FAMILY TREATMENT OF CHILD SEXUAL ABUSE

BY

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PART I

INTRODUCTION

The purpose of this practicum was to provide family focused treatment of intrafamilial sexual abuse through family and couple therapy. Through the application of current theory and knowledge of sexual abuse treatment the student undertook to provide clinical intervention to four families where sexual abuse occurred. This practicum also served as an opportunity for the student to develop and explore her family therapy skills and intervention style.

Part two of this report is a review of the literature concerning the etiological theories of child sexual abuse and its occurrence within the family system. A brief discussion of the knowledge of the effects of sexual abuse is included. Different treatment approaches that currently exist are derived from what is known about the etiology of child sexual abuse. A review of the literature will suggest that the current knowledge base cannot provide clinicians with a single explanation for the occurrence of sexual abuse in families, and in recognition of this that treatment needs to be flexible and individualized to meet the needs of a family, based on a careful assessment of the nature of the sexual offense and patterns and characteristics of the family system. Family centered treatment models which include family and couple therapy are frequently described in the literature.

In part three of this report, the practicum experience and interventions are described. Included is a description of the setting, characteristics of the families and clinical supervision. Other interventions that were provided to families as part of the overall treatment plan (individual; group) will be briefly described.

Part four of the report will describe the evaluation instruments utilized. Families completed the Family Assessment Measure (FAM-3) as pre and post intervention measures. The Dyadic Adjustment Scale was used to measure changes in the couple relationship before and at termination of therapy. Families also completed a problem checklist pre and post intervention. Concluding comments regarding the practicum experience are found in Part V of the report.

Throughout this report the terms incest and intrafamilial sexual abuse will be used. The definition of these terms is borrowed from Sgroi (1982) and refers to any form of sexual activity between a child and a parent or step-parent, extended family member or surrogate parent figure. This is a psychosocial definition where the familial relationship is believed to be of significance rather than merely the biological relationship.

PART II

LITERATURE REVIEW

In the literature that examines the causes of sexual abuse in families, multiple contributing factors are identified. Categorizations of these factors are helpful and are utilized frequently. Haugaard and Reppucci (1988) in their discussion of causes of sexual abuse examine four areas: 1) functional explanation 2) feminist explanation 3) chaotic family and 4) individual pathology. Others have acknowledged that sociological, intergenerational and family characteristics contribute to the development of incest in a family. Kempe and Kempe (1984) identify just two broad categories, the multi-problem or chaotic family, and the superficially stable family with a rigid authoritarian father. This is merely descriptive of family characteristics and does not appropriately recognize other contributing factors. Teirney and Corwin (1983) in a review of factors present in intrafamilial sexual abuse present a model that explores the problem from four levels. These are sociological factors such as household density, geographic or social isolation, family structure including composition, role disturbance and power distribution, individual predispositions and personality characteristics of family members, and precipitating factors such as life stress or parental absence. These authors point out that different theoretical perspectives may be represented by the numerous fields involved in child sexual abuse such as social work, medicine, psychology, psychiatry and sociology. Indeed one's frame of reference may be influenced by a theoretical background, but also by one's observations and role in their involvement with these families.

The categorization presented by Haugaard and Reppucci will be adapted here as a basis for further elaboration on the etiology of incest. Theories about sexual abuse in families can fit into one of the four categories.

The functional explanation involves the principles of family systems theory and structural models of family functioning. Sexual abuse of a child in a family serves some function to maintain the patterns of interaction as they exist in the family unit, although the function is actually damaging to the family. The sexually abusive behavior is viewed as a symptom of an already dysfunctional family system, for example, a way of dealing with tension and distance in the marital dyad. Corrective intervention involves the restructuring of the rules and patterns of interaction within the family, and in the community and outside systems. Alexander (1985) presents a view of the incestuous family system, highlighting the significance of the interaction of the family system with its environment. She describes the incestuous family as dysfunctional and characterized by "entrophy", that is, lack of differentiation, rigid patterning, inflexibility and avoidance of growth and change. Too much homeostatis is said to exist, and the family is isolated from its environment, avoidant of role differentiation and individual differentiation.

The author emphasizes the need for intervention to be directed at increasing the exchange between the family system and the external system. Similar principles are discussed by Mrazek and Bentovim (1981), who also suggest that patterns develop between the systemic characteristics and are

impacted by stressful family of origin events. The systemic characteristics of the family are alliances, communication, parental functions, boundaries, roles, affective processes and exchanges with outside systems. These influence and are influenced by family of origin events and the degree to which these events have been accepted, integrated or resolved by the present parental dyad. The authors suggest that in an incestuous family, what should be nurturant physical contact becomes sexualized. Intimacy and closeness between adults is problematic, and separateness is threatening. The coalition in the parental subsystem is weak, and boundaries are crossed not only in sexuality but in other areas. In this model the occurrence of incest is explained by a combination of family of origin events and present family systems characteristics. Others have identified family dysfunction and intergenerational issues as key to the understanding of sexual abuse in families (Sgroi, 1982; Gelinas, 1983;1986).

Feminist theory has contributed much to our understanding of sexual abuse and exploitation of children and adults in relationships. This has occurred in the analysis of basic sexual inequality and the patriarchal social system. The feminist literature that examined the problem of sexual assault against adult women and abuse of women by men has been adapted to explain sexual abuse of children both in and outside the family (e.g. Brownmiller, 1975). Child sexual abuse was viewed as a consequence of male socialization and historical social processes that identified females as the property of men, with power, inequality and male social control of women and children as key contributing factors. The prevalence of child pornography is another area of victimization that is viewed as perpetuating

more child sexual abuse. Within the family, the fathers excess power and control in the family dynamic is seen as responsible for the development of incest (Herman, 1981). The therapeutic goal is primarily a change in the power balance in favor of the mother. Family therapy is frequently seen as inappropriate since it is viewed as implying shared responsibility for the abuse among all family members. As will be discussed in a later section this is not the implication according to the family therapy literature. Family therapy has been criticized for supporting existing power imbalances and male dominance by seeking family restoration. Herman (1981) suggests that the restoration of the family must begin with strengthening the mother-daughter relationship toward assuring the victim protection and support. The health of the mother-daughter relationship is seen as the most meaningful index of family rehabilitation. In addition, it is suggested that intervention be aimed at the social level, altering the social structures that support victimization by males and at the individual perpetrators of abuse. Herman has observed that a dichotomy exists within different programs - those that criticize family reunification versus those that see it as in the best interest of all family members.

The "chaotic family" is also identified by several authors as a type of family where incestuous child abuse occurs. (Haugaard and Repucci, 1987; Sgroi, 1982; Kempe and Kempe, 1984; Anderson and Shafer, 1979). Chaotic families are said to be characterized by extreme disorganization, lack of behavior control and absence of physical and emotional boundaries between members. Such families are often physically and emotionally isolated from their community. They are perceived by professionals as extremely difficult to engage in treatment. Anderson and Shafer have

referred to these families "character-disordered", suggesting they are multi-problem families often characterized by chemical dependency and physical violence. Individual members are said to lack impulse control, possess criminal records; lack verbal means for expression of feelings and present narcissistic traits. The authors seem to generalize without discriminating between traits of the offending parent and other family members. Kempe and Kempe also refer to the chaotic family but suggest there is an association with their socio-economic status. They cite problems of emotional deprivation, neglect, lack of ability to form lasting relationships, substance abuse, poor impulse control, and violence among such families. Sgroi identified these families as lacking goal-directed negotiation among members and being absorbed in fantasy with little awareness of reality. She also suggests a poor prognosis for these families, but sees them as being less prevalent than the higher functioning families. "Mid-range" families are viewed as rigid with limited coping mechanisms and a high degree of vulnerability (1982).

The category of chaotic families as explaining incest in families can be criticized in that it appears to be a way of describing families that are either minimally functioning or influenced by larger system components. There may be a relationship between multi-problem families and cultural and economic inequality in our society. This explanation is really another way of suggesting that family characteristics contribute to sexual abuse in families, and that there is a range of family patterns and traits that can be observed among such families.

Another way that child sexual abuse has been explained is by seeing the problem as based in the individual pathology of the offender. Few offenders demonstrate severe mental disturbance in the form of psychosis or other clear psychopathology. However, it has been suggested that the offenders pattern of sexual arousal may be pathological in terms of arousal to children. This perspective has important implications also for the treatment of sexual abuse and sexual offenders.

Finkelhor (1984) has developed an elaborate model that is based on the perspective that the offender's sexual impulses are the first precondition that allows sexual abuse to occur. He views the behavior of incest and non-familial sexual abuse of children to be motivated by similar impulses. He model is presented as a way of understanding sexual abuse both in and outside the family. The offenders motivation to abuse must be present before being influenced by situational and familial factors that may inhibit or allow the abuse to occur. He identifies four factors that contribute to the internal motivation. First, the adult's emotional needs are met through sexual contact with the child, due to emotional immaturity and feelings of control and power, or other non-sexual motivations surrounding the behavior. Secondly the offender experiences the child as sexually stimulating as a result of early sexual experiences, biological factors or social learning. This factor may differ among offenders and may be hard to isolate. Another factor referred to as "blockage" is the offenders inability to seek sexual gratification from adult relationships due to psychological conflict, personality traits or early sexually traumatic experiences. Other situational or personality factors are said to contribute to disinhibition to sexually abuse, such as substance abuse

or stressors related to loss. Finkelhor also discusses the early contact between a father and daughter in caretaking as inhibiting sexual abuse and therefore can be considered as a factor where this early contact was lacking, such as in a stepfather relationship. Parker and Parker (1986) compared intrafamily sex offenders with non-offenders, and found significant differences in the involvement of the fathers in the early socialization of their daughters. Sexually abusive fathers were more likely to have been absent from home for periods of time in the early life of the child, and were less likely to have been involved in childcare and nurturant activities during the first three years of their daughters life. This study also found sexually abusive fathers to have experienced greater instability during their early childhood in their family of origin. Sexually abusive fathers were also more likely to have felt emotionally deprived during their own early socialization.

The above explanations for child sexual abuse in the family encompass the prevalent theories concerning its etiology. Much of the literature is now strongly emphasizing that no one theory or explanation alone is adequate to explain its development in all situations where the problem occurs. It is becoming increasingly apparent from observing families that all explanations have relevance. A truly systemic perspective needs to incorporate family systems and functioning, feminist perspectives of power and sexual socialization, and individual psychodynamics of sexual offenders. Several of the authors cited have sought to combine these explanations. Finkelhor's model is a good example. Sgroi (1984) also identifies multiple factors of family dynamics, individual pathology and abuse of power in the family. This allows for a way of conceptualizing the

sexually abusive family that includes both underlying motivation of the offending parent, the familial and social structures that contribute to its occurrence and continuation in any given family situation. Gelinas (1983) has discussed the importance ofthe role of the female, first as an incest victim, and later as a parent in contributing to the intergenerational patterns in sexually abusive families. Again, she views patterns as based in both individual and family processes. In her clinical work with adult women who were incest victims, Gelinas explores how incest victims often enter into relationships with men whose characteristics and dynamics put families at risk for repetitive sexual abuse. Relational imbalances exist in the incest victims family of origin, since the victim was typically parentified by both parents. They may then enter into relationships with men who experienced early emotional deprivation or abuse. Such men may be characterized as insecure, dependent, immature and sometimes sociopathic in personality. Gelinas qualifies that there are variations to this profile. Some patterns involve mothers with multiple boyfriends who abuse their children, or offenders described as domestic tyrants with whom mothers have no influence. In these situations offenders may still possess the aforementioned characteristics. In what is described as a "typical profile", a gradual initiation of incest occurs out of the father's needs for nurturance and affection, the mother's emotional depletion and daughter's parentified role. Mother's are not presented as invariably collusive or as abandoning their partner sexually. The intergenerational pattern occurs when the victim is exploited in subsequent relationships as she gets older, repeating a pattern of marriage to a male possessing similar characteristics as her father. Her early parentification leads to ambivalent feelings toward her own children. She is often able to meet the

earlier biological needs of her children and parent adequately when they are very young. As the child matures, relational problems begin to emerge. While this pattern described by Gelinas seems to fit many of the situations encountered in practice, it has been argued that one should be cautious about generalizing or suggesting that one typical profile exists. For example, while it is true that some cases encountered in practice appear to be a gradual initiation of sexual contact to meet affection and nurturance needs, there are also numerous cases of violent and coercive sexual contact and threatening behavior toward children in a family. It is also not known if sexual abuse that is non-violent would develop into more violent behavior over a period of time or if a child became more overtly resistive. Nor does the existence of violence in the behavior alter the psychological impact and damaging effects on the victim, regardless of the specific nature of abuse, although it does influence the degree of impact.

Haugaard and Reppucci (1987) have suggested that "Perhaps the best approach is to conclude that there are several equally valid explanations depending on the family in question and that the search for an ideal explanation of incest may be fruitless". It becomes clear that a combination of factors and explanations are suitable to the understanding of why sexual abuse occurs in families. Jon Conte (1982; 1984) has also criticized the often assumed distinction between perpetrators of sexual abuse in the family and outside the family. He suggests that they may have more similarities than differences and that the notion that the classic incest offender differs from the pedophile is premature, based on our current knowledge of offender behavior. Conte also points out that there is a tendency to view the problem as originating in interpersonal or

intra-personal functioning. A more systemic perspective would be helpful toward recognizing the contribution of sociological factors such as pornography and socioeconomic conditions. This has been supported by Finkelhor's research as described earlier.

A review of the effects of sexual abuse on children and families also supports the rationale for family-focused treatment. The problem of sexual abuse has an impact on all family members and their interaction with each other. For the child victim in the family, the relationships upon which he or she depends on for security and safety are threatened. There exists little debate among those involved in helping sexually abusive families that physical and psychological harm occurs as a result of abuse. Professionals find themselves confronted with victims presenting both initial effects and long term consequences.

Finkelhor and Brown (1986) conducted a large review of the research literature on the effects of all forms of child sexual abuse. In summary initial effects on children are cited as reactions of fear, anxiety, depression, anger, hostility and inappropriate sexual behavior. Effects on adult survivors of sexual abuse include depression, self-destructive behavior, anxiety, feelings of isolation and stigma, poor-self-esteem, tendency toward re-victimization, substance abuse, generalized mistrust and sexual maladjustment. Finkelhor also found that trauma increased when sexual abuse was perpetrated by a father or stepfather, when there was genital contact, presence of force, and a large age difference between victim and perpetrator. Trauma was also greater when the victim's family was unsupportive and when the victim was removed from the home.

Russell (1986) looked at subjective trauma as reported by adult women survivors of incest. She found a relationship between the severity of incestuous abuse and the degree of trauma reported. For example, the distinction between intercourse and genital fondling was important in predicting trauma. Duration and frequency of abuse also influenced degree of trauma. Russell also confirmed Finkelhor's finding that measure of force and violence affected degree of trauma. She further postulated that stepfathers may be less restrained in their abusive behavior than biological fathers. In her clinical work, Sgroi (1982) has noted many of the destructive effects already mentioned in the above studies. Sexual abuse is nearly always disruptive, disorienting and destructive for a child. One reason is that the degree of stimulation is beyond the child's capacity to deal with and assimilate. The experience interferes with the child's normal developmental tasks of mastering his or her environment and self in relation to others. Exploitation by another person in a powerful position causes confusion for the child. Kempe and Kempe have noted that many of the symptoms seen in children who are victims of intrafamiliar abuse are similar to those in children victimized by someone outside the family. In addition to symptoms noted above they have observed phobias, psychosomatic problems, school difficulties and poor impulse control related to sexual and aggressive behavior (1984).

In attempting to identify the effects of sexual abuse, much of the literature has pointed out that it is difficult to separate the effects of the abuse itself from the effects of numerous other factors in the child's environment (Kempe and Kempe, 1984; Finkelhor and Brown, 1986; Mrazek and Mrazek, 1981). Most often this refers to the dysfunctional aspects of the

family system where sexual abuse occurs. Children frequently experience physical abuse, neglect and impaired family relationships and are exposed to chaotic and isolated environments. These factors that pre-date the onset of sexual abuse and all of the child's earlier experience both positive and negative will influence observable effects on the child victim. Kempe and Kempe (1984) note that the variable behavioral symptoms may relate to the age of the child, the degree of interference with developmental status and the child's basic strengths and vulnerabilities.

