Crisis Intervention In Child Sexual Abuse

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BY

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"Someday, maybe there will exist
a well considered and yet fervent
public conviction that the most
deadly of all possible sins is the
mutilation of a child's spirit. . . ."

Erik Erikson

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Introduction and Purpose

My interest in the area of child sexual abuse began with the first report I received of sexual abuse. I was a social worker in the Child Welfare Unit in Whitehorse, Yukon. The report was that two girls, ages 12 and 8 were being sexually abused by their father. The 12 year old girl was reported to be prostituting and living on the streets, while her 8 year old sister was staying at her friend's house and refusing to go home. I looked up our file on the family and found what little information our Department had on child sexual abuse.

Upon reviewing the family file, I found that the 12 year old daughter had reported the sexual abuse to our Department six times in the past! Nothing had ever been done. According to the file notes, investigations had been carried out but it was clear that the sexual abuse had never been discussed. In the later reports, the older brother had also been identified as sexually abusing the girls. When the file was closed after the last report, the implication was that the 12 year old had been unhappy at home and had made up the story of sexual abuse. This child had started reporting the abuse when she was six years old.

The impact of the sexual abuse was different for these sisters. The 12 year old was trying to cope with the abuse by running away from home, not attending school, abusing drugs and alchohol and prostituting herself. The eight year old had managed to block out most of her memories of the sexual abuse. She was very determined not to go home but chose a friend's family rather than the streets with her sister.

The girl's mother had left the family about six years earlier and although she was in town, had no interest in resuming the care of her daughters. The girls were placed in a foster home. As time went by the eight year old began to remember the sexual abuse, an extremely painful experience. The twelve year old slowly began to turn her life around and attempted to reclaim some part of the childhood of which she had been deprived due to the sexual abuse.

It is clear that if these children had been believed at the time of their first report of sexual abuse, a great deal of damage could have been prevented.

Since that time I have worked with a number of cases of child abuse. Each case was different, but in each case the child was an innocent victim.

In my experience, the need to believe the child and to intervene early was obvious. My need to know more about

this area, particularly regarding intervention and treatment, prompted me to enter graduate school and to complete this practicum.

The purpose of this practicum was to provide crisis intervention for families where a child had been sexually abused by someone other than a parent in the home, and to examine the relevance and applicability of this approach. The object was to intervene at the earliest possible time in the crisis and to provide support to the victim and her family along with educational and preventive material and information.

A guiding orientation for this intervention was the ecological perspective. From this perspective the impact of the sexual abuse on the family and the systems in which they are involved can be assessed. Such an orientation also alerts the social worker to the impact of the new systems (eg. medical and legal) in which the family will be involved as a result of the sexual abuse. This perspective also acknowledges the influence of socio/cultural/political systems on child sexual abuse.

The practicum report is divided into two major parts. In Part One, the literature surrounding child sexual abuse is reviewed. Part Two describes the intervention, provides case illustrations, an evaluation of the practicum and outlines recommendations.

PART ONE

LITERATURE REVIEW

Chapter One

An Historical View and the Current Situation

I An Historical View

Child sexual abuse is not a new phenomenon, but it is only in the last decade that the magnitude of the problem has been identified. Throughout history children have been viewed as the property of adults. Rush (1980) notes that the sexual abuse of young children over the centuries has included rape and ongoing abuse in the home as well as being sold into prostitution or marriage. Schultz (1982) states that children have served adult ends in all historical periods.

The problems created for victims of child sexual abuse have been evident throughout the years. In the late 1800's, Sigmund Freud saw a number of female patients who told him about sexual abuse by their fathers in their childhood. Freud saw the problems these women were experiencing and announced that the cause of their female hysteria was having been sexually abused as children. Later, however, Freud decided to change his theory, because of the implications about the behavior of respectable family men (Herman, 1981). Freud attributed these women's problems to unresolved guilt about their erotic imaginings and fantasies (Rush, 1980).

Many mental health professionals have played a role in confusing the issues where child sexual abuse is concerned. Therapeutic accounts consistently reflect an etiology of "blaming the victim" (Ryan, 1971). For example, in 1937, Bender and Blau published an article entitled "The Reactions of Children to Sexual Relations with Adults". Bender and Blau (1937) noted that these children were all "unusually charming and attractive in their outward personalities." (p.514). The attitude of the authors toward victims of child sexual abuse is summed up in this quote, "This study seems to indicate that these children undoubtedly do not deserve completely the cloak of innocence with which they have been endowed by moralists, social reformers and legislators." (Bender and Blau, 1937, p.514). The author's viewed the children as seducers who, if not having actually initiated the sexual abuse, certainly must have encouraged it.

With the advent of the "Sexual Revolution" came changes in sexual attitudes. Some of these changes may have contributed to the problem of sexual abuse, but these changes also allowed people to talk more openly about sexual issues (Finkelhor, 1982). The women's movement spurred women on to tell about their sexual victimization as children (Rush, 1980; Bass and Thornton, 1983). More and more books and articles are being

written by women telling of their painful experiences and how these experiences have affected them throughout their lives. (For example, see: Brady, 1979; Bass and Thornton, 1983; Forward and Buck, 1978; Rush, 1980; Myers, 1979). The extent of the problem of child sexual abuse is slowly being recognized.

