Learning about these dynamics helped to

reduce self-blame and guilt that the adolescent felt. Teaching the adolescents about the effects of abuse on young people was also effective. Identifying responsibility as being with the offender, discussing and normalizing the ambivalent feelings, guilt and embarrassment that most victims feel, was instructive and helpful for the adolescents in dealing with their feelings.

I learned how helpful play therapy, the use of games, art and other creative techniques can be in working with abused adolescents, no matter what their age. It was surprising that even older children enjoyed the play therapy environment and were able to get in touch with their feelings more easily using these methods. I believe that the play therapy room provided the girls with a strong sense of security and safety, freeing them up to deal with difficult issues.

Working with Susan Maxwell in developing the group therapy sessions was very helpful in my learning. We had a professional relationship whereby we helped each other with research and ideas. We were able to provide good role models to the adolescents in terms of cooperation and showing respect for each other. Group therapy provided the most effective treatment but individual therapy was necessary as an accompaniment to group therapy. This enabled the adolescents to separately process things that came up in the group sessions. Participating in group therapy with peers helped to reduce the guilt and traumatic stigmatization which they were experiencing. It was important to make the group experience fun for the girls. Working together in the group helped the adolescents to build trust and enhanced their self-esteem. Whether targeted for one individual or for the group as a whole, interventions tended to reverberate throughout the entire group.

The third goal of expanding my knowledge and skills in family therapy as an approach

in dealing with incest was not totally met. This was due to the rather short duration of my practicum and the many steps that need to be achieved with incestuous families before family therapy can begin. I did have the opportunity to engage in family therapy with a grandmother and her daughters. In this case the target client was the abused girl who was unwilling to take part in therapy. Family therapy focused on assisting the family members to deal with the abuse which was perpetrated by their father (and husband) and was only disclosed after his death, and to strengthen them as sources of emotional supports to the victim. I learned a great deal about family therapy techniques during this practicum from observing Dr. Trute at work with families and in my own dyadic sessions with mothers and daughters. I would like to further develop my skills in this area.

My fourth goal, to develop a working knowledge of various instruments utilized in clinical practice to monitor and evaluate client progress, was met. In developing my practicum and in working on development of the group with Susan Maxwell, we researched many scales and instruments which could be used. I found some instruments to be more helpful than others. The Impact of Event Scale was very good. It was reliable and appeared to measure what we wanted to measure. The scale was short, quickly administered, had good validity and was easy for clients to complete. While the actual subscores for this measure were not revealing to me, the girl's responses to the various items gave a good indication of how she was being affected by the abusive event. The Rosenberg Self-esteem Questionaire did not appear to me to provide good a indication of the adolescent's self-esteem. Most of the adolescents scored higher than I would have expected, considering their behaviours and other indicators of their self-esteem such as statements which they made about themselves.

The high scores may have been because they tried to please the tester, they did not have realistic self-perceptions or they were in denial about the abuse. I was pleasantly surprised to find, however, that on a pretest and post test of this scale there often was a different score which would indicate change. Use of this scale with a larger sample could have produced results with some statistical significance. The Achenbach Child Behaviour Checklist and Youth Self-report were very helpful to me in understanding the child's problem areas. I did not use this measure in a scientific way but more as a checklist to provide a comprehensive assessment tool. This provided identification of problems which may have been residual effects of the adolescent's abuse, of which I would not have otherwise been aware. These scales helped me to use an ecological approach in assessment of the adolescent in her environment. I learned a great deal about many scales and measurements in the process of choosing appropriate evaluation tools for this practicum.

The therapy which I provided to the adolescents in this practicum appeared to me to become more of a means of temporary emotional support to them rather than a resolution of their abuse issues. I found that the adolescents did not usually want to talk about the abuse that they had experienced. Many did not have a safe environment outside of the therapy room, and had many more impelling issues in their lives at the time. Some of the adolescents were at a point where the therapy was crisis intervention, and we dealt with one crisis after another, and developed formal and informal helping systems. Others required long term therapy and our work together was a way of preparing them for long term therapy rather than to get them to deal with the abuse issues on a short term basis. For some of the girls the therapy became, more or less, a safe haven for them where they could receive some emotional

support in what was usually a very unsupportive environment.

There were many factors influencing the adolescents' readiness for therapy. Some factors that boldly stood out were, their informal support system (or lack thereof), other stressors, such as court, fear of the offender, the severity of the abuse, intergenerational patterns in the family, and the girls basic personalities, abilities and strengths. An overwhelming factor which affected the adolescents' readiness to engage in therapy stood out very clearly. This was the level of safety that they felt in their environment. Judith Herman (1992) states "This work (exploring the traumatic experience in depth) should not be attempted until basic safety has been reliably established" (p.344). I am convinced that one should enter into a therapeutic relationship with adolescents who are recovering from abuse without great expectations of total recovery by the end of the therapy. If these girls can be helped to believe in themselves, and accept that they can always seek help at any stage in their lives, then they will have gained much from their investment of themselves in therapy.