The most obvious gap on the research of the impact of sexual abuse is that of the effects on male victims. Finkelhor and Brown's (1984) review noted that most impact studies contain samples of female victims only. Most studies do not discuss specific effects on adult men or male children. More recently clinicians has recognized a connection between adolescent sexual offenders and a history of sexual or physical victimization in their families. Adolescent offenders may also have been witness to sexual abuse in their families. Male children who are sexually victimized are more likely to be younger and more likely to be physically abused as well. They are also less likely to be identified as victims and they are most frequently abused by men (Finkelhor, 1984).

The risk of the development of intergenerational patterns of incest have frequently been explored in the literature, and this needs to be considered one of the long term effects of sexual abuse on the family as a whole, and even on future generations (Gelinas, 1983; Koch and Jarvis, 1987; Larson and Maddock, 1987; Sgroi, 1982; Kempe and Kempe, 1984; Mrazeck and Bentovim, 1981). The risk is present not only for victimized children,

but also for siblings not directly abused but exposed to the problematic family dynamics and inappropriate sexual behavior. As described earlier, Gelinas examined patterns of abuse transmitted through the female victims experience, and Parker and Parker (1986) had found patterns of early deprivation in the adult male sexual offender. Clinicians working with incestuous families now routinely explore the adults early childhood experience and frequently discover sexual or physical abuse in family of origin history. The evidence strongly supports the need to recognize intergenerational risks and to view the family system as a target of intervention. Larson and Maddock (1987) have gone as far as to say that they have not treated an incest family where sexual abuse was not found in previous generations.

In addition to the consideration of long-term risk, a systemic family focused intervention acknowledges the immediate and short-term impact of disclosure and disruption of the family system. Within weeks after incest is disclosed it is typical for families to have contact with five different agencies. The family is faced with overwhelming information, multiple social service involvement and separation of family members. Solin (1986) has observed the response of the family members toward the social system and interprets their anger as displaced from the offending parent onto the service system. This response is viewed as an extension of family loyalty. She suggests that the child victim needs to reframe the abusive parent as good, and that the families displacement of affect should initially be viewed as an adaptive facilitation of the psychological management of the disclosure.

It is important to carry the above hypothesis even further in order to recognize the strong ambivalence that may be present in each family member. Disclosure of sexual abuse brings both relief and fear. Many sexual offenders express relief at their behavior being stopped by the victims disclosure and the external intervention. Previous attempts at self-control of the behavior may have failed. This relief is mixed with the fear of loss of significant relationships and the threat of criminal charges. The victim is relieved of the burden of the secret and of continued abuse, yet frequently expresses regret at disclosing due to the responses of family members and the numerous disruptive consequences of disclosure. Ambivalence is also present in the non-offending parent who both wants to do the "right thing" to protect her children and yet is faced with mixed feelings toward the victim and her partner and doubts about herself as a parent and as a partner. Sgroi (1982) also discusses the intensity of divided loyalty in situations where parents choose to support one another and ignore the needs of the child victim. During the initial crisis of disclosure, it is unusual for parents to present as choosing to make significant changes in their parenting and behavior. Fear, denial, and ambivalence are manifest by fluctuations in loyalty and conflicting feelings related to complex family and individual dynamics. The recognition and management of these feelings by the professionals involved has strong implications for the outcome of the situation for the family, and suggests that the clinical involvement needs to begin immediately after disclosure. The initial confusion and conflict is a healthy and necessary part of the process of change as family members begin to struggle toward change that will provide a safer environment.

Therapists also need to recognize that often anger toward the social service system is an appropriate response to the inadequacy of that system and the families frustration with its operation. The therapist needs to be sensitive to the reality of the families frustration and its justification, and be able to validate their feelings.

Some have argued against a family focused treatment approach. In reference to child abuse of any form, Williams (1983) suggests that current child abuse programs that have a goal of keeping the family intact discourages a focus on strategies directed toward creating new alternatives to keeping children at home and protecting their well being. She states that most treatment services are focused on parents and neglect psychosocial problems of abused children. She argues for a child advocacy orientation directed at removal of children, termination of parental rights and freeing children for adoption. While few would disagree that there are situations where this approach would be recommended, decisions need to be made upon careful and ongoing assessment of each family in question with the degree of risk to a child being the first consideration. Assessing degree of risk is not always a simple matter. Professionals are often faced with a dilemma in making their recommendations. In referring to incestuously abused children, Fine and Carnevale (1984) point out the complexity of determining the needs of the child: "First, incest intensifies relationships within the family, yet tends to destroy the family as a social system; second, traumas resulting from incest increase the child victim's needs for sensitive parenting, yet continuous parenting relationships may become less available when the child is removed from family ties; and third, the practice of placing child victims into

foster-care shields them from abuse but also increases their risk for abnormal personal development." These authors view foster-care as a valuable part of social network treatment as facilitating support and protection for the child and modeling for the parents, as part of the overall treatment for the nuclear family. Temporary foster care can be a valuable part of family intervention only if it is part of coordinated treatment plan.

The following section will explore specific models of treatment discussed in the literature and applied in various programs.

FAMILY TREATMENT

There are several models of family treatment described in the literature that are based on a combination of therapeutic modulates incorporating individual, dyad, group and family therapy within an overall treatment plan. These models are based on the premise that members of sexually abusive families have both individual treatment needs and relationship problems that require intervention to facilitate healthier family functioning. Peer group support and therapy are also viewed as effective components of a treatment plan promoting resolution of some of the issues common to child or adolescent victims, offending fathers, and their partners. The most frequently cited program originated in California and was developed by H. Giaretto (1981). Subsequently, other programs have been developed based on the principles and structure of the Giaretto model, such as a program in Calgary, Alberta (Anderson and Mayes, 1982). This program treats families where the offender is a parent or occupies a

parental role. It is described as a humanistic approach, based on family systems theory and emphasizing the martial/parental system as the foundation of the family system. The health of the family is seen as reflecting the strength or health of the parental dyad. The first phase of treatment consists of individual counselling for the victim, mother and father, followed by dyad work in combinations. The final phase of treatment is family therapy if reunification is chosen by the family. The family work focuses primarily on adjustment to living together again, with open discussion of the abuse, the changes in earlier therapy and implications of the fathers return. Group therapy is also a component of treatment. It should be noted that the family therapy sessions in this program are not initiated until the final stage of treatment. Therefore siblings are not included as a focus of intervention until the final stage. This approach is different than the family treatment program outlined in the work of James and Nasjleti, (1983). Like other family treatment programs, this model incorporates individual, couple, group and conjoint family therapy, and depends on the involvement of the criminal justice system and child protection agency to assist in motivating therapeutic involvement. In contrast to the Anderson and Mayes approach, this model includes family sessions from the point of disclosure and assessment to termination of treatment. There is a progressive increase in the frequency of family sessions. The conjoint family therapy is guided by several tasks:

1) To confront the sexual abuse openly for the first time as a family.

2) To define the patterns of abuse in the family.

3) To define the families short term and long term goals.

4) To establish a visitation plan.

5) To discuss progress toward accomplishment of goals.

6) To discuss adjustment after family is reunited or adjustment to separation.

7) Termination of court-ordered treatment.

While individual, dyad and group work are included, the system dynamics and patterns of abuse in the family are much more a focus of the change and intervention. Siblings of the victim are included in treatment with the overall focus on behavior and interaction in the family, boundary disturbances and parenting skills. The therapeutic stance tends to be direct and confrontive, particularity in terms of defining the circumstances and patterns of abuse in the family. Change involves restructuring of rules and patterns toward minimizing the potential for recurrence of abuse, with specific attention to rules of relating and behaviors.

In contrast to the above, Herman (1981) emphasizes the strength of the mother-daughter relationship as providing the best assurance for protection ofthe victim. She also sees the need for confrontive and supportive offender treatment with attention to intimacy and affection needs and control of sexual impulses. The problematic family dynamic is viewed as the father's excess power and control. Essentially Herman's ideas can fit into a more family focused model if the mother-daughter relationship is viewed as one dyad in the system. James and Nasjleti would agree that the strength of this relationship is significant to the mother's ability to

protect and support the child. It must be recognized however, that this goal cannot be accomplished without intervention also focused on the mother's individual needs and relationship issues with her partner.

Larson and Maddock (1987) also utilize a family systems approach to treatment. Their understanding of sexual abuse in the family is based on the interactional dynamics in the family, boundary issues and sexuality. Structural and strategic family therapy techniques are employed toward realigning intergenerational boundaries, establishing clear interpersonal boundaries, creating intrapsychic boundaries and developing flexibility in the boundary around the family system. Therapeutic goals are achieved in individual, group, couple and family therapy. Extended family and parents of adults in treatment are also included in family sessions in order to address intergenerational issues surrounding abuse. These clinicians have also strongly emphasized the sexual dynamics in the couple relationship as well as the way in which sexuality is expressed in the family as a whole. For example, it is important for the clinician to note how affectionate touching and physical interaction occurs, and the physical and emotional boundaries between family members. The parents communication with children about sexual feelings and attitudes needs to be assessed. Couple therapy includes exploration of their sexual relationship as well as their roles as parents. The therapists seek to empower parents as much as possible to develop competence in parental functions. In sex therapy clinicians assess the meaning of the sexual relationship to the couple, and their repertoire of sexual interactions with each other. Gender issues and stereotypes are explored. Couples need to learn to feel permission to be sexual while having a sense of responsibility for their own sexual fulfillment as well

as an ability to be responsive to their partner. Intervention involves sexual re-education and exercises to increase self and partner awareness. In comparison to other treatment models reviewed, Larson and Maddock have placed a much greater emphasis on the sexual aspect of the couple relationship in treatment. An exception is Mayer (1983) who provides a guideline for sexual history of partners and identifies sex therapy as a focus of couple work.

Like the approaches described above, most family system based interventions involve attention to the structural characteristics of the family system, and target structural changes with particular emphasis on boundaries, family rules and family roles. Crumbly (1985) describes a case study of family therapy where an adolescent female was sexually abused by her father. Family therapy focused on differentiation of roles, boundaries and hierarchy in the family system. Life cycle and intergenerational issues are also addressed with extended family involvement in therapy sessions. In this case study, the dynamics contributing to the sexual abuse are identified as the breakdown of the parental subsystem, parentification of the daughter and unresolved intergenerational issues. The incestuous behavior is seen as having the underlying systemic function of being how the parents perceived the adolescent meeting their needs. In their work with the family the therapists used structural interventions to differentiate clear boundaries and roles and develop appropriate expectations of the adolescent in parenting. Couple work focused on nurturance and support in the relationship. While the intervention was determined to be effective in stopping the sexual abuse, it is not clear if the therapists dealt directly and openly with the sexual abuse in the

treatment of the family, as is apparent in the other approaches (James and Nasjleti, 1983; Larson and Maddock, 1987).

In another case study (Dale et al, 1986) a team of therapists describe their work with an incest family over a period of 1.5 years. Based on the Giaretto model, treatment phases included couple therapy, individual therapy and later family therapy. The discussion focuses on the dilemmas encountered by the therapists, in that they tended to "get stuck" when the family encountered natural ambivalence and confusion. Processes in the team became conflictual and polarized in response to the family, with the team mirroring the conflict occurring in the family. Consultation and processing of team involvement facilitated identification of role confusion and counter-transference and clarified process issues. The confusion and ambivalence in the family is reframed as a predictable and natural process; rather than a barrier to intervention.

Sgroi (1982) identifies several treatment issues in family intervention similar to those issues identified by others and cited earlier (isolation, denial, boundary and communication issues). She emphasized abuse of power as a key treatment issue. As in other programs described, family therapy is suggested as part of a comprehensive treatment plan. Sgroi also points out that intervention needs to take the form of aggressive outreach involving the therapist's entry into the physical environment of the family. She suggests further that "total life support" is needed for the family whose patterns of functioning have been disrupted after the disclosure. The therapist needs to attend to environmental services as well as provide support and guidance. It may be said that

Sgroi is referring here to the adoption of an ecological framework in the intervention. It is important to perceive the family system as a part of it's ecological environment with social and physical components surrounding it. Therapists need to examine the nature of the transactions occurring within this ecological network of systems. Many families where sexual abuse occurs are identified as socially isolated and lacking meaningful and healthy interaction with outside systems. An important part of any intervention may involve, for example, mobilizing resources for a family such as financial needs, or access to training or child care. James and Nasjleti (1983) for example, describe the facilitation of enrolling the child victim in nursery school where she began to develop connections with other children. With families in treatment, the therapeutic network also becomes a part of the families ecological environment. Relationships and interaction between individual professionals and agencies become significant to the outcome and process of the intervention program. Gelinas (1986) identifies how such multi-agency involvement can become problematic and fragmented if not structured as a cooperative therapeutic network. Personal connections cultivated among professionals is extremely valuable to the process of treatment.

In summary, the various case studies tend to highlight different contributing factors and targets of intervention while dealing with commonly identified treatment issues. Structural dynamics, intergenerational issues and environmental needs are consistently cited targets for change and exploration in treatment, with the goal of stopping the sexual abuse. A structural model as a basis for evaluating families explores characteristics of boundaries, subsystems distance, involvement,

and connectedness. These concepts are useful for describing family functioning and defining targets for change. The structural model does not claim a causal link between the family system and the problem of sexual abuse, but rather is a way of conceptualizing how a system maintains a problem behavior. The process of change involves changes in the relative positions of family members, while exploring new rules for transacting (Colapinto, 1982).

The case study in sexual abuse literature has been criticized with respect to the tendency to focus only on father-daughter incest, and the overall lack of control to determine the effectiveness of a family system approach to treatment (Conte, 1982). It is clear that insufficient data has been generated regarding the effectiveness of sexual abuse treatment programs in stopping abuse. One evaluation of the Giaretto program found that it was successful in increasing the offenders feelings of responsibility for the abuse and in decreasing recidivism, but was less successful in keeping the family together (Sagatun, 1982). It is not clear in this evaluation if the issue of family reunification is related to the stage of intervention. It also presupposes that effective intervention means reunification. Certainly the question of recidivism is difficult, since one must judge duration of follow-up of offenders and means of detecting recidivism.

Finally it is important to recognize, as Haugarrd and Repucci point out (1987) that some clinicians identify the offenders deviant arousal pattern as the first contributing factor to child sexual abuse. Assessment of arousal patterns to deviant versus normal stimuli can be determined

through specific testing methods of physiological arousal. While such testing is not 100% valid, it can suggest tendencies in arousal patterns with the belief that men with deviant arousal to children are more likely to repeat incest and more likely to abuse children outside the family. The treatment of choice involves behavioral oriented therapies designed to reduce the offenders arousal to children together with insight therapy to assist in his understanding of the meaning of his incestuous behavior. The contribution of alcohol or drug abuse is also assessed and identified as a target of treatment. Some family systems oriented therapists appear to recognize this category and refer to their programs as unsuitable for pedophiles (Anderson and Mayes, 1982). James and Nasjleti (1983) however, seem to treat incest offenders and non-related child molesters as mutually exclusive groups, suggesting that their family systems approach is suitable for all intrafamilial abuse. Conte (1984) has reminded us that this may be erroneous since some sexual offenders are known to sexually abuse both in and outside of the family, and that these individuals may indeed represent those with deviant arousal to children. Larson and Maddock do not address this issue. They suggest rather that some offenders are motivated more by rage and aggressive impulses more than affection needs and that victimization in the offenders history is always a contributing factor. Based on what is known currently about the possibility of deviant arousal patterns contributing to offending behavior, it needs to be considered in the treatment plan for any family, and behavioral treatment techniques can be incorporated into a family treatment program as a part of the father's individual therapy.

PART III

PRACTICUM EXPERIENCE

The setting for the clinical practicum was the Children's Hospital Child Protection Centre at the Health Sciences Centre in Winnipeg. This is a Provincial child protection program where the overall objective is the prevention and treatment of child abuse. Services at the Centre include diagnostic and treatment services using both inpatient and outpatient facilities, and consultation for cases of child physical, sexual and emotional abuse, failure to thrive and neglect. Two of the programs operating out of the Child Protection Centre are the sexual assault clinic and offender treatment. In the sexual assault clinic a multidisciplinary team assesses children who have been referred as victims of sexual abuse. These children are seen by appointment three half-days a week, for psychosocial assessments and medical examinations. Staff also meet with and interview parents and social workers accompanying the child. In cases of intrafamilial abuse, siblings residing in the home are also assessed by the team. Most often this assessment occurs at a time of crisis for the child and family, when a disclosure or discovery of sexual abuse has recently occurred. The assessment is also investigative since the medical examination may provide evidence for a future criminal investigation of a parent. Beyond this initial assessment, follow-up may involve, where appropriate, consultation and recommendations to Child and Family Services Agencies. The Centre works with these agencies and others in the community in an attempt to mobilize treatment resources for families and children

seen in the clinic. All current cases of child physical and sexual abuse are discussed at weekly team meetings of Child Protection Centre staff.