II Incidence

Most writers in the field of child sexual abuse believe that the incidence is not rising. Rather, it is believed that we are only aware of what is considered to be the "tip of the iceberg". With the increasing number of women who are telling about their victimization as children, it becomes evident that there have always been large numbers of children who were sexually abused and never told anyone.

In a retrospective study of 796 college students in New Hampshire, Finkelhor (1979) found that one in five females and one in eleven males reported incidents of sexual molestation in their youth. Vincent De Francis (1969) conducted one of the first large studies demonstrating that child sexual abuse is a serious problem. From the core sample made up of 250 families De Francis reports that girls were sexually abused 10 times more often than boys. As De Francis (1969) notes, findings strongly point to the probability

of an enormous national incidence. Finkelhor (1979) found that 63 percent of females and 73 percent of males never told anyone about the sexual abuse.

In Ontario, the number of known child sexual abuse offenders reported to the government child abuse registry has increased 73.5 percent over the same period in 1983 (Winnipeg Free Press, 1984). In the same article it was noted that the number of child sexual abuse perpetrators has surpassed the number of non-sexual assaults.

In Manitoba, reports of child sexual abuse are soaring. In 1977, the first year for which statistics on sexual abuse were even kept, there were eleven investigations (Winnipeg Free Press, 1984). In 1983, the provincial government reports 205 cases of sexual abuse of infants and children (Winnipeg Free Press, 1984), and in the past six months, the Child Protection Centre of the Children's Hospital in Winnipeg reports more cases of sexual abuse than they received in the entire preceeding year (112 reports in 6 months, compared to 101 reports in the preceeding year) (Child Protection Centre, 1984). Clearly, child sexual abuse is a problem which affects a tremendous number of children.

III Child Sexual Abuse Defined

There are many different factors involved in defining child sexual abuse. Some of the most important ones deal with the degree of coercion used by the offender, the sexual acts involved and the relationship of the child to the offender. Following is a brief review of some available definitions.

Berliner and Stevens (1982) categorized child sexual abuse into three areas using the criteria of degree of coercion and relationship between child and offender. The three areas they identify are rape, child sexual abuse and sexual exploitation. Rape is described as usually being a single violent act by a stranger or an acquaintance of the victim. Berliner and Stevens (1982) note that with rape, the sexual acts are usually forced intercourse--oral, vaginal and anal, and that injury is not uncommon. When a teenage victim is raped it usually involves situations where the adolescent is in a high risk situation, such as accepting a ride, being a runaway, meeting someone at a party or where alcohol or drugs are involved. Berliner and Stevens (1982) note that rape of younger children often involves kidnapping and brutality.

Child sexual abuse is described as the offender, related or known to the victim, using coercion by virtue of his powerful position to perpetrate sexual abuse. The authors note that if the victim is available, the sexual abuse will likely be repeated. Berliner and Stevens (1982) list a range of sexual acts included in sexual abuse--touching the genitals, forced masturbation, digital penetration, oral-genital contact, intracrural intercourse, and vaginal and oral penetration. Voyeurism, exposure, and involvement in photography or filming for pornographic purposes are also included.

Sexual exploitation usually involves a situation where a child or adolescent believes they are not a victim, but where the offender uses a wide age difference or greater life sophistication to sexually exploit the child. Sexual exploitation as defined by Berliner and Stevens (1982) also includes paid participation in pornography or prostitution rings for the benefit of adults.

Geiser (1979) breaks incest down into four types. The first type is the usual legal definition where sexual intercourse occurs between two persons so closely related that marriage is prohibited by law. The second type is what Geiser (1979) calls "psychological incest", where an adult in a parenting role (step father, foster father, mother's boyfriend) has intercourse with a child who is emotionally

dependent on him. The third type of incest Geiser (1979) describes is where all manner of sexual abuse takes place (touching the genitals, mutual masturbation) but does not include sexual intercourse. Geiser considers this incest because it occurs among family members. The fourth category of incest occurs between family members of the same sex.

Legal Definitions. The Criminal Code of Canada (1983) contains several sections that address sexual abuse. In defining child sexual abuse the Criminal Code uses the criteria of the sexual acts involved and the blood relationship between the offender and the victim. For example, Section 150 describes incest as being sexual intercourse between blood relations and brings a maximum sentence of fourteen years. Section 153 refers to sexual intercourse with a step daughter or female ward and only brings a maximum sentence of two years. It would appear that the Canadian law makers have neglected to consider the child's perception of her father which is seldom based on a biological relationship.

Canadian law further provides that sexual assault of a person under fourteen years of age will bring a maximum sentence of ten years, whereas sexual intercourse with a

female under fourteen years of age brings a maximum sentence of life in prison. These sections appear to discriminate against male victims of child sexual abuse because the offender could not be charged with the more serious offense. As the perceived seriousness of the crime is indicated by the length of the sentence available, we can see that sexual intercourse is considered to be much more serious than sexual assault. Sexual intercourse occurred in only 4% of the childhood sexual victimizations reported by Finklehor (1979) and 25% of childhood sexual victimizations as reported by Conte and Berliner (1981). Finklehor (1979) noted that intense sexual activity with a child may not include sexual intercourse due to physiological and psychological reasons. Conte and Berliner (1981) found that in 83% of the cases involving family members, sexual abuse took place repeatedly, often over a number of years. According to Canadian law, this ongoing sexual abuse is not as serious a crime as a one-time rape situation, although the effects may be more harmful and longer lasting.