The clinic, now called the Elizabeth Hill Centre, was a perfect setting for this practicum. It was viewed by most clients as a safe, comfortable place where they could work on their issues at whatever level they would. My advisors for this practicum were supportive and challenged me to go beyond my comfort zone to grow and learn. The girls and their families were also my teachers. Whether they wanted to deal with their abuse or, as in some cases, not deal with their abuse, I was constantly impressed. Their resilience, openness, and willingness to try new things made the clinical experience exciting and constantly challenging. I was overwhelmed at the integrity and the resourcefulness of these girls and I learned a great deal from them. I only wish that I could give back as much as I received.

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APPENDIX A

MAJOR TOPICS AND WEEKLY SCHEDULE FOR GROUP SESSIONS

SECTION ONE - SEXUAL ABUSE

Week One	- Introductory Session - getting to know each other
	- Identifying goals
	- Group goals
	- Group rules and guidelines
Week Two	- About sexual abuse (dynamics)
Week Three	- More about sexual abuse (effects)
Week Four	- Feelings about sexual abuse
Week Five	- Offenders and Non-offending parents

SECTION TWO - SELF

Week Six	- Identifying and expressing feelings about self
Week Seven	- Assertiveness Skills
Week Eight	- Relationships with males and safety
Week Nine	- Values Clarification and sex education
Week Ten	- Wind up

APPENDIX B

GROUP RULES

Note: These rules were developed by the group.

1. Sharing our stories is voluntary - nobody has to talk about anything of they do not want to.

2. No cross talk - if someone is talking, pay attention to her - be kind to each other.

3. It is OK to let out your emotions in this group.

4. Everything said or displayed in group is confidential.

5. Respect others - do not interrupt if someone is talking.

6. Call ahead of time if you are sick and cannot attend the group.

APPENDIX C

WEEKLY AGENDA

Coming Together: Snack

Go Round - one good thing and one bad thing that happened to each participant through the previous week

Ice Breaker -

Business: Go over agenda for this session

Weekly Topic: Major topic for this weeks session (usually 20 minutes)

Journal Writing: Participants given time to make entry in their personal journal

Wind Down: Relaxation exercise or self-nurturing exercise

APPENDIX D

IDEAS FOR JOURNALLING

1. What was helpful today?
2. What was not helpful today?
3. Draw a picture if words are too hard then describe the picture.
4. Was it easy to ask questions?
5. Do you feel comfortable with what we talked about today?
6. Did you understand everything we talked about today?
7. If you did not understand everything we talked about what things do you still not understand?
8. Do you still have some questions that you would like to have answered in the group or in your journal?
9. How did you feel about what we discussed today ?
10. Write about anything you want.

APPENDIX E

PSYCHO EDUCATIONAL SCALE

"Things to Think About - Things to Learn"

Please read each of the following statements and Circle True or False

1. Many children make up stories about being sexually abuse	True False
2. Most sexual abuse offenders are strangers.	True False
3. Teaching children about their bodies (that they are special and they own them) is helpful in preventing child abuse.	True False
4. Most sexual abuse offenders are strangers.	True False
5. The child who is believed when he/she reports sexual abuse has the best chance of recovery.	True False
6. Parents should ignore and incident of sexual abuse because it is part of growing up.	True False
7. Many children who are sexually abuse feel guilty and feel that it was somehow their fault.	True False
8. Only female children are sexually abused.	True False
9. It is better to keep the secret of sexual abuse than to tell someone about it who cares about you.	True False
10. Most offenders stop sexually abusing children after they get caught.	True False
11.Children who have been sexually abused will never lead "normal" lives.	True False

12. Once a child has been sexually abused they are more vulnerable to being abused again. True False

13. Children who are sexually abused are responsible for what happened to them. True False

14. Boys or girls who have been sexually abused sometimes act out what happened to them in a sexual way with other children. True False

15. Many children who are sexually abused feel very angry. True False

16. Children who have been sexually abused sometimes think they are ugly or look different than other children. True False

17. People who sexually abuse a child should admit that it is their fault and should apologize to the child. True False

18. Most children tell someone right away when they have been sexually abused. True False

19. Children who have been sexually abused can be confused about whether they like or dislike the person who abused them. True False

20. Child sexual abuse happens so rarely it must mean that you are strange if it happens to you. True False

21. Mothers always know when their children have been sexually abused. True False

APPENDIX F

GROUP EVALUATION BY PARTICIPANT

Thank you for completing this evaluation of the group. Your ideas will help us to understand what helped you, and what you did not find useful.

1. What did you find to be the hardest thing about being in the group?
2. What did you like best about the group.
3. What would you have liked to do in the group that we did not do?
4. What do you think about the length of the group? (It was eight weeks)
5. Do you understand more about sexual abuse now than when the group first started?
6. Would you recommend a group like this to friends?
7. What suggestions do you have to the leaders for future groups?
8. What do you think about the place where the group was held? (e.g. was there enough space, enough privacy, warm/cool enough, etc.)
9. What do you think about the time of day for the group? (e.g. after school?)
10. What other comments or suggestions do you have?

(This questionaire was answered in writing by each group participant. The original questionaire was two pages in length, allowing for space between each question for the answers to be written.)