The offender treatment program is a group therapy program targeted for men who have sexually abused their children. This program includes a corresponding treatment group for the partners of these men. Both groups meet weekly for a nine month period, with termination of involvement being determined on an individual basis in consultation with group therapists. All offenders have a father or father-figure relationship to the child victim(s). Criteria for group involvement includes that he must accept responsibility for the sexual abuse and enter a guilty plea to criminal charges in court. Because of limited resources for offender treatment, priority for group membership is given to offenders who, with their family, intend to reunite. A change in this goal during treatment does not effect continued involvement in the program. The main objectives of the offenders group is to assist the men in accepting full responsibility for the sexually abusive behavior, and to develop methods to control deviant sexual arousal. Offenders must be prepared to disclose and examine in detail their sexual offenses, determine the patterns of their behavior and identify rationalizations used that allowed it to continue. Victim impact is also a focus of the group, toward developing greater empathy for their victims. Treatment includes exploration of any victimization experiences in the childhood of the offenders to resolve painful feelings associated with past abuse in their own history. The group promotes confrontive discussion to explore alternatives to lifestyle patterns that contributed to the sexual abuse. Films, articles, role-play and self-awareness

exercises are used to provide new information in areas of sexuality, social skills, assertiveness and stress management (Annual Report, 1986).

The partners group takes place at the same time each week as the offenders group. This group offers support for the women and explores many of the same issues dealt with in the men's group. Objectives include helping the women to adjust to and cope with the circumstances confronting themselves and their families, and to explore how they can more effectively protect their children. Many of the women have felt trapped and helpless while being consciously or unconsciously aware of the sexual abuse. Past victimization in their family of origin may have been a barrier to dealing with the abuse in their own family. Group members are also provided with new information related to sexuality and assertiveness. Each group is facilitated by one female and one male therapist, and may include participant observers who are interested in becoming more familiar with the clinical issues and group process of this treatment program. This year the two groups met together for a five week period with the focus on sex education, sexuality and sexual awareness. This allowed for the clients to learn and develop awareness of sexual issues as couples rather than in separate groups.

Prior to beginning clinical work, the student spent one week becoming oriented to the functioning of the Child Protection Centre and the sexual assault clinic. Families for the practicum study were then selected in consultation with the senior therapist at the Child Protection Centre and the student's clinical advisor. The senior therapist is responsible for the coordination of the group treatment program and co-facilitates the

men's group. All of the families had a history of involvement with the Child Protection Centre. Families were chosen on the basis of the following criteria: 1) The father's involvement in offender treatment and admission of responsibility for the sexual abusive behavior of his child(ren). 2) The expressed intention of the offender and partner to reunite as a family and the motivation of all members to be involved in couple and family therapy, and group therapy when available. Again, it was acknowledged with family members that a change in the goal of reunification would not affect involvement in treatment, since ambivalence or change with respect to this intention is viewed as a natural and healthy process of questioning the value and suitability of continuing the relationship.

Clinical supervision was provided by the student's program advisor. All therapy sessions with families were videotaped and processed by the student and her advisor. This allowed for valuable exploration and detailed analysis of specific interventions, client response, and progress in therapy. Videotape segments were sometimes shown to families in therapy sessions as a part of the intervention process, enabling families to view their own interactions with one another. Regular and ongoing consultation with the senior therapist responsible for the offender treatment also occurred. She also took part in therapy sessions with families when it was deemed to be suitable to have a co-therapist and the father's therapist present.

While some therapy sessions were conducted at the Child Protection Centre offices, the majority of sessions took place at the Manitoba Adolescent Treatment Centre. This setting was available for the student's

use and offered large, comfortable therapy rooms and video equipment. This was also a centralized location for families close to the offices of the Child Protection Centre.

A description of the families and overview of the intervention process is provided in the pages to follow. Two cases will then be described in greater detail. The student initially accepted five families for treatment. Four of these families remained in treatment for the duration of the practicum study. The fifth family, while initially felt to be suitable, presented some difficulty concerning the father's admission of sexually abusive behavior toward his daughter. While he admitted to sexually abusing one of his younger sister-in-laws a year earlier, he denied allegations concerning another sister-in-law and his daughter. Subsequently the family displayed reluctance to be involved in treatment and was referred back to Child and Family Services after a meeting with the couple and the senior therapist. All of the four families who remained in treatment were from the Winnipeg area. One family resided in a middle class area of the city, while the other three were representitive of a lower socioeconomic group and were supported by some form of social assistance. All clients economic status was negatively affected by the sexual abuse disclosure in terms of the necessity of maintaining separate residences, loss of employment and/or incarceration of the offender. Two of the families were caucasian of anglo-saxon ethnic origin, and one family was Native. In the fourth family the mother was Native and father caucasion. Their three children were a mixture of white, black and Native origin.

In all cases the father represented a stepfather or father-figure relationship to the children in the family. They had been living with the family for periods of time ranging from four to eleven years when the abuse occurred. In one family the partners had been married. In some families biological children of both partners were a part of the family or biological children of the father from previous relationships resided in the home. Three of the men also had biological children from previous marriages not residing with them. While denied in all cases it cannot be known for certain if any of these children were victimized by their fathers in the past. Only in one case did the father have recent and ongoing contact with his child who resided out of the province. One of the men had been known and admitted to sexual abuse of female children in extended family as an adolescent.

The age of the children in the families ranged from one to 15 years. Female children were sexually abused in all families and in one family a male child was also sexually abused. Sibling incest involving intercourse occurred in one family in addition to the parent-child abuse. In three of four families alcohol abuse by the offending parent was occurring at the time (not necessarily surrounding all incidents) of sexual abuse, and was considered to be a factor contributing to the pattern. All had been abstaining from alcohol and involved in alcohol treatment prior to commencing family treatment.

The student's role was to provide family and couple therapy for a period of six months. For some, family sessions included fathers where appropriate or included fathers toward the end of the practicum. This was

related to the specific needs and stage of treatment of the family. Others involved sessions with mothers, and children, while fathers were seen in couple therapy. Families varied in terms of length of time since disclosure of abuse and status of criminal charges. In the L. family, the student became involved immediately after disclosure and assessment at the sexual assault clinic. In the W. family, disclosure had occurred a year prior to intervention and the father had completed a sentence of incarceration. Two families awaited disposition of charges in court.

All families received couple therapy on a weekly basis, and family sessions occurred weekly. For the S. family, the children were less frequently included because the student had conducted family therapy with this family for three months prior to the six month practicum. The focus of treatment for this family was couple therapy and some sessions involving the child victim. While the student's intervention began in June, the offender and partners groups did not begin until midway through he practicum, in October. One couple had been in the group program the previous year, and became involved in group again during the practicum. All couples began the group treatment program, with the exception of one father who was ongoingly involved in individual and group treatment with an external therapist. This client did attend the couples group sexuality portion of the Child Protection Centre program. Where available, child victims participated in individual or peer group therapy offered by the Marymound Family Resource Centre, the Manitoba Adolescent Treatment Centre, and Child and Family Services of Central Winnipeg. The male adolescent offender was also involved in treatment at the Marymound program.

During the course of the practicum all families were living in separate residences, with mothers residing with child victims. In the S. family the two biological sons resided with their father, the adolescent offender in a foster home, and the child victim with her mother. The adolescent offender later was placed in Seven Oaks Centre Youth due to a offense occurring in the foster home. The W. family lived separately for over a year but the father moved back with the family in September.

The initial stages of intervention focused on engagement with families and assessment. The therapist found it necessary to clarify her role with the families often more than once. Since families had typically encountered multiple social service professionals in relation to the abuse disclosure, they often responded with confusion to the involvement of yet another professional. Other families expressed relief at the learning that this therapist would be working with everyone in the family, since this type of intervention had not been available earlier, and treatment had often been limited to one person in the family. Another issue for families was their concern about the degree of influence the therapist would have concerning legal or child welfare issues. Families needed to know that information was shared with the Child Protection Centre team where appropriate, and that the therapist represented a part of this team. This role was presented to families in a direct and positive way through emphasis on the goal of the treatment process being to promote a safer environment for everyone in the family, with safety referring to emotional, sexual and physical safety and comfort. It was also presented that the team's clarity on goals and issues in treatment provided the family with optimum services. The therapist also needed to acknowledge the reality of

the involuntary nature of their involvement in treatment and feelings associated with this. This is balanced with clients genuine motivation for change and growth. Essentially this reflects the ambivalence experienced by all individuals entering therapy who are confronted with the possibility of change. For the individuals in these families who tend to be closed and threatened by emotional intimacy the thought of sharing feelings can be particularly threatening even when there is a real investment in change.

All families were requested to complete the Family Assessment Measure III, and a problem checklist. Couples were also asked to complete the Dyadic Adjustment Scale. The therapist explained to families the meaning and use of the testing materials. Pre-test results were sometimes introduced to families in therapy sessions for discussion in terms of how they may perceive different aspects of their family as different or similar, and how this may relate to disturbances contributing to difficulties or patterns of abuse. The evaluation component of the practicum will be explored further in Part IV.

Genogram drawings were done with each family and used as both an assessment tool and in ongoing therapy. These were done with families and couples and were valuable sources of information revealing intergenerational issues, relationship patterns, abuse in family history and the meaning of events to individual family members. Information about previous marriages and relationships among current family members was also clarified. The use of the drawings in therapy sessions provoked disclosure and discussion around many of these issues, such as the meaning and impact of emotional cutoffs from extended family, or loss from premature death.

Ecomap drawings done with families contributed to an understanding of the families social network and current relationships to external systems or persons in their social and physical environment, including friends, family, social services, employment and housing situations. A visual representation of the families ecological environment and the nature of the transactions among the components was useful to identify needs and changes that could promote healthier connectedness for families to their social and physical environments. Some families were socially isolated or had mainly stressful connections with external systems.

Structural and family systems were a focus of assessment and treatment. The therapist sought to identify and target characteristics of the family that could be described in structural terms, such as boundaries, subsystems, roles, distance and closeness, triangulation, level of involvement, and family organization. In all families the boundary around the marital/parental subsystem was poorly defined and the strength of the marital subsystem weak. This was demonstrated in different ways. For example, in the S. family, the couple could be described as too child focused, needing to draw children in to all activities in order to meet the adults needs for relatedness that were not being met in the couple relationship. Age appropriate disengagement of adolescents from parents was met with negative guilt-inducing responses from parents. In the L. family, the couple relationship was extremely disengaged, in that the father had most of his needs met outside the relationship and provided only a role of financial support with minimal involvement in child care.

A significant component of the intervention provided by the therapist involved attention to and direct involvement with the therapeutic system surrounding each family. The families were typically involved with numerous agencies in the community providing treatment or practical services that functioned as the therapeutic network for the family. The therapist found, that as the person most regularly and frequently in contact with families, she was most familiar with the families ongoing needs in relation to this network. Intervention often involved enabling families to access other systems or directly advocating for supports. Periodic interagency team meetings with the involvement of families in treatment planning and progress toward accomplishment of goals was an important part of the treatment process.

It was found that there were several problematic areas common to all families involved in treatment that contributed to or supported the pattern of sexually abusive behavior. The following needed to be targets of intervention in each family:

1) Parents having unresolved family of origin issues including relationship disturbances, parentification in family of origin, sexual, physical or emotional abuse.

2) Long-standing disturbances in the couple relationship predating the onset of sexual abuse in the family. Couple relationships tended to be characterized by power and control disturbances, sexual difficulties and communication problems. Historically parents tended to have patterns of disturbed relationships with sexual partners prior

to the current relationship, characterized, for example, by abusive interaction.

3) Multiple boundary disturbances between family members in areas of autonomy, sexuality and intimacy and boundary issues with external systems.

4) Parents demonstrating poor impulse control in relation to each other and their children. Aggressive behavior and physical violence between spouses and toward children was an identified problem in three families in addition to the sexual abuse.

THE W. FAMILY

Children: This family has three children residing in the home. Peter is 12 years old and is black in appearance, as his father was black and mother Native. He is quiet and cautious around adults, but very active and finds it hard to sit still without distracting. He has presented some school problems related to aggressive behavior with peers and distracting classroom behaviors. Both Peter and his brother William, who is 10, are talented at drawing. William is also quite aggressive in his behavior. The boys are competitive with one another and seek parental attention through negative behavior at home. While he is younger than Peter, William is physically tougher in appearance. He is Native. Danielle is eight years old, and black in appearance. Her status as the youngest and only female child seems to acquire her special attention in the family. Danielle does not encounter social difficulties at school. She is very

attractive and it is evident that her mother affords special attention to her dress and appearance.

Father: Bill is 41 years old, caucasion, and very overweight. He presents as somewhat anxious, wary, and sometimes angry. He talks in a rambling fashion, often repetitiously in an effort to deal with anxiety and control interaction. The youngest of four children, Bill's parents had him late in life. Bill recalls little about his own childhood. His mother abandoned the family when he was 15. In his earlier memories of his mother Bill describes feelings of embarrassment over what he describes as her childish behavior. He saw her relate to his father as a child would with a parent. His father, who died many years ago, is remembered as strict and authoritarian, using physical punishment to discipline. Bill was sexually abused by an uncle when he was nine. "I had no one to talk to about what happened to me". At age 10 he initiated sexual fondling of an eight year old male cousin. His first consenting sexual relationship was with his first wife when he was 23 years old. This relationship lasted 6 years and produced two daughters who are now young adults. He has only limited contact with them, and recently saw one of them in a restaurant and was disturbed to find she did not recognize him.

Bill's mother resides in a home in Brandon. He has seen her only once or twice in the past several years. Bill had a well paying factory job prior to the sexual abuse disclosure. Currently he is unable to find employment and this problem is strongly effecting his self-esteem. He has an image of himself as a selfish and self-centered person.

Mother: Joanne is 10 years younger than Bill. She is Native and the middle sibling of a very large family of 13 children. She is also very overweight. She grew up on a reserve environment with poor social and economic conditions. Joanne was sexually abused by an uncle as a child. When Joanne was young her mother left the reserve to pursue a career in nursing. Joanne moved to the city at age 12 and became pregnant at 16. This child, Linda, was raised and continues to reside with Joanne's mother who is Linda's legal guardian. Linda often stays with the W. family to help care for the younger children. Joanne has worked to complete her interrupted high school education and plans a nursing career in the future.

Bill is the biological father only to William. While his stepfather relationship to Peter is acknowledged, the paternity of Danielle is a secretive and toxic issue, despite the fact that it is obvious that her father must have been black.

Both Bill and Joanne have a history of alcoholism, but have not misused alcohol for two years.

Events preceding treatment:

The history of Joanne and Bill's ten year marriage is characterized by chaos and violence. Early in their relationship Bill was sexually involved briefly with Joanne's sister, for which Joanne has never forgiven Bill. Joanne herself engaged in numerous sexual relationships with men and describes herself as "promiscuous". Frequent arguments between them were precipitated by alcohol abuse and often involved violence. Bill

experienced unexpressed feelings of rage and hostility that were often unleashed onto the children in physically abusive behavior. "I would punish them for something but I would go overboard. I wouldn't stop hitting them". A pattern was established whereby Joanne would stay out with friends, often not returning home all weekend, and Bill was left alone with the children. Sexual abuse occurred during these times and increased in frequency. Abuse of Peter involved mutual masturbation and anal intercourse. He also abused Danielle involving fondling and intercourse. Abuse of Peter began at age 5 and Danielle at age 6. Peter disclosed the abuse at age 9, after viewing a prevention program at school. The children were apprehended briefly and returned to their mother after Bill left the home. Joanne acquired a legal separation from Bill. He served a prison sentence of fourteen months before being paroled in the community. He initially resided in a community halfway house upon his release.

Treatment Program:

Both parents became involved in alcohol-focused treatment before any treatment dealing with the abuse was provided. Involvement in therapy was considered semi-voluntary, since there were no specific orders for treatment but the child protection file remained "active". Bill began individual treatment focusing on sexual offending shortly prior to leaving prison. This treatment continued upon his release. Individual therapy focused on early family of origin experiences, and feelings surrounding his own experience of abuse. Feelings of isolation, rage, hostility and powerlessness were revealed. Therapeutic intervention also focused on anger control and recognizing cues to violent behavior and sexual offending

behavior. Bill was also able to make some initial connections between his relationship with Joanne and anger directed at the children. Bill identified mistrust and poor communication as problems in the marital relationship.