The Child Welfare Act of Manitoba (1983) defines abuse as acts of commission or ommission on the part of the parent or the person in whose charge the child is, which results in injury to the child, including sexual abuse. The Act

provides that a child is in need of protection when subjected to abuse. There are no criteria outlined to define child sexual abuse. The blood relationship is not important, as anyone caring for the child can be guilty of child sexual abuse. This Act allows that any type of sexual activity can be considered abusive and that a sexually abused child is in need of protection.

From the evidence presented in Family Court, the child may be found in need of protection due to sexual abuse in the home. However, the offender may not even be charged, let alone convicted, of child sexual abuse in a criminal court due to lack of evidence. In order to protect the child from the offender, the child is often removed from the home. From the child's perspective this move often reinforces feelings of guilt around the sexual abuse and its disclosure. In this way it is seen how our Canadian legal system tends to perpetuate the "blaming the victim" attitude in current definitions of child sexual abuse.

Clearly, child sexual abuse is not easily defined. For the purposes of this practicum, child sexual abuse will be divided into two categories with the emphasis being placed on the relationship between the offender and the child. As Herman (1981) notes, the blood relationship is not as

important as the power relationship between the offender and the child. The first category, family child sexual abuse is divided into two types. The first type of family child sexual abuse is when the offender is the victim's parent or anyone acting as a parent. Step fathers, foster fathers or mother's boyfriend are all included here. The second type of family sexual abuse is when the offender is not a parent but is related to the child such as an uncle, older brother or grandfather.

The second category of sexual abuse, non-family child sexual abuse, is also divided into two types. The first type is where the offender is known to and trusted by the child. The second type of non-family child sexual abuse is where the offender is a stranger.

In both of these categories, family and non-family child sexual abuse, sexual acts can range from exhibitionism to touching the genitals to sexual intercourse. All child sexual abuse involves some type of coercion whether it is an unspoken understanding that the child will do as he or she is told or the use of physical force. From his* powerful position the offender often further coerces the child into keeping his behavior a secret.

* Statistics show that 80-90 percent of child sexual abuse offences are committed by men (Rush, 1980), and that the

majority of victims are female (De Francis, 1969). Throughout this practicum report the offender will be referred to as male and the victim as female to reflect these statistics.

Chapter Two

Child Sexual Abuse

I Introduction

There are different kinds of family child sexual abuse, but the most reported kind is that between father and daughter. Many writers in the field believe that brother-sister sexual abuse is more widespread but not reported as often (Sanford, 1980; Geiser, 1979). Sexual behavior between a brother and sister becomes abusive rather than exploratory when there is a wide age difference between the children (Geiser, 1979). When one sibling holds a powerful position such as babysitter, and is more powerful physically than the other, the relationship is likely abusive rather than exploratory (Sanford, 1980).

Father-son sexual abuse is not reported as often as father-daughter sexual abuse (Rush, 1980). Rush (1980) notes that the male victim reacts differently than the female victim to sexual abuse. The humiliation of the experience, the concern about his masculinity and fear of being homosexual will keep many boys from telling about the abuse (Rush, 1980). Nasjleti (1980) states that male victims do not report as often and do not want to talk about the victimization as

they feel they cannot show their fear and vulnerability. The father who sexually abuses his son is seldom a homosexual (Sanford, 1980). Although this area has not been studied to any great extent, there is a growing awareness of and concern about father-son sexual abuse.

Mother-son and mother-daughter sexual abuse are the least reported and it is felt that this kind of sexual abuse is rare (Rush, 1980; Geiser, 1979), although Goodwin and DiVasto (1979) state that mother-daughter sexual abuse is more common that the few reports would indicate. Geiser (1979) notes that female homosexual involvement with children is virtually never reported.

Extended family child sexual abuse is most often perpetrated by an uncle or grandfather (Sanford, 1980). With grandfathers who sexually abuse their grandchildren, issues of divided loyalty among aunts, uncles and cousins may tend to suppress reports. Many times, due to the offender's age and place of respect in the family, pressure will be put on the victim to recant his or her report of sexual abuse.

In the following section I will examine family and non-family child sexual abuse from the perspectives of the victim, the offender, the non-offending parent or parents,

the victim's siblings, and the extended family. As father-daughter sexual abuse and male-female non-family child sexual abuse are the most reported forms of child sexual abuse, I will focus on these areas.

II The Victim

The Sexual Assault Centre (1981,A) in Seattle, Washington estimates that 25 percent of all children, male and female are sexually abused. Finkelhor's (1979) study mentioned earlier, showed the average age of the victim at the onset of the sexual abuse to be ten years, when signs of puberty had not begun to appear. These statistics may not be representative, as many children do not report the sexual abuse until they are older (Chandler, 1982). Often, children cannot remember exactly how old they were when the abuse started.

Finkelhor (1979) found that 76 percent of the time the offender was known to the child and 43 percent of the time the offender was a family member. The Sexual Assault Centre (1981, A) notes that in their experience in working with families where sexual abuse had occurred, in 80 percent of the cases the abuse happened more than once and in some cases went on for many years. The sexual abuse usually started

when the child was quite young with touching the genitals and then intensified to oral, anal and vaginal penetration (Sexual Assault Centre, 1981, A).