Joanne did not receive individual therapy until she and Bill had discussed reconstitution of the family. She was seen for brief individual therapy in which she chose to deal with her own past abuse and family of origin issues. Initially Peter was seen by a school social worker, with some focus on his experience of victimization and the aggressive episodes at school. None of the children were seen for individual treatment (beyond assessment interviews and crisis intervention) until some time later after Bill was again residing with the family.

Family therapy began prior to Bill's returning to live with the family. No probation orders were in effect to prevent his contact with the children in any form. The agreement to maintain a separate residence was voluntary upon the recommendation of therapists. This agreement was initially kept. Joanne had stated that she did not want Bill to live with them until he found employment. In the early stages of therapy it became apparent that he was in fact spending a great deal of time in the family home, but Joanne was not allowing Bill to be alone with the children. Later on the family revealed that he was permanently residing in the home, but they did not inform the therapists of this until some time later. Parents were confronted with the attempt at deception and the importance of sharing information with the therapist. Joanne continued to maintain her position of not leaving the children alone with Bill. While he at times

became defensive around this and his insistence that he would not abuse the children, he also gave subtle messages that Joanne's vigilance was necessary. The fact that Joanne sought assistance from family services for child care when he had to be absent from the home was taken as her continuing to protect the children. The availability of a homemaker for the family became a system issue in that this resource was very hard for them to access. This is an example of conflict in the expectations of the family by the system and the actual support provided. The therapist advocated for child care support and helped the family to access this.

Bill continued weekly individual therapy during the phase of family therapy. Joanne was offered ongoing individual therapy but did not initiate this.

In family sessions the abuse incidents were discussed openly between members of the family for the first time. Joanne acknowledged that when she had tried on her own to talk to the children about it that it was too painful for herself and for them. Bill was able to sincerely accept responsibility for the abuse and recognize that he had hurt the victims as well as everyone else in the family. Each of the children were encouraged to share their feelings about what their father had done, and were able to share conflicting feelings of anger, guilt, confusion and self-blame. Peter was able to talk about his fear that his father was angry for his having told about the abuse. Both parents were able to reinforce for Peter that he had done the right thing by telling. Peter's disclosure was framed for the family serving to stop the abuse and to get help for everyone in the family. The children talked about how they had discussed the abuse

with one another before disclosing outside the family. They told William who defended by denying and "forgetting". "I forgot about it right away". In therapy it was acknowledged how difficult it was for Peter and Danielle when William did not believe them. The children also had to know how hard it was for William to believe that his father had hurt his brother and sister. William would disclose "I tried to picture it, it was shocking". Before he was able to express his anger verbally, William had been exhibiting destructive behaviors, such as cutting up the mattress on his bed.

Both Bill and the children were asked to relate specific incidents of abuse. Bill described how he would set up the situation when Joanne was not at home. he would send the other children out to play, and call Peter into the bathroom or bedroom. Sometimes the other children would come into the house and listen from the other side of the bathroom door. Danielle's molestation by Bill would often occur in the living room in front of the boys.

The children shared their fears that had inhibited disclosure to their mother at the time of the abuse. Her frequent absence from home was identified as a factor contributing to the children's feelings of being unprotected. Peter worried that if he told his mother that he would have been hit. In this family, as with many families, physical abuse of children was tolerated more than sexual abuse. This also contributed to setting up the conditions of lack of trust and fear in the family with children feeling unprotected. Peter talked about feeling angry at himself

for not disclosing sooner, and feeling angry toward his father for putting him in this position.

Rules around privacy and secrets were also explored with the family, identifying changes in rules to ensure privacy and safety. The therapist helped the family to develop a set of rules that included rules for parents, that was placed in the kitchen where everyone would be aware of it. Rules included for example, only one person in the bathroom at a time, always knocking to request entrance into bedrooms and no secrets that threaten feelings of safety and comfort.

The physical abuse experiences were discussed in the same manner as sexual abuse, with Bill accepting responsibility and apologizing to the children for his behavior. The children identified feelings of fear surrounding these experience, yet were less able to recognize the wrongfulness of their father's punishment of them. The therapist was firm in establishing a no physical punishment rule, while introducing new child management techniques emphasizing positive attention to appropriate behavior, an area lacking in the parenting repertoire.

Other child care issues emerged such as the amount of time the children were left to manage alone. This placed Peter in a parental role with the younger children. Parents were provided with guidelines around attention to the children's developmental needs and the importance of appropriate supervision in their absence. Bill and Joanne also began to take a more active role in organizing family activities and outings as a replacement for an excess of television and video viewing. Joanne

expressed concern over the violent content of some of the movies brought home for the children to watch. The therapist need to support Joanne in maintaining rules around appropriate viewing material. It was also recognized that such material was of course inappropriate for Bill to be watching and this needed to be pointed out. He had to begin to accept responsibility to change the conditions that made it easier to abuse.

In family sessions Peter was able to ask his father why he abused him, saying that it felt as though he did not care about him. Bill responded appropriately by sharing some of the things he was learning about himself in individual therapy, while still accepting responsibility. William, who had not been abused and who had initially denied the existence of problem, began to ask similar questions of his father, about why he sexually abused and for how many years. William continued to be protective of his father. "How do you feel when we are talking about what you did?". Peter was also able to talk about some of his fears around associating the abuse with homosexuality. "My friends say that means you are gay". He needed reassurance that his fears were normal, and that his experience did not mean he is gay. This fear and confusion was one of the responses addressed with Peter later in individual therapy, in the Marymound program.

Protection plans for the children were also addressed in family therapy sessions, involving discussions of what they would do if one of the rules were broken, or if they experienced physical or sexual abuse again. All of the children indicated a sense of being protected by their mother, saying they would tell their mother right away or "run away and tell mom" or "tell someone else". The therapist also focused on how to identify

uncomfortable feelings and what circumstances might provoke uncomfortable or unsafe feelings. The physical presence of Joanne was associated with safety in the children's responses, and this needed to be emphasized for the family by the therapist.

Couple therapy with Bill and Joanne began at the same time as the family sessions. In couple work the areas addressed were trust issues, family of origin, sexual relationship, roles and parenting issues. Both partners needed to address anger and hurt from past betrayal. Eventually Joanne was able to ackowledge that she had not thought that Bill had recognized how much he had hurt her by his involvement with her sister many years ago. One of the ways Joanne had dealt with this in the past was to engage in sexual relationships outside the marriage, thus a cycle of retaliation and resentment characterized their interaction. Joanne needed to identify for Bill what he needed to do in order for her to be able to forgive him. Eventually she began to feel that he truly recognized her hurt and this was important to her. The therapist needed to ask the couple if they thought they would be able to put the past betrayal in the past once these feelings were dealt with. It was easier for Joanne to express hurt and anger around the distant past than it was for her to talk about her feelings toward Bill for sexually abusing her children. Joanne needed support to be able to express these feelings. She was able to confront Bill around incidents when he was "loosing patience" with the children, and identify how she now stepped in to control the situation. Bill needed to learn to take cues from Joanne when this occurred, in addition to being more aware of his own cues that he was becoming angry or frustrated.

Couple sessions also continued to address child care and child teaching concerns. Following years of exposure to a fairly chaotic and inconsistent approach to child teaching, the children were now unaccustomed to changes in the parental attempts at behavior control. The therapist also facilitated the adult's recollection of memories of their own past abuse in family of origin, helping them to express feelings about what this was like for them. This was viewed as an important task toward developing empathic responses toward their own children. Bill's response to the children's disruptiveness or misbehavior was one of feeling that his ego was threatened; an example of his immaturity and belief that the children had to meet his needs. As he experienced feelings of increased self esteem and effectiveness in his relationship with Joanne, this destructive response became less apparent.

A major focus of couple therapy was intimacy and affection needs and their sexual relationship. Several long-standing problems existed in this area. The couple had a limited sexual repertoire and avoided discussing needs and feelings related to sexual desirability. Eventually both partners were able to share feelings, desires and responses with one another with increasing comfort. Bill shared feelings of inadequacy and both identified his avoidance of initiating sexual encounters. He would watch excessive amounts of television to sometimes avoid sexual interaction. Both partners were conscious of their weight as a hindrance to sex. Increasingly the couple began to discuss sexual feelings, dispel myths and assumptions and deal with some inhibitions, toward a more mutually satisfying sexual relationship. Some of the sexual difficulties were also attributed to fears surrounding childhood experiences. The

therapist gave the couple encouragement to experiment with their sexual repertoire and reframed the weight issue by suggesting that making love was a good way to lose weight.

Day to day conflicts tended to frequently escalate into damaging verbal disputes and destructive patterns. Attentive listening and responding exercises were introduced to facilitate clear and direct communication and enhance listening and responding skills. The couple also needed to learn that it is okay to be different, and that to have different perspectives did not always need to be threatening. This enmeshment was apparent in terms of their decisions concerning work or education in that whatever Joanne decided to do, Bill would chose to do also.

Both partners also were invited to participate in the Child Protection Centre group treatment program for offenders and their partners. This is a longer term group program consisting of about 10 members in each group (one group for offenders and one for their partners) with two therapists for each group. Joanne did participant in this partners group, while Bill chose to participate in a different offenders group run through the Corrections Department, because the therapist was also his individual therapist. In Joanne's group program, a portion of the program was a five week segment dealing with sexuality, in which couples were to attend together. Bill did participate in this part of the group. In group sessions Joanne began to deal with some feelings surrounding her past victimization, and felt strongly supported by the group members.

After the family therapy sessions had commenced, a therapist became available to work with Peter individually and in a group treatment program for male adolescent victims. This program also offered a siblings group for non-victim siblings of sexually abusive families, for which William is eligible. Danielle is on a waiting list for a group treatment program, and at the end of the practicum had still not had the opportunity to access this. Surprisingly this resource was unavailable through the usual organizations.

At the point of termination there remained several problematic areas and unresolved issues for the W. family. Bill still had not found employment or training that would enable him to feel secure in his role as an effective and productive member of the family. He did, however, appear to have developed a more realistic perspective of his alternatives rather than dwell on the status of his long lost job as he did earlier in treatment.

Danielle's paternity remained an unresolved issue for the couple and the family. This highly charged issue was important to address and labeled as such by the therapist upon termination, and as a source of secretive resentment between the couple.

The families anxiety surrounding termination with the therapist was expressed through the younger son in healthy and direct communication and questioning. Both adults would continue in group therapy and father in individual treatment. Peter would also be continuing in his treatment program. Family and couple work was recommended to be continued and the

therapist helped them to access new services. At the end of treatment they were on a relatively short waiting list (2 to 3 weeks) at another agency to provide this intervention.

CASE EXAMPLE 2: THE D. FAMILY

Child: Holly is 12 years old, caucasion, and very physically and socially mature for her age. She performs extremely well at school, and is involved in numerous extracurricular activities such as drama and YMCA programs. She also likes to read and involve herself in other solitary activities. An only child, she describes herself as lonely and has a hard time making friends, yet presents as very outgoing socially around adults. She has difficulty sharing feelings directly or to identify her needs.

Father: Jeff is 41, anxious and very introspective. He speaks cautiously and slowly as though afraid to share spontaneous thoughts and feelings and searching for the "right" words. Jeff has one younger brother who resides in another province with his family. He initially described his early family life as "normal", although he felt that his father was somewhat cold and distant. As a teenager Jeff was the "rowdy" one, and his parents were quite tolerant of his behavior. He minimizes violence in his family of origin. His father was physically abusive to his mother, and Jeff remembers running away from home after one violent incident. Jeff describes his childhood neighborhood as a rough environment, where violence in families was the norm. His father drank heavily. Jeff is an alcoholic and associates drinking with a way of coping with stress and depression throughout his life. His first marriage ended in failure and remains an unresolved issue for him, in that he felt manipulated and deceived by his first wife. He also blames the failure of the marriage on his drinking. He has one daughter from this marriage who resides with her mother in another province.

Jeff works for the city at a stable job that he enjoys, although it involves irregular hours and shift work. He and his current partner (Holly's mother) have maintained a common-law relationship for the past 8 years since Holly was 4 years old. They reside in a middle class area of the city.

Mother: Sharon is 32 years old, slim and fragile in appearance. She also communicates cautiously and slowly. She describes herself as weak and "feeble", and is passive and controlled in her interaction. She has been employed in the same position for many years and feels very secure in her job, but has turned down promotional offers in favor of familiarity and predictability. Sharon was the oldest sibling in a family of five children. She wishes she had older siblings. She found herself in a parental role in relation to the younger children. During the past year Sharon's father died and this loss gave rise to many unresolved family of origin issues.

Sharon married Holly's father when she was 19 years old. Her husband literally abandoned the family before Holly was two years old. Many years ago he wrote to Sharon requesting a photograph of Holly. Sharon did not respond. This has been the only contact.

Events preceding treatment:

Holly disclosed to her school guidance counsellor that her stepfather had been touching her sexually on several occasions since she was six or seven years old. The sexual abuse involved fondling of her vagina and

breasts. A child and family services social worker was contacted and Holly was immediately placed in a foster home. While upset by the dramatic action, Holly was fearful of returning home and of her parent response to her disclosure. Holly had told her mother several times about the abuse over the years, and her mother would occasionally confront Jeff about it. He would promise not to do it again, but the abuse would continue. Holly learned that her mother did not have the power to change the situation. Sharon stated that "I thought that we could handle it, you know, within the family. It never occurred to me that we could not deal with it". There were also incidents of physical and emotional abuse of Holly from the time they lived with Jeff. Physical abuse occurred under the guise of "spankings" for misbehavior. The parents perception of "misbehavior" tended to be highly related to their having adult expectations of her. She would be punished for such things as loosing an item of clothing at school. Jeff's behavior toward Holly was threatening and hostile. Holly dealt with this often by finding excuses to stay late at school and when at home she would withdraw to her room.

Holly's abuse disclosure was met with classic denial by both parents, and an inability to empathize with her. While many children can be returned to their mother's care after the offender leaves the home, Holly's foster home stay was drawn out over 3 months. Two weeks after the disclosure, the couple embarked on a southern holiday. Eventually mother and daughter moved into an apartment together, while Jeff remained in the comfort and convenience of the family home. Jeff was also formally charged and ordered not to have contact with Holly.

Treatment Process:

Jeff immediately became involved in an alcohol treatment program after the disclosure crisis. He was also seen by the senior therapist for assessment and initial treatment. He began to reluctantly admit to the sexually abusive behavior, while hanging onto much of his defenses. "I'm not the child molester type". He also minimizes the extent of the abuse. Sharon's denial was even stronger, particularly with regard to the sexual nature of the abuse. She produced elaborate explanations for the problem. "Holly and Jeff have never got along - she always lied a lot. She may have been angry because we were not taking her on the trip with us". Sharon struggled to find excuses for Jeff's behavior. "He was always drunk ... he may have mistaken Holly for me. She may have misconstrued his behavior". Sharon defended Jeff and tried to blame Holly.

In addition to individual sessions, weekly couple therapy and mother-daughter sessions formed the first phase of the treatment plan. All three family members later began peer group therapy while the dyadic work continued. Sharon and Jeff attended the same peer group program described in the first case example. Holly participated in a group program for adolescent sexual abuse victims.

In couple therapy one of the priority targets of treatment was the couples denial. Rationalizations were constantly challenged by the therapist who had to confront them with reality as well as empathize with the need to deny. Gradually some rationalizations were abandoned, as the couple began to less frequently refer to alcohol as "the problem". The

videotape of Holly's police statement was shown to the parents and proved to be an effective method of dealing with their denial. It became more clear to Sharon that her daughter was not lying.

In exploring with the couple the atmosphere of the family home during past years, Jeff was able to see how he had tried to control both Sharon and Holly, and needed to feel he was the "master" in the home. He recognized the fear he had produced in his stepdaughter by his abuse.

Genogram drawings were used to explore family of origin material in depth, making connections between family of origin relationships and experiences and present relationships in their family now. Jeff became aware of how power was distributed in his family and how angry feelings were dealt with when he was young. Jeff often identified himself as a "bad boy" and continued to do this in his adult life. He recognized a pattern where his parents seemed to excuse anti-social forms of behavior, and seems to now expect that an apology for his behavior will undo harm done. Even with regard to his present circumstances involving his stepdaughter, Jeff's father's response was "she must have deserved it", clearly not holding John responsible. In relating this to the therapist Jeff remarked on the absurdity of his father's response, and that it was consistent with the pattern from his childhood.

In her own family of origin Sharon identified emotional distance between she and her mother. In exploring this Sharon began to make connections between this distance and her own relationship to Holly. She was able to recognize how this contributed to her inability to protect

Holly from Jeff's abuse, and to see what was happening. One session took place with Sharon and her mother, in which Sharon's mother was able to relate some of her feelings and experiences when Sharon was an infant and small child. Mother and daughter were able to mourn the loss of a closer relationship as well as share some of the positive feelings for one another that had been unexpressed. This session was seen as therapeutic in terms of Sharon's expressing feelings about her mother, setting the stage for relationship work with Holly.

Further exploration of Sharon's family of origin revealed that her mother was oppressed and abused by her father and that Sharon had a need to deny this and defend her father by idealizing him. The abuse had been emotional and sexual. The process of exploring the reality of this relationship was a painful one for Sharon, and complicated by the death of her father the year before. In therapy Sharon was helped to see that she could both love her father and retain positive memories of him while recognizing the destructiveness of some of his behavior. This represented a basic characteristic of Sharon's belief system in terms of her rigidity and need to have a "black or white" perspective of most things. Persons or behaviors were seen as good or bad; right or wrong. This influenced many aspects of her life and interaction with others. Challenges to her belief system in therapy involved helping her to understand the implications of this and presenting an alternate reality each time this interfered with Sharon's insight and positive growth.

The cycle of violence pattern was presented to the couple. They were able to identify how the pattern was reflected in their family interaction,

the stages of escalating stress and abusive episodes followed by periods of remorse. Both Sharon and Jeff benefited from and responded well to visual stimuli and the pictorial diagram of the cycle.

Both partner's earlier marital relationships were explored, in terms of issues and feelings left over from these and their impact on trust and communication in their present relationship. Jeff had a stereotypical view of men and women. Exploring his beliefs and attitudes provoked some insight into how this was damaging to his relationships. In their present relationship one of the communication patterns that was apparent and was challenged in therapy was Sharon's tendency to communicate Jeff's thoughts and feelings for him, and assume that she knew what they were. Jeff allowed Sharon to do this. "Jeff feels sorry for what had happened and he wants to change things". This adoption of the "forgiving parent" role by Sharon interfered with Jeff's accepting full responsibility for abuse of Holly. The interactional pattern was interrupted by the therapist by empowering Jeff to challenge Sharon when this occurred. For example, the therapist would say "I know Sharon is trying to be helpful, but how does it feel when she is talking for you all the time?". Also, "Here you are Jeff, working hard to understand your responsibility for the sexual abuse, and Sharon is confusing you by her statements. She is doing exactly what your parents used to do when you did something wrong".

In addition to the direct sexual contact with Holly, other sexual boundaries and privacy rules were not respected in the home. For example, Jeff would walk around the house undressed in front of Holly with no regard for her feelings about this. Holly was afraid to say anything to him for

fear of punishment. "You don't tell Jeff what to do". Parents needed education around sexual boundaries and privacy in the home, and Jeff developed new insight into Holly's feelings of embarrassment and humiliation related to his violation of privacy boundaries.

Therapy also dealt with some issues in the couples sexual relationship. Sharon was extremely sensitive to rejection and had a negative body image. She did not feel that she fit the image that was attractive to Jeff. Both partners had previously unexpressed concerns about their desirability that were addressed in therapy. The couple needed to talk about why Sharon felt this sensitivity and how it inhibited their relationship. For example, she did not initiate sexual interaction, which in turn left Jeff doubting his desirability.

In mother-daughter therapy the therapist needed to support Holly to confront her mother's neglect to protect her. Initially Holly was not able to share her feelings about Jeff with Sharon, or her feelings of not being cared for. As Sharon began to accept Jeff's responsibility for the abuse, and her role of not protecting, Holly felt more at ease in expressing her feelings. Defining patterns of abuse was a task in both couple and mother-daughter therapy. Jeff identified circumstances surrounding the abuse. Usually he would call Holly into the bedroom to watch television with him when Sharon was not at home. He would also tell Holly not to tell Sharon what he was doing. Holly also talked about specific incidents of abuse, some of which were different than the ones Jeff related. Outside of the therapy sessions, Sharon began to recall other episodes and she discussed these with Jeff both during and outside of the sessions.

Another focus of mother-daughter therapy was exploring their feelings around the loss of Holly's biological father. Holly needed permission to express ambivalent feelings about him, and to be able to ask Sharon questions about him. Holly had always wondered why she had dark curly hair but had never asked her mother questions about his appearance. Sharon was able to tell Holly stories about his showing positive feelings for Holly as a baby.

The strengthening of the relationship between Sharon and Holly was viewed as a necessary prerequisite to sessions involving the three family members together. One session involving all family members occurred prior to termination with their therapist. Preparation for this session was facilitated through role-play with the family members for one or two sessions before the meeting. The goal was defined as Jeff being able to apologize to Holly for his treatment of her, and for him to express his feelings about what he had done as well as share with her the changes he felt he had accomplished and his future goals in treatment. He was also able to let her know that she had done the right thing by disclosing since he saw a positive outcome for each member of the family. In this meeting Sharon also shared her regret at not protecting Holly from the abuse, and also expressed positive feelings about the disclosure and the subsequent changes. Holly was given the opportunity to share feelings or ask questions but no expectations were placed on her to do so. The accomplishment of this session was seen a positive step toward talking together about the abuse and feelings surrounding it, and discussing future treatment goals.

Upon termination of the practicum intervention, both adults remained in group treatment at the child protection centre, and Holly in peer group therapy. The family also had an appointment time arranged with a new family therapist to continue family and dyad counselling.

PART IV

EVALUATION

As a part of the practicum experience the student wanted to be able to evaluate the effectiveness of the intervention provided to families and couples. In addition to observed changes in interaction, behavior and beliefs, it is useful to apply independent measures to evaluate outcome and effectiveness, and to be able to compare these with clinical observations. Here it must be recognized that, while there are long-term goals for successful outcome of treatment for these families, the practicum intervention was only six months long. Long-term goals that may be said to represent successful intervention could be defined in various ways, and may include the following general goals:

1) Absence of abusive behavior directed at children - physical, sexual, or emotional.
2) Healthier relationships between parents and children that allows for protection of children and attention to physical and emotional needs.
3) Understanding and awareness of the individual, environmental and familial factors that contributed to the abuse.

The above may involve continuation or termination of the couple relationship but in either case individuals should be able to examine their roles as adults and accomplish changes that will allow for more satisfying and stable adult relationships.

Six months is not sufficient time to see the completion of the above goals, however, these were discussed with families as desirable outcomes of their therapy. We know from the literature on treatment that some families remain in treatment for periods of two to three years. Based on what is known about therapeutic outcomes of treatment for abusive families, this must be taken as an estimate. Perhaps it is too long, or too short. It inevitably depends on the families strengths and weakness and capacity for change. Treatment goals and therapeutic involvement must be determined on an individual basis for each family. Successful outcome for a family may include permanent separation of family members, where protection of the child cannot be achieved and the treatment goals would include adaptation to separation.

Throughout the practicum the student needed to be aware of the limitations of the therapy duration and to define and prioritize realistic treatment goals accordingly for each family. It was then extremely important to identify with family members areas for further change after termination with this therapist. The therapeutic value for the intervention during the practicum was evident among all families. They were able to identify contributing factors to the abuse including predisposition due to early experiences of parents, patterns in the functioning of the present family, aspects of family environment structure,

communication and isolation, and relational issues between couples and between parents and children. Families were able to actively seek ways to change some interactional patterns, resolve family of origin issues, and problem-solve more effectively. Most families were able recognize the impact of abuse on the child although in some families this was apparent more in one partner.

Evaluation Instruments:

1. The Family Assessment Measure.

The Family Assessment Measure or FAM-III is an instrument designed to measure the individuals perception of their families functioning, strength and weaknesses, in seven areas (General Scale). It is based on a process model of family functioning and integrates different approaches to family therapy. The process model applied to an understanding of families emphasizes family dynamics, a concept of family health as well as pathology, and seeks to incorporate both intrapsychic and environmental factors that influence family dynamics. It is easy to administer with families, requiring about 20 minutes. The instrument includes two response style scales that indicate social desirability and defensiveness. As recommended by the scale developers, the measure is used as a complement to clinical assessment by providing an independent verification of clinical observations. Reliability studies have shown the FAM-scale to significantly differentiate between problem and non-problem families (Skinner, Steinhauer and Santa-Barbara, 1983). One of the limitations in the use of this measure in this practicum is that in some families, children were too young to complete the measure and thus their perceptions could not be evaluated with this instrument.

2. The Dyadic Adjustment Scale.

The student also wished to use an independent measure of the couple relationship, since the couple therapy was a key focus of intervention. The Dyadic Adjustment Scale is a measure developed to assess the quality of marriage or co-habiting couple relationships. The measurement of dyadic adjustment can be divided into 4 subscales that have been empirically verified: dyadic satisfaction; dyadic consensus; dyadic cohesion, and affectional expression. This scale was developed with a theoretical basis of a process definition of adjustment along a continuum which can be viewed in terms of negative or positive adjustment. It can be administered in a short period of time and has been evaluated for content, criterion and construct validity with positive results. The total scale reliability coefficient is .96. There are norms and standard deviation figures for groups of married and divorced couples. The measure does not control for social desirability or defensiveness (Spanier, 1976).

One of the difficulties encountered in using this measure (or potentially any other measure of marital adjustment) for evaluating the nature of the couple relationship was that, with the exception of one family, couples were living apart due to the protection needs of the children. Partners were therefore limited by circumstances in their opportunities to interact with one another. Despite this limitation, couples had a history of involvement for as long as 11 years, and continued to perceive themselves as being "a couple". In considering the problem of opportunity to be together, this also became a focus of clinical intervention in terms of exploring the commitment and investment or avoidance of interaction with one another. Some partners took the initiative to find regular times when they could be alone together, while

others seemingly used the enforced separation to avoid contact and hense avoided confronting and dealing with the problems inherent in their relationship. The scale does assume however, that respondents are living together and some items may be considered inappropriate to the circumstances of these particular families. For example, item 23 and items 24 to 28 inquire as to frequency of certain interactions which would be impaired by enforced separation. This needs to be considered in the analysis of the results.

3. The Family Problem Checklist.

A 22-item family problem checklist was also used which allows 5 possible answers to indicate level of satisfaction with each item. These items reflect specific areas of concern that are considered relevant to several of the families including the use of force and dealing with matters concerning sex (Trute, 1985). The scores for all families were tabulated to give an overall comparison of pre and post intervention scores. These results, FAM-III Graph representations and Dyadic Adjustment Scale scores are provided with case descriptions to follow. A sample of the family problem checklist in in Appendix i.

Some treatment programs have developed specific criteria or guidelines designed to evaluate the families readiness for reunification. It has already been pointed out that reunification of families is not always an appropriate goal of intervention, although it may be one of the goals for some families. These guidelines, such as that used by the California based Child Sexual Abuse Program (Giaretto, 1981), do contain some items that a clinician can consider in monitoring and evaluating progress in treatment. (See Appendix ii for example of guideline). This form does include

descriptions of many components of family functioning that have been found to be especially relevant to the problem of sexual abuse in families. It asks questions that pertain to individual, dyadic and family dynamics. The most obvious difficulty with this particular assessment tool is, that if relied upon for clinical decisions, it reflects subjective impressions of the evaluator in each case. It also asks the evaluator to make judgements about complex dynamics, such as item 5, "Mother-child bonding has been re-established with all children - yes or no". The evaluator is left to make a judgement about what constitutes adequate bonding. Some of the items appear to be idealistic in view of the potential extent of damage to the child's psychological and emotional well-being. Despite these criticisms, it is important for clinicians working with sexually abusive families to try to isolate and identify areas of change necessary to ensure the safety of children in the home. Many sexually abusive parents do return to live with the children whom they have victimized and it is important to be able to identify clearly and measure changed interaction and behavior and level of comfort of family members. This guideline as an example may be a useful checklist to refer to when the family is moving toward reunification. Some of the items are applicable to a situation when the offender is not returning to the home, since children are often at risk for sexual abuse by multiple partners of the custodial parent (e.g. Mother). Here the focus needs to be more on the protection capabilities of the parent.

Results:

W. FAMILY : FIGURE 1 : TABLE 1

The FAM-III scores include the parents and oldest child in the family who is 12 years of age. This child was also one of the sexual abuse victims, and was victimized for the longest period of time. Test scores prior to intervention revealed similar perceptions of problem areas by parents, with elevated scores in role performance, task accomplishment and affective involvement. Mr. W. also identified control as a problem area. Several other areas suggested weaknesses in that they scored just within the average range. The problem of role performance and task accomplishment reflect much of the disorganization that characterized this family, particularly in the form of poor parenting, difficulties in meeting children's needs and evidence of role reversal, where children felt protective of parents feelings. Rules and family management were also ambiguous and undergoing change. After father's separation from the family a year prior to treatment, mother had assumed all of the parenting tasks and depended upon her older daughter and extended family a great deal for childcare support. Father's re-entry into the family environment, first partially and then completely, contributed to confusion and some conflict around parenting. Different parenting roles and shared responsibility was an adjustment, with new parenting skills being one focus of treatment. The role of provision of economic support for the family was also disrupted, since in past father had occupied this role. This also contributed to confusion and uncertainty for the family. Post-intervention scores for the couple were all within the average range, suggesting perceived improvement in all areas. The child's pre-test profile shows high defensiveness and

scores in average and strength range in all areas, and hence large discrepancies with parents scores. Parents scores are interpreted as reflecting the true picture of the family functioning. The only area of agreement is in that of communication. In the child's post-intervention measure, he was more anxious than defensive, and his perceptions of strength or weakness more closely resemble those of his parents. Parents post-test scores show agreement with each other in several areas. The profiles on the whole fit with clinical observations in changes occurring during treatment. This couple was able to display increased awareness of children's needs for consistent and flexible direction and demonstrated ability to deal effectively with difficulties encountered in child management. They also showed awareness of children's needs for safety and stability. Family members displayed increased interest and involvement with each other, with parents initiating more recreational activities that children enjoyed. Parents also emphasized and supported activities for children that they could pursue individually to achieve a sense of competency and autonomy.

While this couple showed some improvement in their marital relationship, such as discussing sexual needs and communication, clinical observations suggested that there was continued change necessary in this area. The Dyadic Adjustment Scale scores revealed problems in and little change upon post-test on the dyadic consensus subscale. This is consistent with observations in that the couple continued to argue frequently in a non-productive manner, and showed little toleration for differentness in their perspectives on several issues. In the remaining subscales the couple's pre and post-test scores were within the range of the norms for

married couples. In the dyadic satisfaction subscale, scores were slightly higher in the post-test. On all subscales there is considerable agreement between the couple about how they feel in the relationship.
Overall, Mr. W's scores reflected the most positive change while his partner's scores remained fairly constant. Both partners reported enhanced feelings of satisfaction in the relationship upon termination.

Comparison of pre and post problem checklist results for this family reveal similar trends for each child who completed the form. The older child shows an increase in feelings of satisfaction dealing with matters concerning sex, however less with regard to use of discipline and physical force. Mother also reported increased satisfaction in dealing with sexual matters and drug or alcohol use. Both parents also report increased satisfaction generally in dealing with problems and father sees improvement in overall relationships among family members. Children's scores may suggest ongoing concerns regarding parents' use of control, or aggressive behavior among siblings, consistent with clinical observations.