In both family and non-family child sexual abuse, when the offender begins to sexually abuse a child, he will want to keep it a secret. Bass (1983) notes that every time a child is sexually abused, some form of coercion is used. There is most often no physical force involved. Instead, the offender uses threats and promises to ensure the secret is kept. When the offender is the victim's parent, this coercion can take the form of threatened dire consequences for the mother (she will have a nervous breakdown if you tell), for the child (they will take you away), for the offender (they will put me in jail) and for the whole family (you will destroy the family). Not only does this method of coercion keep the secret intact, it also leads the victim to believe that she alone is responsible for keeping the family together and for the welfare of her parents.

In cases of child sexual abuse where the offender is not a parent, similar threats are employed. The offender may threaten to beat up the child and her mother, or again may tell the child that she will be taken away from the family or the offender will be sent to jail. Many children

are given extra attention, favors, candies and money if they go along with what the offender wants (Butler, 1978). The offender has worked at developing a relationship where the child trusts him. Children believe what trusted adults tell them, and the offender twists this trust around to suit his own ends.

Victims of child sexual abuse have different methods of dealing with the incidents of abuse. Many victims state that while the abuse was taking place they tried not to think about it (Butler, 1978). Some victims viewed themselves as two people. One person was being sexually abused and the other was watching, on the side lines (Butler, 1978). Bass and Thornton (1983) note that many victims have repressed their knowledge of the sexual abuse. Many women are now remembering what happened to them as children, memories that they had suppressed for years.

The impact of the sexual abuse will be different for different victims. Schultz (1982) states that the great majority of victims are not traumatized by the sexual abuse. Most writers in the field disagree with this statement. The relationship of the offender to the child, the type and duration of the sexual abuse and the kind of coercion used will all contribute to the intensity of the traumatization

of the victim. Greenberg (1979) notes that the age of the child and the quality of care and experiences with parents in other matters will also determine the seriousness of the outcome. Conte and Berliner (1981) note that the victim may be psychologically traumatized not only by the sexual abuse, but also by being deprived of a normal parent-child relationship. Burgess and Holmstrom (1978) point out that many victims will develop tension-related symptoms (e.g. anxiety, frustration and constant fear) due to being pressured into keeping the secret over time.

Many victims of child sexual abuse feel isolated (Herman, 1981), which is especially difficult for adolescents whose development depends so much on the acceptance and approval of their peer group (Blick and Porter, 1982). The guilt and shame that many victims feel as a result of the sexual abuse erodes their self-confidence and results in a negative self-esteem (Blick and Porter, 1982; Burgess and Holmstrom, 1978).

The impact on victims of non-family child sexual abuse is often as intense as it is for the victims of intra-family abuse. Again the relationship of the offender to the victim and the duration and type of sexual abuse will determine the extent of the victim's traumatization.

For the victims of family and non-family child sexual abuse the response they receive at the time of disclosure will also influence impact. The child who is believed and supported has the best chance of recovery.

In a study done by Silbert and Pines (1981), 70 percent of the 200 juvenile and adult street prostitutes interviewed reported that being a victim of child sexual abuse definitely affected their decisions to become prostitutes. Only 10 percent of these women had been sexually abused by strangers (Silbert and Pines, 1981), the others being victimized by family and friends. Other responses of victims of child sexual abuse may be increased alcohol and drug abuse, running away and acting out (Conte and Berliner, 1981).

Gordon and O'Keefe (1984) state that in the cases of family child sexual abuse they have seen, the abusive situation ended when the victim left home, an outside authority discovered the abuse or, least frequently, another family member discovered the abuse. Victims may tell a friend who in turn tells an adult such as a parent, teacher or school counsellor. No matter how the "secret" is told, this disclosure will precipitate a crisis.

III The Offender

Berliner and Stevens (1982) state that most child sexual abuse offenders are not mentally ill, mentally retarded or criminal in settings other than the child sexual abuse. Typically, child sexual abuse offenders commit the offenses alone (Groth, 1978) and recidivism is characteristic (Drieblatt, 1982). Groth (1978) describes child sexual abuse offenders as isolated individuals who have poor skills in interpersonal relationships, feel inadequate and see themselves as victims of an overpowering environment. Child sexual abuse offenders have poor impulse control and are unable to be concerned about the victim's feelings and needs (Groth, 1978).

Finkelhor (1980) found that girls from stepfather families were five times more likely to be sexually abused than others. Children are also in a high-risk situation where mother's live-in boyfriends are concerned (Summit, 1979). In a random sample of 930 adult women, Russell (1984) found that one out of six women who had a stepfather reported sexual abuse by him. Further, almost half of the women sexually abused by a stepfather reported "very serious" sexual abuse, where just over one quarter of the women sexually abused by a natural father reported serious sexaul

abuse (Russell, 1984). Very serious sexual abuse included vaginal and anal intercourse, fellatio and cunnilingus (Russell, 1984). Some explanations offered by Russell for these differences are the lack of the incest taboo and the lack of early bonding between stepfather and stepdaughter. It seems evident that children with stepfathers are at a high risk for sexual abuse.