FIGURE 1

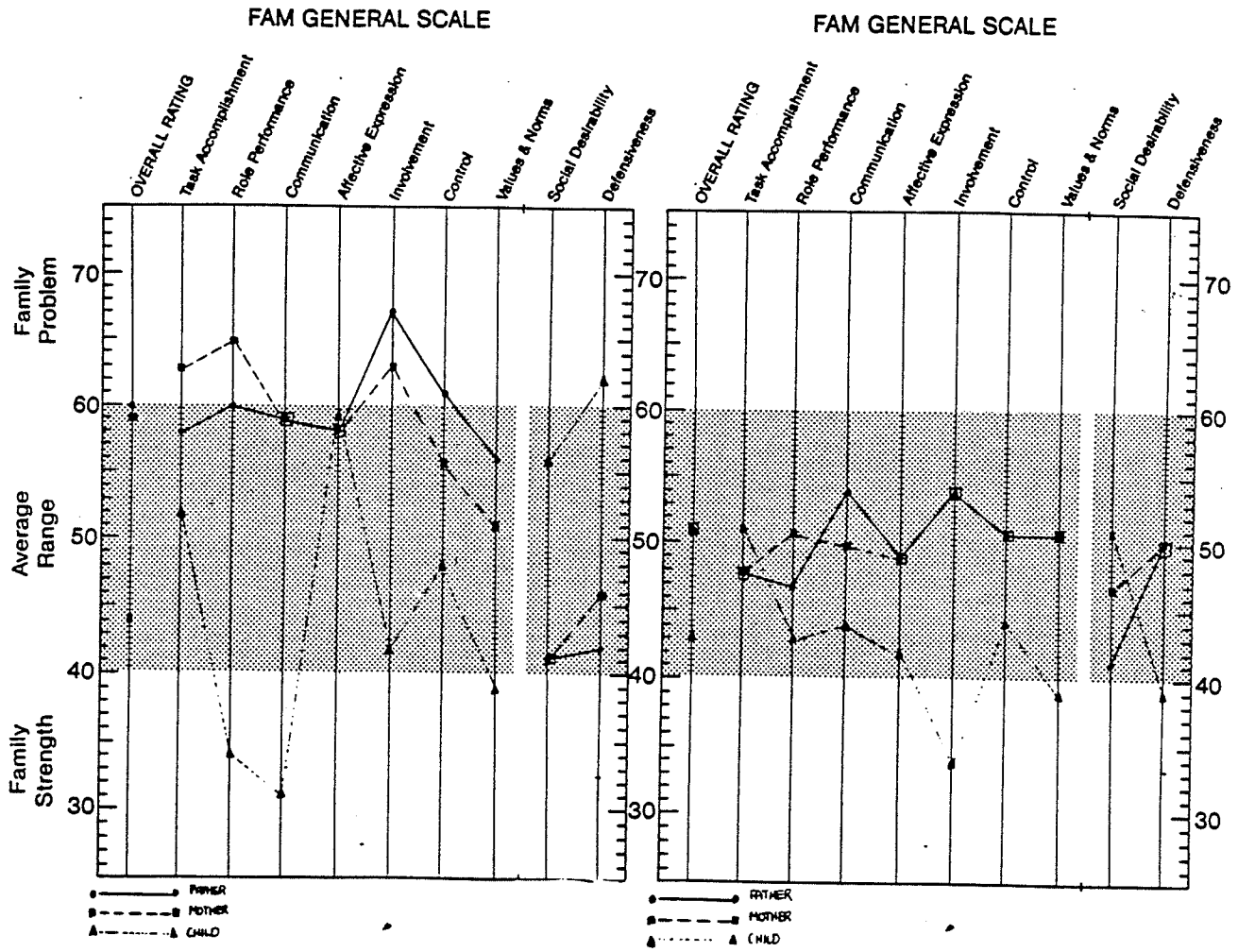

FAM GENERAL SCALE
FAM GENERAL SCALE
OVERALL RATING
Task Accomplishment
Role Performance
Communication
Affective Expression
Involvement
Control
Values & Norms
Social Desirability
Defensiveness
Family Problem
Average Range
Family Strength
70
60
50
40
30
FATHER
MOTHER
CHILD

TABLE 1

PRE AND POST INTERVENTION SCORES FOR DYADIC ADJUSTMENT SCALE

	MALE		FEMALE	
	PRE-TEST	POST-TEST	PRE-TEST	POST-TEST
DYADIC CONSENSUS (65)	49	47	45	47
DYADIC SATISFACTION (50)	33	40	35	37
AFFECTIONAL EXPRESSION (12)	7	10	9	7
DYADIC COHESION (24)	13	17	17	17
DYADIC ADJUSTMENT (151)	92	106	114	108

THE D. FAMILY: FIGURE 2 : TABLE 2

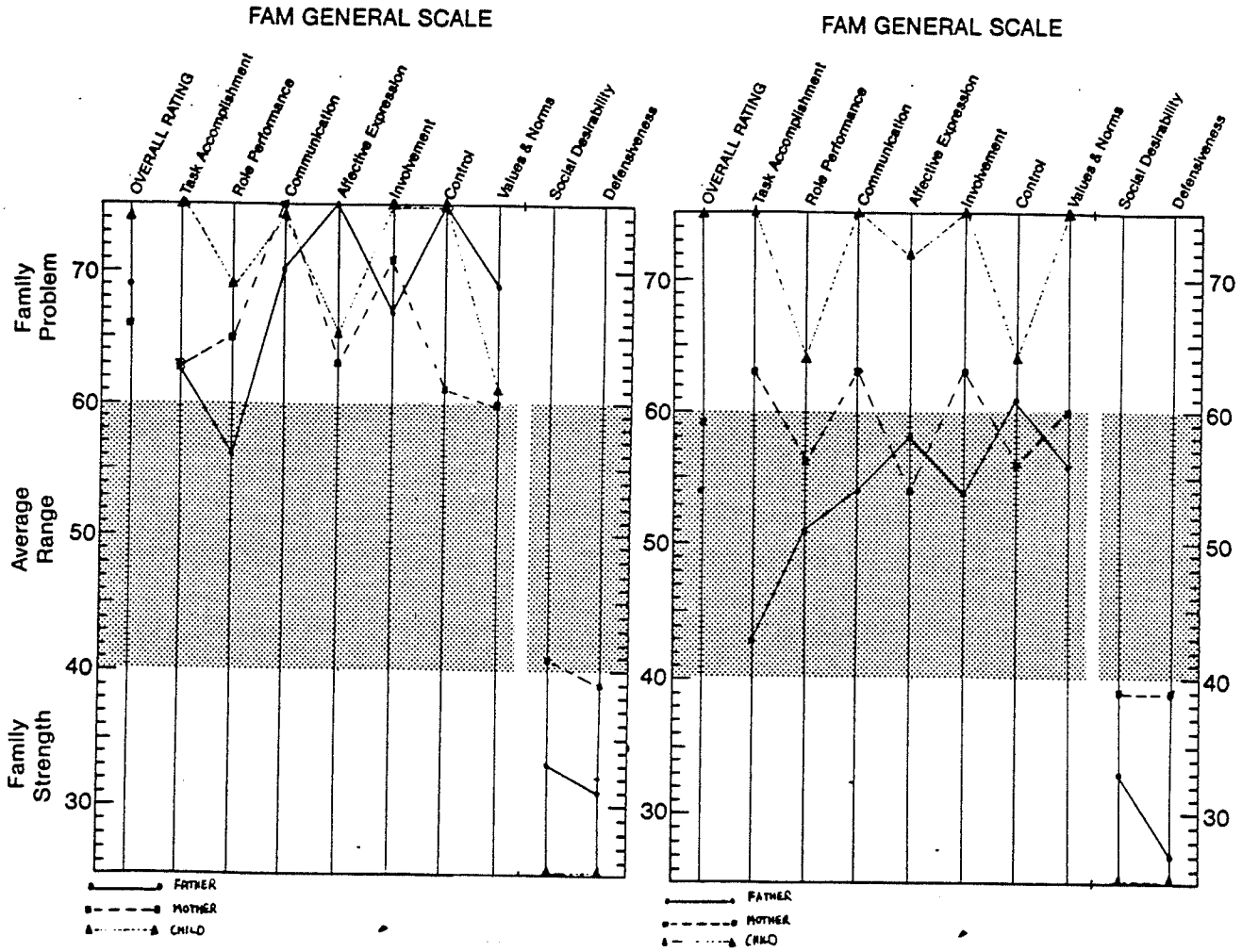
The FAM-III profiles for the D. family included each member of the family. Pre-test profiles show all areas of functioning in the problem range. The adolescent's profile also reveals a high level of anxiety about her family. Father is also very anxious. In clinical observation this would be masked anxiety with family members initially exhibiting a high level of denial and a "we're okay" presentation. There is more agreement between mother and daughter, although father and daughter both identify control as problematic, more so than mother. Control and influence in this family tended to be laissez-faire in style with destructive patterns of control in response to the attempt to accomplish tasks. Post-intervention scores showed movement toward the average range in all areas for the adults, however Mother still see problems in three areas. The daughters scores remained very much in the problem family range in all areas. Task accomplishment, communication and affective involvement are still seen as problematic for Mother. In general there is wide discrepancy in the scores. If Mothers scores are viewed as the anchor on this profile, the problem areas may be interpreted as reflecting more difficulties remaining in her relationship to her daughter. This is particularly seen in her difficulty experiencing empathy for her daughter and in meeting her emotional needs. The high scores for the daughter may reflect her sense of her mother's ambivalence, for while she took risks to confront her mother about existing problems and feelings related to the abuse, this resulted in her increased vulnerability to rejection by mother. All family members perceived change in the direction of the average range in the area of control. This reflects the changes observed clinically related to the

style of control towards more consistency and a less destructive style of influence among family members.

The couples Dyadic Adjustment Scale scores do not reveal notable changes. There is a high level of agreement and total scores are within the married range of norms. The couple agree that there are difficulties in dyadic consensus. This couple did remain consistently optimistic about their relationship and certain of their commitment. They were able to acknowledge and identify problem areas in their relationship and seek ways to change, although this often fluctuated with a tendency to minimize or externalize problems.

In the comparison of pre and post-test problem checklist, all family members reported increase in feelings of satisfaction concerning ability to share positive and negative feelings and to handle anger or frustration. Mother and daughter's scores reveal increased satisfaction in dealing with sexual matters. The child's post-test also reflected positive change in the area of discipline and use of physical force, a problem clearly evident in the assessment.

FIGURE 2


FAM GENERAL SCALE
OVERALL RATING
Task Accomplishment
Role Performance
Communication
Affective Expression
Involvement
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Values & Norms
Social Desirability
Defensiveness
Family Problem
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Task Accomplishment
Role Performance
Communication
Affective Expression
Involvement
Control
Values & Norms
Social Desirability
Defensiveness
70
60
50
40
30
FATHER
MOTHER
CHILD

TABLE 2

PRE AND POST INTERVENTION SCORES FOR DYADIC ADJUSTMENT SCALE

	MALE		FEMALE	
	PRE-TEST	POST-TEST	PRE-TEST	POST-TEST
DYADIC CONSENSUS (65)	40	42	48	43
DYADIC SATISFACTION (50)	34	36	33	35
AFFECTIONAL EXPRESSION (12)	10	10	10	10
DYADIC COHESION (24)	15	16	20	22
DYADIC ADJUSTMENT (151)	99	104	111	110

THE S. FAMILY: FIGURE 3 AND 4 : TABLE 3

Pre-test profiles of this family reflect the extreme disorganization and dysfunction evident in clinical observation. This family had been in treatment for the longest period of time, with the team consensus being that they demonstrated the least capacity for change. This family was characterized by chaos and enmeshed relationships, demonstrating over-involvement in some areas and neglect of children's emotional needs. It is a blended family in which the adults each brought two adolescent children from earlier relationships. Mother had a history of involvement in physically abusive relationships and considerable unresolved family of origin issues involving her parentification and suspected sexual abuse. Father had a history of failed relationships which had involved marriages to adolescent women. He also carried unresolved loss issues from family of origin, including his adoption and the premature death of his adoptive father. Both these adults also lost infant children to illness in their earlier marriages. Their relationship developed through Mrs. S's escape from a physically abusive spouse, moving in with Mr. S who was her neighbor. Both children of Mrs. S were physically abused by their natural father. The father's two boys had resided with him for the past 6 years, but were the focus of an ongoing custody dispute between he and their mother.

The sexual abuse in the home involved Mr. S sexually molesting the 10 year old female. Sibling incest also occurred between this child and her 15 year old brother. Family members demonstrated weak interpersonal boundaries. The sexually abusive behavior was later discovered to also

extend outside the family boundary, involving another family residing in the same apartment complex. While Mr. S was charged and incarcerated for abuse of his partner's daughter, there remained considerable discrepancy between his admitted sexual offenses and the victims initial statement.

The pre-intervention FAM-III profile shows extreme discrepancies in perceptions of family members, with some approach to agreement in the area of role performance as problematic. There are certainly unclear expectations of roles as parents or as adolescents. The parents in this family tended to desperately need the adolescents to be involved in their activities and to have adolescents buffer any interactions, since closeness between them was very threatening. One had the sense that, without the children, this couple did not have a relationship. One intervention by the therapist involved simply instructing the couple to come alone to sessions without children in an effort to separate the subsystems. This was met with protest and resistance. Couple therapy revealed that Mrs. S was uncomfortable with her sexuality and needed to discount and criticize any essence of femininity. Both partners demonstrated a lack of sexual knowledge. Mrs. S was able to do some insightful family of origin work toward beginning to make connections between her earlier experience and present sense of self. She was also able to acknowledge some feelings surrounding her past physically abusive relationship and the impact on her children. Her current relationship with her daughter was symbiotic in many respects and she focused on the psychosomatic complaints of both she and the child. She described pushing her daughter toward Mr. S for affection needs with no insight into the way this contributed to sexual abuse. Mrs. S was also threatened by the emotional development of her daughter. The

couple desperately needed the children in their lives and tended to infantilize them. The scattered profiles can also be interpreted as showing the extent to which family members have little concept of what constitutes more normal family functioning in the different areas. For children the post-test scores showed high defensiveness and elevations in the area of task accomplishment. It was felt that children did not feel permission from parents to express concerns in a number of areas. For example, the adults' need to have the children look after their emotional needs made it impossible for the two boys to express any positive feelings for their natural mother. One adolescent scores showed perceptions of family strength in some areas and the average range for others. This boy had been living out of the home for a prolonged period of time and may have had an idealized view of the family, not being currently influenced by the family environment and interactional patterns. At one point this boy perpetrated a sexual offense in a foster home. It was felt that this was in part a destructive way of communicating his unreadiness to return home, since at the time his parents were insistent upon this. He did not feel permission to express his anxiety to his parents, and the sexual offense, in addition to being destructive, guaranteed his continued removal. His mother's response was one of anger, while his stepfather's own sexual disturbance was revealed in his response, which was to show disgust at the fact that the victim had been another male. The message was that sexual aggression toward females is more acceptable.

Mr. S's scores present as suggesting that he sees everything as okay in the family, while in fact the opposite is true. This individual had a strong defensive presentation, tending to gloss over problems, externalize

problems through blaming the system, rather than accept responsibility for change in treatment. Statements of responsibility or acceptance of the need to change lacked any reflection of genuine feelings or sincerity.

The dyadic adjustment scale scores reflect lower scores on three of four subscales with two scores in the divorced range for Mrs. S on the post-test. Interpretation may suggest that she was able to become more aware of differences and conflict and percieved her relationship with Mr. S as less satisfactory after developing some insight into the nature of their interaction.

This families' level of dysfunction is again revealed in the problem checklist scores. Two of the three children completing the checklist report dissatisfaction in areas of sharing problems, handling anger and frustration and in dealing with matters concerning sex on both pre and post-test. One item of note in mother's responses upon post-testing is the indication that she is satisfied with "housing" and "time family members spend together". This is of clinical interest since she resided separate from Mr. S. and saw him infrequently, yet remained dysfunctionally enmeshed with her daughter supporting the impression that intimacy in the couple relationship was threatening.

FIGURE 3

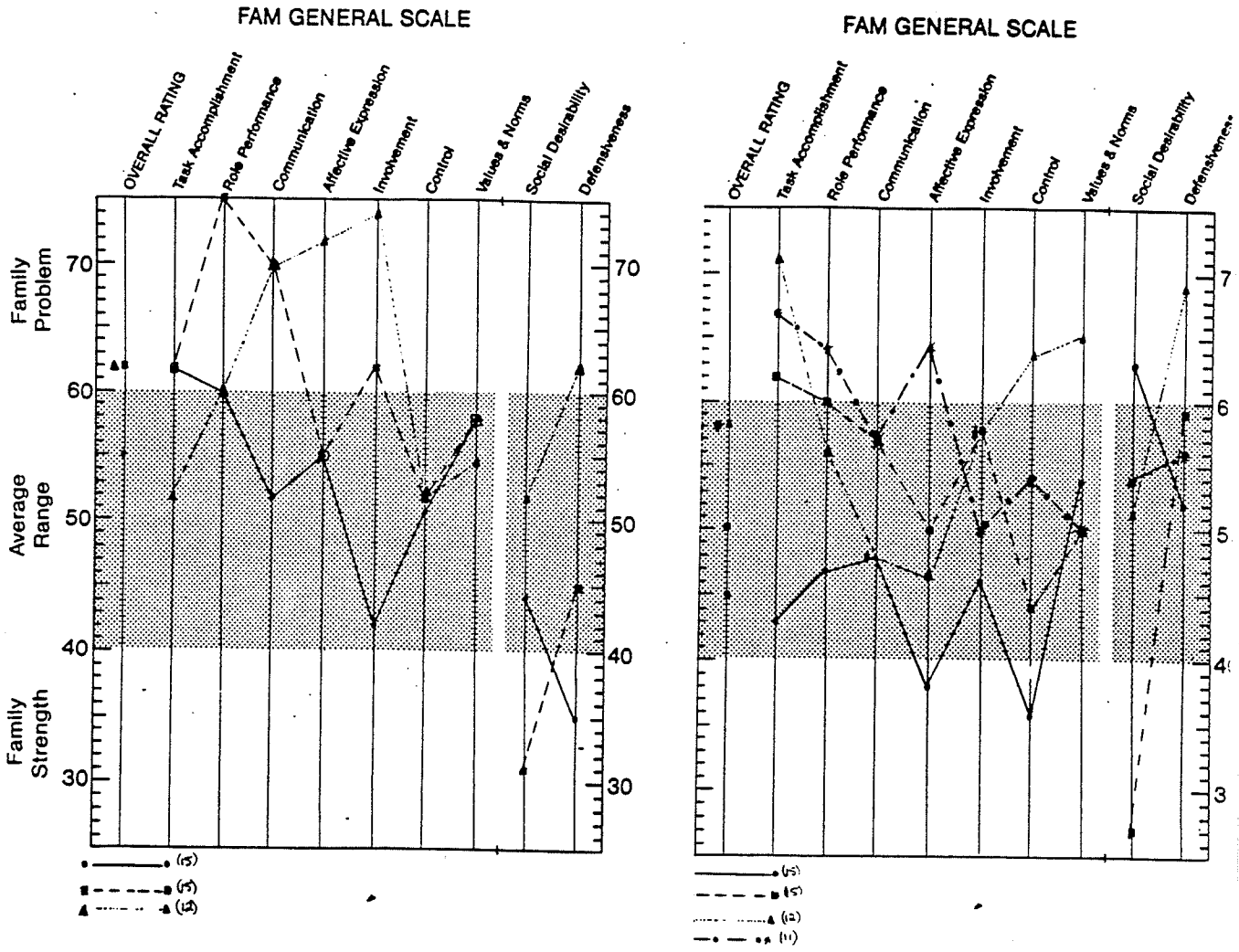

FAM GENERAL SCALE
OVERALL RATING
Task Accomplishment
Role Performance
Communication
Affective Expression
Involvement
Control
Values & Norms
Social Desirability
Defensiveness
Family Problem
Average Range
Family Strength
70
60
50
40
30
FAM GENERAL SCALE

FIGURE 4

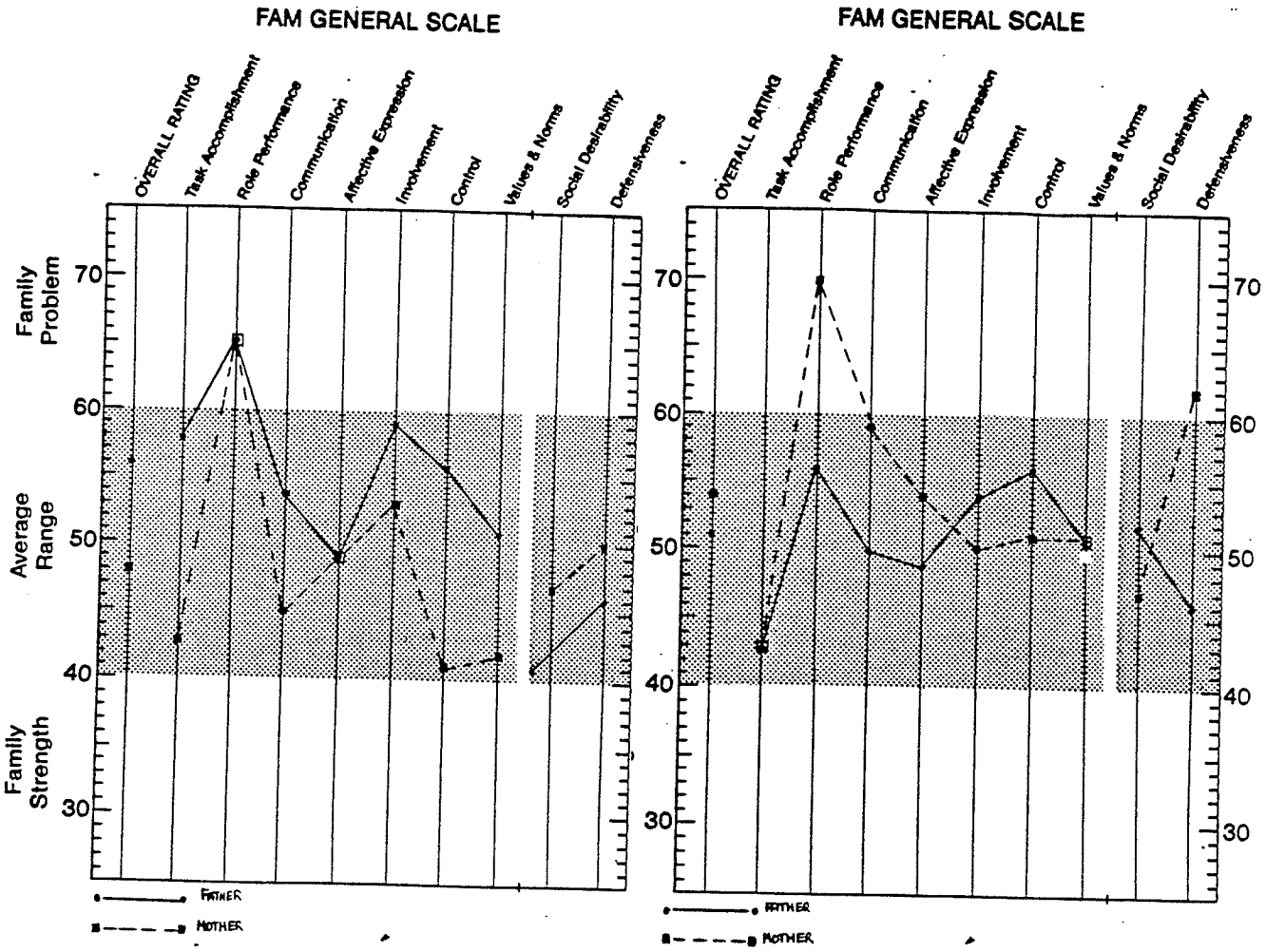

FAM GENERAL SCALE
FAM GENERAL SCALE
OVERALL RATING
Task Accomplishment
Role Performance
Communication
Affective Expression
Involvement
Control
Values & Norms
Social Desirability
Defensiveness
Family Problem
Average Range
Family Strength
70
60
50
40
30
FATHER
MOTHER

TABLE 3

PRE AND POST INTERVENTION SCORES FOR DYADIC ADJUSTMENT SCALE

	MALE		FEMALE	
	PRE-TEST	POST-TEST	PRE-TEST	POST-TEST
DYADIC CONSENSUS (65)	54	52	44	34
DYADIC SATISFACTION (50)	36	37	38	31
AFFECTIONAL EXPRESSION (12)	12	11	11	9
DYADIC COHESION (24)	20	17	17	19
DYADIC ADJUSTMENT (151)	122	117	110	93

THE L. FAMILY: **FIGURE 5 : TABLE 4**

In this family, there were two female children age 8 and 10 who were both victimized by the stepfather. The couple had two younger sons age 1 and 4 and had been in a relationship for six years. Both adults had a history of sexual abuse, disruptiveness and abandonment in childhood. The father disclosed earlier sexual abusive behavior of his younger sister. Mother had a history of involvement in abusive relationships with two men, including the girls father who had physically abused them as well. She managed to disengage from this relationship several years earlier before meeting Mr. L. He was not physically abusive but had a great deal of repressed anger related to childhood experiences. During the course of treatment, the couple were seen as evaluating and gradually disengaging as a couple toward eventual decision to terminate the relationship. Mrs. L's relationship with her oldest daughter was impaired and judged to have been so since prior to the sexual abuse.

The FAM-III profiles include the parents only. Both pre and post-test scores show discrepancies in their perceptions and movement from average to problem area during the course of treatment. Father's pre-test scores also show a high level of defensiveness. He was in fact very suspicious of the therapist but became less so over time.

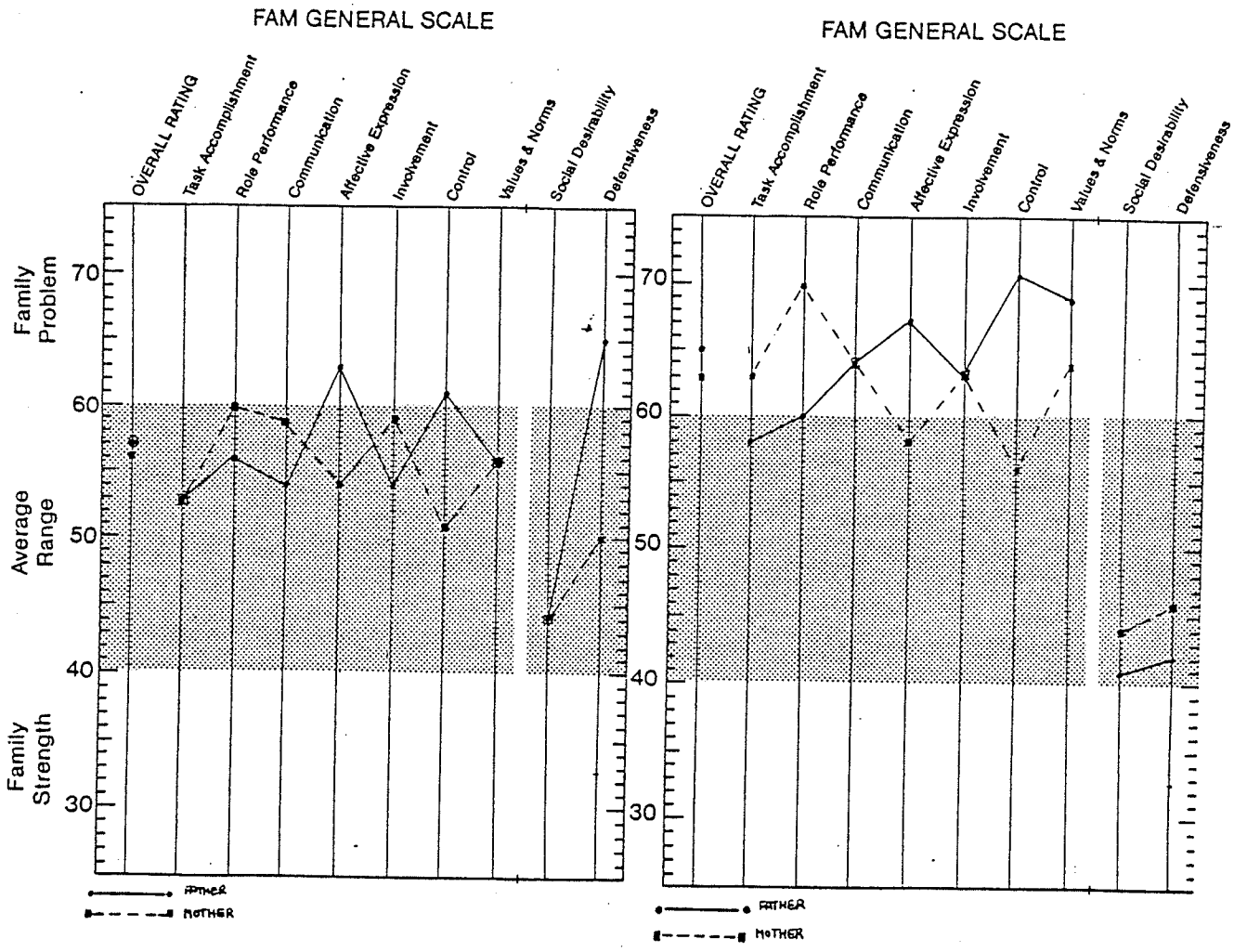
Interpretation of the profiles would be that initially the couple were less prepared and able to recognize the problem areas in the family. The process of treatment gave rise to a re-evaluation and exploration of individual issues for both partners and a truer evaluation of the problems

evident in the family as a whole. Mother was able to do some positive work around family of origin issues, relationship with her mother and siblings. She was able to use her energy to begin to take charge of her life by dealing effectively with her mother's interference. In exploring her sense of self and her own needs she focused on a commitment to return to school, and to get a drivers licence. Prior to this she had depended excessively upon her partner. Mr. L was unable to fulfil the role of a partner or a parent in this relationship, focusing on his sons as meeting his own needs for love and affection, only when it was suitable for him.

While Mrs. L could demonstrate true caring and affection for her oldest daughter, negative feeling were also projected and this child was scapegoated constantly. The child was in need of a tremendous amount of support which her mother could not provide. Episodes of running away and risk-taking to punish herself left her at risk and vulnerable to further abuse. This child was involved in a peer therapy group and was also in need of individual therapy which the system could not readily provide. The therapists approach involved consistent and supportive reparenting of the mother which appeared to result some positive interactions with the child.

The Dyadic Adjustment Scale scores are interpreted as reflecting a true picture on the males part, showing poor adjustment at both testing times. At the time of the post-test both had initiated relationships with new adult partners.

FIGURE 5


FAM GENERAL SCALE
OVERALL RATING
Task Accomplishment
Role Performance
Communication
Affective Expression
Involvement
Control
Values & Norms
Social Desirability
Defensiveness
Family Problem
Average Range
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FATHER
MOTHER
FAM GENERAL SCALE
OVERALL RATING
Task Accomplishment
Role Performance
Communication
Affective Expression
Involvement
Control
Values & Norms
Social Desirability
Defensiveness
70
60
50
40
30
FATHER
MOTHER

TABLE 4

PRE AND POST INTERVENTION SCORES FOR DYADIC ADJUSTMENT SCALE

	MALE		FEMALE	
	PRE-TEST	POST-TEST	PRE-TEST	POST-TEST
DYADIC CONSENSUS (65)	33	29	59	47
DYADIC SATISFACTION (50)	27	23	43	37
AFFECTIONAL EXPRESSION (12)	5	4	9	8
DYADIC COHESION (24)	9	8	19	19
DYADIC ADJUSTMENT (151)	74	64	130	111

PART V

CONCLUSION

This Practicum experience has been a valuable one both in terms of providing the student with specific insights into the treatment of sexually abusive families and as providing an opportunity for professional growth and development of clinical practice skills.

First, the experience has confirmed earlier documentation of the need for family therapy to be a part of a multi-faceted treatment plan. Family members have both individual and family system problems, that, if addressed only in isolation of each other, will be limited in their capacity for inducing change. The timing of the intervention is also highly related to the overall process and outcome. For example, in the L. family it was found to be very useful for the student to become involved at the point of the disclosure and assessment. The mandated child protection crisis intervention cannot help but be somewhat investigative in nature and has a specific and necessary focus on the immediate protection needs of children. The availability of a therapist to support and provide direction for a family, to meet frequently with these parents and children was found to be of long term therapeutic value for the family who, like many, can easily become lost to the system once basic protection needs are addressed. Therapeutic intervention offered at this time deals with the confusion displaced anger and feelings of lack of control. For the L. family, the initial focus needed to be mother's management of the problem and her

response to her children. Without therapy during this stage the children would have been at risk for rejection by her.

In another situation, the D. Family, therapy was not provided until four months after the disclosure, when the family was referred to the student. In this case the child spent three months in foster care. While certainly some time in care may have been necessary, the prolonged stay is felt to be partially associated with the period of time before family therapy was available. This contributed to increased distance in relationships feelings of rejection and parental denial. Once the family became engaged in treatment with the therapist some of these emotional issues have become more engrained and thus more difficult to change. Perhaps earlier family-centered treatment would facilitate more efficient resolution of these issues. Based upon these experiences, the student finds that family-focused treatment is a service that should be provided from the initial discovery of abuse, in addition to the crisis and child protective services.

A different timing issue of therapeutic intervention surrounds the provision of individual and group treatment needs for each family member during the period of family and couple therapy. As noted in Part III, the group treatment did not commence until sometime after the initiation of the students family work. It was found that for all families, certain targeted areas of change were difficult to address when the father particularly was not yet engaged in intensive offender treatment. Once this was initiated, family and couple treatment was felt to be more effective. This is also consistent with most of the treatment literature. In the W. family, the

father was involved in weekly individual treatment throughout the duration of the family and couple treatment. In comparison to one of the men where this was delayed, his capacity for insight and ability to discuss his offending behavior openly in sessions was apparent. This will also be influenced by the individual degree of motivation, personality and readiness for change, for although Mr. S. had been in offender treatment for several months prior to referral to the student, he demonstrated a low level of insight and high denial.

In her work with these families the student recognizes the problem of dysfunction in the couple relationship to a greater extent than is generally identified in the literature. As is noted in Part III, several areas of disturbance in the couple's relationship were found, suggesting that this dynamic requires careful assessment when families are beginning treatment. Couple therapy should be defined as a treatment focus with attention to their sexual relationship, interaction and the influence of family of origin issues.