Groth, Hobson and Gary (1982) divide child sexual abusers into two categories, the fixated offender and the regressed offender. A fixated offender is one who is sexually attracted to children, not adults. This attraction begins in adolescence and sexual maturation does not occur (Groth etal, 1982). The regressed offender is one whose usual sexual interests are not focused on children, but due to stress and an inability to cope with adult life demands, a sexual attraction to children emerges. Groth etal (1982) notes that the majority of child sexual abuse offenders have themselves been sexually abused as children. The authors also note that fixated offenders tend to abuse boys whereas regressed offenders tend to abuse girls. These authors state that for the offender the abuse is often accompanied by fantasy. The fixated offender fantasizes that he and the child are on the same level; that he, the offender, is a child rather than an

adult. The regressed offender relates to the child as a pseudo-adult, fantasizing that the victim is more mature than she is.

Berliner (1983) outlines four conditions which play a role in a man's sexual abuse of a child. The first condition is a sexual interest in children. For the fixated offender this interest begins in adolescence. The regressed offender may not be aware of this interest until adulthood when the pressures on him are perceived as overwhelming. The child sexual abuse offender develops an inappropriate arousal pattern and is sexually aroused by and sexually attracted to children. Berliner (1983) states that this is a conditioned response which can become a pattern reinforced by, for example, masturbating to ejaculation while fantasizing about children. This can happen many times until it becomes a pattern which the offender believes he cannot control. If the offender was sexually or physically abused as a child or witnessed sexual or physical abuse in his home, the roles of victim and offender are already established in his mind.

The second condition Berliner (1983) outlines is the need for the offender to rationalize his desires and rid himself of internal inhibitions. Although the offender knows it is morally and legally wrong to sexually abuse a child, he

will justify his behavior through a process of resolving cognitive dissonance (Sexual Assault Centre, 1981, B). Offenders do this by telling themselves they are providing sex education to the child, responding to the child's seductive behavior, or anything else that will allow them to rationalize and justify the sexual abuse.

External inhibitions to sexually abusing a child must also be overcome and are the third factor outlined by Berliner (1983). This refers to gaining access to a child and to a place where the sexual abuse can be perpetrated. In a family, a father has ample opportunity to be alone with his child. Many offenders sexually abuse their children after their wives are asleep. Other times, such as when the mother is at work, shopping or visiting will also be taken advantage of. A non-family child sexual abuse offender may provide babysitting services, or invite children into his home as a friendly neighbor (Sexual Assault Centre, 1981, B).

Berliner (1983) states that the fourth condition to be considered is the child's resistance. The offender seldom abuses a child in a sudden loss of control. Usually the sexual abuse is premeditated and calculated (Gordon and O'Keefe, 1984). The offender is counting on the child's

powerlessness. If the child goes along with the sexual abuse and does not tell anyone, the offender has succeeded. A child who reacts to the offender's advances in an assertive manner and refuses to go along with the sexual abuse may not be sexually abused. This is not meant in any way to imply that the child is responsible for the abuse. Rather, some children are more vulnerable to abuse by virtue of their extreme need for affection, low self-esteem or need to please adult authorities. There are some child sexual abuse offenders who do brutally rape children, but these are not typical offenders.

When the sexual abuse is disclosed, the offenders will most often deny it (Sexual Assault Centre, B, 1981). It is typical for offenders to lie about the abuse and be very defensive. Rist (1979) states that offenders use denial, projection and rationalization to block their feelings of guilt. Even when offenders do admit to the sexual abuse they often minimize it by saying that it just started and only happened once or twice. Often the offender will blame his wife (she would not have sex with him), the child (she seduced him), or the influence of alcohol or drugs (Sexual Assault Centre B, 1981; Rist, 1979). These rationalizations are common to both family and non-family child sexual abuse offenders.

IV The Non-Offending Parent or Parents

The non-offending parent in most family child sexual abuse situations is the mother. In the literature, the major issue concerning the mother is whether or not she was aware of the sexual abuse in the home. One view is that the mother is aware of the abuse and that she pushed the daughter and husband into the situation (Justice and Justice, 1979; Sgroi, 1982). The other view is that most often the mother is unaware of the sexual abuse occurring in the home (Summit, 1979; Sexual Assault Centre, 1981, A). In some cases mothers may have felt that something was "not quite right" in the home, but these mothers did not suspect that their husbands were sexually abusing their daughters, (Sexual Assault Centre, 1981, A).

There are, no doubt, some mothers who are aware of the sexual abuse in the home. Herman (1981) states that these mothers, for whatever reason, are powerless and tolerate many forms of abuse. Many of these women are battered by their husbands. Dietz and Craft (1980) point out that to accuse these powerless women of not protecting their children while they are powerless to protect themselves results in "blaming the victim".

In some extreme cases, there are mothers who actually participate in the sexual abuse. However, Groth, Hobson and Gary (1982) note that the typical child sexual abuse offender works alone.

When a child is sexually abused by someone other than a parent, the issue of whether or not the victim's parents were aware of the abuse is seldom addressed. Geiser (1979) describes a situation where an eight year old boy was being sexually abused by his uncle. The boy's parents were aware of the sexual abuse and felt that all children must learn about these things sooner or later. They further stated that the eight year old boy had not been singled out as the uncle had sexually abused all of the children. It is safe to assume that this attitude is not a usual one. The majority of parents are not aware that their child is being sexually abused.

V The Victim's Siblings

There is very little in the literature regarding the effect of the child sexual abuse on the victim's siblings. Again the issue arises of whether or not they were aware of the abuse. One way or another, the siblings are affected by the sexual abuse (Cohen, 1983).

If a sibling is aware that child sexual abuse is occuring in the home but realizes that nobody mentions it, he or she may conclude that they too must keep the secret. Children are aware of what can be talked about in the home without necessarily being told. Siblings are often aware that if they mention the sexual abuse, trouble will result.

A sibling's complicity in the child sexual abuse may cause serious problems for him or her. Brothers who see this behavior as a role model may repeat the sexual abuse when they become parents (Sanford, 1980). Sisters may not rock the boat for fear that the offender will turn to them next (DeYoung, 1981). Alternatively, the victim's sisters may learn the role of the victim and repeat this pattern throughout their lives.

If the siblings are not aware that the sexual abuse is occurring, there may be feelings of jealousy regarding the victim's perceived special place in the family (Sanford, 1980). The offender may give the victim extra attention, money or special privileges in return for her quiet acquiesence to his desires. This mistaken perception isolates the victim further, as her siblings cannot be counted on as supports in her dilemma. Also, this can increase the importance for the victim of keeping the sexual abuse a secret so that

she does not lose the little esteem she gets from her siblings due to her perceived special place in the family. If, upon disclosure, the offender leaves the home, siblings may be angry at the victim for causing them to lose a parent who never hurt them.

Siblings of victims in cases of non-family child sexual abuse are also affected by the abuse. Although not discussed in the literature, we can assume that their responses to the child sexual abuse would be similar to those of the siblings in cases of family abuse, particularly in regard to resentment of the extra attention the victim may receive. When the siblings are older than the victim they may feel that they neglected to protect the victim.

VI The Extended Family

Where family child sexual abuse is concerned, the extended family will react either in support of the victim or in support of the offender. Whatever their reaction, Sanford (1980) notes that it will be intense. If the offender's family does not believe the victim, they will often put pressure on him or her to recant allegations. Even when the offender's family does believe he sexually abused the child, many members will minimize the abuse or the seriousness of it.

In cases of non-family child sexual abuse the extended family will most often support the victim. There are seldom any issues of divided loyalty.

Chapter Three

Theories on the Etiology of Child Sexual Abuse

I Introduction

There are a number of theories regarding the etiology of child sexual abuse. Depending on the ideological orientation of the person proposing the theory, different aspects of the problem are emphasized. For example, psychoanalytic theories maintain that incest occurs as a form of revenge of the daughter against the mother, and as a form of oral gratification due to oral deprivation in the preoedipal stage (Dixen and Jenkins, 1981). This theory purports that the daughter sets up the incestuous situation and that the father has no responsibility for his behavior. There are, no doubt, many daughters who experienced oral deprivation at the preoedipal stage whose fathers chose not to sexually abuse them.

The two main schools of thought regarding the etiology of child sexual abuse can be classified as "dysfunctional family system theory" and the "feminist perspective". In the next section the major tenets of each will be outlined and the argument made that neither is completely adequate.

The section concludes with the author's attempts to integrate reading and practice toward a more complete understanding of child sexual abuse.

II Etiology According to Dysfunctional Family System Theory

The dysfunctional family system is one of the most frequently cited causes of child sexual abuse (Dixen and Jenkins, 1981). The contention here is that the whole family initiates and maintains the family child sexual abuse (Sgroi, 1982; Poznanski and Blos, 1975; Forward and Buck, 1978). The family dysfunction theorists indicate that an impaired marital relationship and disintegration of generational and sexual boundaries allows the mother to coerce the daughter into taking on adult responsibilities, which include the sexual relationship with her father (Dixen and Jenkins, 1981). Poznanski and Blos (1975) state that the mother gives her permission for the family child sexual abuse which they see as the key factor in this situation. The mother is seen as having failed to set and enforce appropriate limits on the father-daughter interactions and thereby as having allowed the sexual abuse to occur (Poznanski and Blos, 1975). Herman (1981) notes that views comparable to Posnanski and Blos' abound in the psychiatric literature.

Forward and Buck (1978) view family child sexual abuse as a family problem and contend that the mother is guilty of pushing the daughter into the maternal role. These authors further state that the child may have been seductive (Forward and Buck, 1978). Giarretto (1977) notes that some mothers in family child sexual abuse situations send messages to their daughters which are "subtle and suspicious" and could only come from a "rival". Giarretto (1977) however, does insist that the father must be held responsible for his behavior.

Poznanski and Blos (1975) state that the offenders in family child sexual abuse are generally weak, ineffective men who have poor relationships within the family and outside of it. These authors remove the responsibility of the sexual abuse from the father and place it with the mother and daughter. They state the daughter is scarcely an innocent victim (Poznanski and Blos, 1975).

Sgroi (1982) notes that in child sexual abuse there is always some degree and type of family contribution. In cases of family child sexual abuse Sgroi (1982) states that the three areas of family contribution are the failure to protect, the failure to set limits and the abuse of power. The non-offending parent has failed to protect the child and failed to set limits with respect to roles in the family,

(Sgroi, 1982). The offender in these cases has failed to set limits on himself and has abused his position of power in the family (Sgroi, 1982). In cases of non-family child sexual abuse, Sgroi (1982) also looks for the victim's family's contribution in the area of failing to protect the child. Sgroi (1982) appears to have combined some aspects of the dysfunctional family systems view with the feminist perspective which will now be described.