The student has also found in her practice with these families that the need to confront the abuse experiences and to explore incidents with family members is an important part of the therapy process. It is through direct exploration that much underlying denial of abuse is brought to light despite seemingly clear or apparent admission of responsibility and occurrence of the abuse. It seems that this is the most effective technique of discovering evidence of denial and reasons behind lingering defenses among parents who abuse their children. Secondly, as described earlier, this is one of the ways of helping the family to identify the

conditions which allowed the abuse to occur or made it easier for it to occur. Specific conditions can henceforth be avoided if this is addressed in therapy. Not all family therapists would be so inclined to extract details of abuse patterns in the family during the therapy sessions. It is often viewed as inappropriate to the task of family therapy. In fact, to not do so may be considered erroneous and gives the family the message that it is not important to deal directly and openly with harmful patterns of abuse. While much of the current literature now emphasizes this point, the student is concerned that in practice this may often be neglected. This practicum experience has confirmed the therapeutic value of addressing the abuse incidents directly.

The existence of general physical and emotionally abusive patterns among the four families and in their intergenerational histories is a disturbing observation. Only in one family was evidence of physical abuse toward children not confirmed. This suggests that one needs to be less categorical in one's thinking about "incestuous families" and to be aware of the need to assess general abusive patterns of all types when such families are identified in the community and referred for therapy. Physical abuse is not less damaging to children than sexual abuse, but is less sensationalized in our society. Social workers have a responsibility to address this problem in the community as a whole. Clinicians must be able to respond to the therapeutic needs of child victims of sexual abuse and their families where physical abuse has occurred as well. Sexual abuse is often perpetrated on children in families where physical violence and emotional abuse is occurring. Family therapists must be prepared to

explore all forms of violence and to plan specific interventions to change patterns contributing to any form of abuse.

The student had an opportunity to increase her knowledge of the functioning of the legal and child protection system that impacts on families, and the ways that this inhibits or promotes the treatment process. Some of these larger system issues have been cited in the case examples earlier. Overall, the importance of the role of Child and Family Services for the family engaged in treatment should not be underestimated. This agency should be considered a key in the helping network that includes the family therapist and others. Once crisis oriented child protection needs were addressed the level of involvement of the child and family service social worker with the student's families varied considerably. This did not appear to correspond with a families' particular needs. For example, some social workers continued to provide case management, monitoring of child protection needs, resource seeking and provision and direct contact with the family. This is valuable to the treatment process. In other situations, the agency social worker tended to withdraw their involvement once learning that the family was involved in treatment. Clearly the circumstances are influenced by a number of child welfare operational issues that are the subject of ongoing controversy. The point of interest for the student, however, was the benefit of the continuous and regular involvement of the social worker for the families where this was provided.

A related issue of concern involving the larger system is the lack of availability of resources in the system. Currently there are insufficient

support resources for practical services, as well as individual and group treatment components for families. Professionals working to provide treatment for families where children are abused are well aware of this problem, and need to continue to advocate for increased resources and treatment programs.

Apart from the aforementioned concerns, family therapists must also be aware of the complications arising for families who are involved with the legal system. The inefficiency of this system often contributes to considerable distress for families who are already struggling with so many other difficulties. The most common involve stressful events for child victims and repetitive sentencing remands for parents convicted of abuse. The family therapist must be prepared to respond to the anxiety, frustration and fear associated with the legal processes, as well as advocate for improvements toward a less disruptive process for families in treatment.

In undertaking to begin this clinical practicum the student had personal learning goals that were fulfilled by the experience ahead. She wished to develop her family therapy skills in both assessment and intervention techniques and specifically in application to clinical work with abusive families. The student found that she was able to become more aware of her specific skills, personal approach and therapeutic style. In the challenge to balance confrontation with empathy toward providing structure and direction for families, the student became confident in her ability to do so. Through the experience of intensive clinical supervision, the student learned the value of discovering

"countertransference" issues that may arise for her in therapeutic work with families or individuals. This part of learning is imperative for growth and effectiveness in clinical practice.

Some comments concerning the evaluation instruments are provided in Part IV. Further thoughts that may be useful for future students are the following. Of the measures employed, the FAM-III was found to be of most benefit in terms of revealing differences and level of defensiveness among family members. The problem checklist was also useful in terms of clients' being able to indicate feelings about problem areas especially relevant to some of the presenting difficulties of this population. Students interested in undertaking similar practicum studies should consider the use of a separate measure for children in the family that would be able to identify a change in the child's sense of safety and feelings of being protected within the family environment.

REFERENCES

Alexander, P.C. (1985) A Systems Therapy Conceptualization of Incest, Family Process, 24: 79 - 88.

Anderson, C. and Mayes, P. (1982) Treating Family Sexual Abuse: The Humanistic Approach, Journal of Child Care 1:2: 150 - 165.

Anderson, L. and Shafer, G. (1979). The Character Disordered Family: A Community Treatment Model for Family Sexual Abuse, American Journal of Orthopsychiatry, 49:3: 436 - 445.

Annual Report. The Children's Hospital Child Protection Centre. Department of Pediatrics and Child Health University of Manitoba Faculty of Medicine. Health Sciences Centre, Winnipeg Canada. 1986.

Bentovim, A. (1987). Physical and Sexual Abuse of Children - The Role of the Family Therapist, Journal of Family Therapy, 9: 383 - 388.

Brownmiller, S. (1975). Against Our Will. Men, Women and Rape. Simon and Schuster.

Colapinto, J. (1982) Structural Family Therapy. In A. Horne and M. Ohlsen. Family Counselling and Therapy. F. E. Peacock Publisher. Illinois.

Conte, J. (1982). Sexual Abuse of Children: Enduring Issues For Social Work, Journal of Social Work and Human Sexuality, Vol. 1 No. 1/2: 1 - 19.

Conte, J. (1984). Progress in Treating the Sexual Abuse of Children, Social Work, May/June: 258 - 263.

Crumbley, J. (1985). Child and Adolescent Maltreatment: Implications for Family Therapy. In M. P. Mirkin and S. L. Koman (Eds). Handbook of Adolescents and Family Therapy, Gardner Press, New York.

Dale, P., Waters, J.; Davies, M.; Roberts W.; Morrison, T.; (1986). The Towers of Silence: Creative and Destructive Issues For Therapeutic Teams Dealing With Sexual Abuse. Journal of Family Therapy, 8: 1 - 25.

Fine, P. and Carnevale, P. (19984). Network Aspects of Treatment for Incestuously Abused Children. In I.R. Stuart and J. G. Greer (Eds) Victims of Sexual Aggression: Treatment of Children, Women and Men. Van Nostrad and Reinhole, New York.

Finkelhor, D. (1984) Four Preconditions: A Model. In Child Sexual Abuse: New Theory and Research, Free Press, New York.

Finkelhor, D. and Brown, A. (1986) Impact of Child Sexual Abuse: A review of the Research, Psychological Bulletin Vol. 99 No. 1: 66 - 77.

Gelinas, D. (1983) The Persisting Negative Effects of Incest. Psychiatry, 46: 312 - 332.

Gelinas, D. (1986) Unexpected Resources in Treating Incest Families. In M. Karpel (Ed). Family Resources. The Hidden Partner in Family Therapy, The Guilford Press, New York.

Giarretto, H. (1981) A Comprehensive Child Abuse Treatment Program. In P. Mrazek and C. H. Kempe (Eds) Sexually Abused Children and Their Families, Pergamon Press, New York.

Haugaard, J. and Reppucci, N. (1988), The Sexual Abuse of Children. Jossey-Bass, California.

Herman, J. and Hirschman, L. (1981). Father-Daughter Incest. Harvard University Press.

James, B. and Nasjleti, M. (1983) Treating Sexually Abused Children And Their Families, Consulting Psychologists Press; Palo Alto, California.

Kempe, R. and Kempe, C. H. (1984) The Nature of Intrafamilial Sexual Abuse: Incest and Evaluation and Treatment of Intrafamilial Sexual Abuse: Incest. In The Common Secret: Sexual Abuse of Children and Adolescents. W. H. Freeman, New York.

Koch, K. and Jarvis, C. (1987). Symbiotic Mother-Daughter Relationships in Incest Families. Social Casework, 2: 94 - 101.

Larson, N. and Maddock, J. (1987) A Family Systems Approach to The Treatment of Sexual Abuse. Conference Presentation March 1987 Calgary, Alberta.

Mayer, A. (1983) Incest: A Treatment Manual for Therapy with Victims, Spouses and Offenders. Learning Publications Inc.

Mrazek, P. and Bentovim, A. (1981). Incest and The Dysfunctional Family System. In P. Mrazek and C. H. Kempe (Eds). Sexually Abused Children and their Families. Pergamon Press, New York.

Mrazek, P. and Mrazek, D. (1981) The Effects of Child Sexual Abuse: Methodological Considerations. In P. Mrazek and C. H. Kempe (Eds) Sexually Abused Children and Their Families. Pergamon Press, New York.

Parker, H. and Parker, S. (1986). Father-Daughter Sexual Abuse: An Emerging Perspective. American Journal of Orthopsychiatry, 56, 4:531 - 549.

Russell, D. (1986) The Secret Trauma: Incest In The Lives of Girls and Women. New York. Basic Books Inc.

Sagatun, I. J., (1982) Attributional Effects of Therapy with Incestuous Families. Journal of Marital and Family Therapy 8:1: 99 - 104.

Sgroi, S. (1982) Handbook of Clinical Intervention In Child Abuse. Chapter 9: Family Treatment. Lexington Books, Lexington, Mass.

Skinner, H. A., Steinhauer, P. and Santa Barbara, J. (1983), "The Family Assessment Measure, "Canadian Journal of Community Mental Health, 2, No. 2: 91 - 105.

Solin, C. A. (1986) Displacement of Affect In Families Following Incest Disclosure. American Journal of Orthopsychiatry, 56:4: 570 - 576.

Spanier, G. (1976). "Measuring Dyadic Adjustment: New Scales for Assessing the Quality of marriage and Similar Dyads". Journal of Marriage and The Family, February P. 15 - 28.

Tierney, K. and Corwin, D. (1983). Exploring Intrafamilial Sexual Abuse: A Systems Approach. In D. Finkelhor; R. J. Gilles; G. T. Hobaling and M. Straus, (Eds.) The Dark Side of Families; Sage Publications.

Trute, B. (1985) Evaluating Family Practice In Clinical Service Settings - Basic Issues and Beginning Steps. Canadian Social Work Review: 100 - 122 (Refers to: The Morrison Centre for Youth and Family Service, 3355 S.E. Powell Blvd, Portland, Oregon, 97202, U.S.A.)

Waterman, J. (1986). Family Dynamics of Incest With Young Children. In K. MacFarlane and J. Waterman (Eds.). Sexual Abuse of Young Children: Evaluation and Treatment. The Guildford, Press, New York.

Williams, G. R. (1983) Child Abuse. In E.C. Walker and M. C. Roberts (Eds). Handbook of Clinical Child Psychology. Wiley, New York.

APPENDIX i

FAMILY PROBLEM CHECKLIST

Below is a list of family concerns. Indicate how satisfied you are with how your family is doing NOW in each area. Put a check (x) in the box that shows your feeling about each area.

	Very Dis-Satisfied	Dis-satisfied	In Between	Satisfied	Very Satisfied
1. Showing good feelings (joy, happiness, pleasure, etc.)					
2. Sharing feelings like anger, sadness, hurt, etc.					
3. Sharing problems with the family					
4. Making sensible rules					
5. Being able to discuss what is right and wrong.					
6. Sharing of responsibilities					
7. Handling anger and frustration					
8. Dealing with matters concerning sex					
9. Proper use of alcohol, drugs					
10. Use of discipline					
11. Use of physical force					
12. The amount of independence you have in the family					
13. Making contact with friends, relatives, church, etc.					
14. Relationships between parents					
15. Relationships between children					
16. Relationships between parents and children					
17. Time family members spend together					
18. Situation at work or school					
19. Family finances					
20. Housing situation					
21. Overall satisfaction with my family					

Make the last rating for yourself:

22. Feeling good about myself					

APPENDIX ii

INSTITUTE FOR THE COMMUNITY AS EXTENDED FAMILY

GUIDELINES FOR ASSESSING A FAMILY'S
READINESS FOR FINAL REUNIFICATION

These guidelines can be filled in on each family
and included in letter to JPD at the appropriate time.

DATE _____ CASE NAME _____

INDIVIDUAL AND GROUP COUNSELING

1. Each parent is well grounded in their own identity and self-confidence, each able to stand on their own two feet, no longer dependent on each other, but rather interdependent in their relationship. Scale 1-10: _____

2. Each parent is able to effectively communicate their own needs and goals utilizing communication skills. Scale 1-10: _____

3. Each parent is free of alcohol or drug use if a drinking or drug problem was part of the family dynamics or linked to the molesting or failure to protect behavior. Yes ___ No ___

4. Father is gainfully employed, or if disabled, has found ways to make a contribution so feels important (such as in home management). Yes ___ No ___

5. Child victim(s)
   a. Verbalizes that responsibility for the decision to molest is the offender's and not his/her own. Yes ___ No ___
   b. Demonstrates and has internalized an attitude of owning own body, being able to say "no", and taking care of self by reporting a remolest. Yes ___ No ___
   c. Demonstrates the ability to verbalize concerns about family re-unification (fear, apprehension, distrust, etc.) Scale 1-10: _____
   d. Can verbalize what needs to change before father can return home. Yes ___ No ___

6. All children have been grounded in their own identity and self-confidence. Yes ___ No ___

DYAD AND GROUP COUNSELING

7. Parents understand the relationship between the sexual molestation and the dysfunctional aspects of their old relationship of the past. Yes ___ No ___

8. Parents demonstrate ability to effectively communicate their needs and wants to each other, resulting in adult support and nurturance to each other. Give examples. Scale 1-10: _____

9. Sex therapy has been an integral part of marital counseling resulting in the couple in process of developing mutually satisfying sexual relationship. Scale 1-10: _____

10. Parents demonstrate trust in each other (as observed when alone and with partner). Yes ___ No ___

11. Roles of each spouse have been clearly defined (who's responsible for what in the home?) Scale 1-10: _____

12. Parents have developed ways to spend time with each other and have fun. Give examples. Scale 1-10: _____

13. Offending parent has expressed full responsibility with victim(s) for decision to sexualize the relationship. Yes ___ No ___

14. Victim has fully integrated the right to say "no" to offending parent's advances and anyone else's (without fear of losing love). Has demonstrated this through role playing in sessions with offending parent. Yes ___ No ___

15. Mother-child bonding has been re-established with all children. Yes ___ No ___

FAMILY AND GROUP COUNSELING

16. All minors in the home who may be at risk have been informed of situation and right to say "no". Yes ___ No ___

17. All children are able to share their feelings about the molest with family members. Yes ___ No ___

18. Child/children able to identify reasons why he/she did not report molest earlier and has shared with family members. Yes ___ No ___

19. Offending parent has taken full responsibility with siblings for decision to molest victim(s). Yes ___ No ___

20. Roles of parents and children are clearly defined. (Role reversal no longer evident.) Give examples. Yes No

21. Children demonstrate trust in mother and see her as protector. Yes ___ No ___

22. Parents demonstrate respect for their children's privacy. Yes ___ No ___

23. Children can openly communicate feelings, problems, and differences of opinion with parental support. Scale 1-10: _____

24. Children can actively participate in age (appropriate) decision-making. Scale 1-10: _____

25. Capacity for impulse control present in ALL family members. This requires that specific limits of behavior, particularly those related to molest issues, be outlined for each member in WRITING. Yes ___ No ___

26. All family members are clear on what is appropriate vs. inappropriate touch in their family and what are appropriate expressions of affection. Yes ___ No ___

27. All family members express a desire to have offender home. Yes ___ No ___

28. Family has demonstrated over period of time capacity to resolve problems in a constructive manner, utilizing newly acquired skills. Scale 1-10: _____

29. Family can demonstrate socially acceptable ways to have fun with each other. Scale 1-10: _____

30. Family is committed to continuing therapy sessions to deal with re-integration and any remaining individual issues. Yes ___ No ___

SELF-HELP COMPONENT

31. Parents have consistently volunteered their time to the self-help component of Parents United. Yes ___ No ___

Number of hours volunteered to date: Father ___ Mother ___

TEAM MEMBERS	RECOMMENDATIONS
_____	Yes ___ No ___
_____	Yes ___ No ___
_____	Yes ___ No ___
_____	Yes ___ No ___
_____	Yes No
_____	Yes No