III The Feminist Perspective

The feminist perspective contends that family child sexual abuse is a result of male domination in the home. From his position of power, the father is seen as exploiting his daughter (Vander Mey and Neff, 1982). Rush (1980) states that the child sexual abuse offender is not the product of a dysfunctional family. Rush (1980) sees the child sexual abuse occurring because a child has less experience and physical strength, and is more trusting and less threatening than a woman. These ideas clearly identify the offender's power over the victim as the base of the feminist approach. Feminist theory identifies similarities between child sexual abuse and rape, seeing both as a function of the predatory and misogynist attitudes towards women that permeate society (Finkelhor, 1982).

Herman (1981) states that male supremacy and an unequal division of child care labor between the male and female are the root causes of family child sexual abuse. The powerful place of the male in the home allows him to exploit his wife by forcing her to be dependent on and subservient to him. This same male will sexually abuse his daughter and his wife will be afraid to protect her child (Herman, 1981). Kroth (1979) states that feminists view child sexual abuse as a continued extension of male dominance and sexism.

IV Critique and Integration

Dietz and Craft (1980) point out that with the lack of empirical research and objective information, social workers must rely on their own attitudes and beliefs when working in the area of child sexual abuse. In building a theory on child sexual abuse the theorist's opinions about children, women, sexual abuse and families form the base.

It is the author's belief that the child who is sexually abused is <u>always</u> an innocent victim, and that most mothers are unaware that the family child sexual abuse is occurring. This is not to deny that child sexual abuse is a family problem, because it does have a tremendous impact on the whole family. For a theory to adequately account for abuse, it is my opinion

that the offenders must be held responsible for their actions. I believe Berliner's (1983) four factors previously reviewed in Chapter 2, III, can form a helpful base in an ecological understanding. Briefly, the four factors are: (1) a sexual interest in children, (2) the ability to rid oneself of internal inhibitions, (3) the ability to overcome external inhibitions and (4) the child's response to the abuse.

I disagree with the idea that the whole family initiates and maintains the child sexual abuse. Many families are dysfunctional but not all of these fathers sexually abuse their children. There may be social stresses present such as marital conflict or unemployment, but responding to these stresses by sexually abusing a child is the offenders responsibility.

As noted earlier, most mothers are not aware of the sexual abuse until disclosure. They therefore do not play a role in initiating the sexual abuse nor do they give permission for the father to sexually abuse a daughter. Refusing to have sex with one's husband cannot be interpreted as encouraging him to have sex with a daughter. Child sexual abuse offenders use many techniques to rationalize their behavior. Blaming his wife for not having sex with him is one of the methods an offender may use to rationalize sexual abuse of his daughter.

To blame the mother for not wanting to have sex with her husband and for pushing the daughter into this role is to validate the offender's rationalizations. Further, in the author's view, it is incredulous to suggest that an abused three year old was engaged in "role reversal" with the maternal figure.

Many dysfunctional family system theorists maintain that the child is not an innocent victim and that she seduced the offender into the sexual abuse. This is also a rationalization employed by offenders which is being validated by the theory. Pre-pubertal children do not have the knowledge of sex to seduce an adult. Further, if an adult views a child's behavior as seductive, which stimulates his sexual interest, it is up to him as the adult not to act on this interest. A child may enjoy the closeness and extra attention she initially receives from the offender, but this cannot be interpreted as seduction. A child has a right to physical affection but this is not synonymous with sex.

The feminist perspective views the male as abusing his position of power and does not see the child sexual abuse as an issue of a sexual nature. That the sexual abuse is only an abuse of power negates the issue of the offender having a <u>sexual</u> interest in children. Adults can exert their

power over children in many ways. The child sexual abuse offender's deliberate, calculated and often long term coercion of the child indicates that there is more to the abuse than an issue of power. This whole process is an abuse of power, but there are many other ways of misusing that power. Many fathers are domineering and controlling and abuse their children physically and emotionally, but there must be a sexual interest in children for sexual abuse to occur.

Therefore, we can see that neither of these views is adequate to explain the etiology of child sexual abuse. Each theory has valuable points to offer -- the dysfunctional family system perspective in acknowledging that this is a family problem and the feminist perspective as they do hold the offender responsible for his actions. A combination of these aspects with Berliner's (1983) four conditions to be considered in the etiology of abuse can be used to explain both family and non-family child sexual abuse. Such a perspective is the foundation of this practicum.

Chapter Four

Prevention of Child Sexual Abuse

There are a number of excellent books and pamphlets available to parents and professionals that outline ways of helping children to become less vulnerable to a sexual assault. (For example see: Adams and Fay, 1981; Freeman, 1982; Hart-Rossi, 1983; Sanford, 1980, 1983) These booklets stress the fact that a child's body is special, that it is their own and that they can say no to uncomfortable touch. As Berliner (1983) points out, the fourth factor to be considered in the etiology of child sexual abuse is the child's response. If we can assist children to say no and to tell their parents right away, there will be some prevention of child sexual abuse.

This method of prevention identifies children as the target group for preventive intervention and does not look at controlling the agent of the problem, the offender. As noted by Rappaport (1977) we are attempting to make the victims less vulnerable and to "send them into battle with better weapons and a higher level of morale". (p.119).

The majority of child sexual abuse is perpetrated by someone known or related to the child, where trust and

dependence has been established. Children are put in an untenable situation when each parent is telling them to do as they are told, but what they are being told conflicts. A child's mother may have told her to tell if anybody ever touches her and it is an uncomfortable touch. At the same time, the child's father may be sexually abusing her and warning her that if she tells she will break up the family and send him to jail. In many cases, the very people who are supposed to be responsible for teaching children how to avoid being sexually abused are the people committing the crime of abuse. Perhaps this is the main reason why these prevention programs cannot end child sexual abuse. Such programs may arm the child with some weapons against an attack by a stranger but they may be ineffective in preventing the child from being sexually abused in her home where the biggest battle is taking place.

Watzlawick, Weakland and Fisch (1974) discuss first and second order change. First order change is change that occurs within a system while the system itself remains the same. The prevention programs described above are examples of first order change. Watzlawick etal (1974) also note that in utilizing first order change, when we see that it is not working, we tend to try harder with that same solution.

In child sexual abuse we can teach children not to keep secrets and to say no to uncomfortable touch from adults. When children are still sexually victimized we work harder at trying to reinforce the necessity of the children protecting themselves. By applying more of the same solution we may be forcing the offender to become even more coercive and demanding in his victimization of the child (Herman, 1980). He may use more violent behavior and threats to ensure the secret is kept. This leaves the victim with virtually no options.

Watzlawick, Weakland and Fisch (1974) describe second order change as change of the system itself. Rather than insisting that victims protect themselves better, we look at changing the "rules of the game" that made them victims in the first place. Second order change must begin at the point of the power base. We know that the majority of child sexual abuse offenders are male and that they come from every socioeconomic level of society. Further, the majority of legislators, judges, lawyers and police officers are male. It only stands to reason that some of these powerful men may be child sexual abuse offenders. In a society where one sex is given more power and seen as dominant, abuse will continue. The norm is for a man to have a smaller, weaker partner. This

is seen in marriages where the majority of husbands are older and physically stronger than their wives. In child sexual abuse, this is taken one step further, and the victim becomes the smaller, weaker partner.

Sex role socialization teaches men that they must suppress their emotional needs. Men are told they must be tough and that they should be "studs". Pornography encourages people to objectify sex. "Kiddie Porn" provides fantasy material for the child sexual abuse offender who may then attempt to make the fantasy a reality. Through sex role socialization and the use of pornography and Kiddie Porn, affection becomes sexualized. It is clear that the "rules of the game" need to be changed and that this change must begin where the power is situated.

Children have very few rights in Canada and need adults to advocate on their behalf. It is apparent that women, who are also the victims of sexual assaults by men, are the most likely group to provide this advocacy. As advocates, women must challenge the people holding the power.

Changes in the Canadian legal system must occur. At this time, many offenders are not even charged, let alone convicted of child sexual abuse (MacFarlane and Bulkley, 1982). The young child is not considered to be a good witness

and there is seldom a corroborating witness or conclusive medical evidence. A child may show with anatomically correct dolls what happened to her and name the offender, but our courts will not allow this alone as sufficient evidence. If the offender denies having sexually abused the child there is nothing that can be done and he is free to carry on sexually abusing children.

First order change, providing children with methods of protecting themselves, should continue as it can be effective for some children. However, only through second order change will there be change of the system that allows children to be sexually abused.

Chapter Five

The Ecological Perspective

Germain (1981) notes that a concern for person-in-environment is the distinguishing and unifying characteristic of social work. From this perspective social workers view the interactions between individuals and their environment, and their reciprocal influence on each other. Hoffman (1981) describes Auerswalds "ecological systems approach" as "directed at the total field of the problem, including other professionals, extended family, community figures, institutions. . . and all the overlapping influences and forces that a therapist working with. . . families would have to contend with." (p.257)

In its early development, social work activity reflected an ecological orientation. In the mid and late 1800's, social workers were involved in assisting immigrants to America adjust to their new environment. As Gavin (1962) notes, social workers did not strive primarily to supply relief, rather, they worked at eliminating the conditions that made relief necessary. Lubove (1965) points out the valuable role social workers played in the medical, psychiatric and educational fields. This contribution was an overall view

of the patient or child, taking all the factors of the individuals situation into account. This view, of the person-in-environment, provided an understanding of the individual, his or her family and the social networks with which he or she interacted.

As social work became involved in the psychiatric framework, the ecological view was set aside to a great extent. As McCord (1928) notes, the social workers welcomed the psychiatric approach eagerly and almost all children's case workers incorporated it into their work. Thus the psychodynamic principles were emphasized and more attention placed on intrapsychic determinants of life difficulties.

In the 1970's the ecological perspective began to re-emerge. The burgeoning field of family therapy has helped to shift the focus from the individual and intrapsychic exploration to the family and the interaction that takes place within the environmental context. Today many practitioners and educators recognize that it is necessary to view the individual as part of a network, influenced by the transactions that take place within that system.

In a family where a child has been sexually abused, an assessment of the individuals functioning within the family and within the environment is important. Rappaport (1965)

stresses the importance of the social worker viewing ". . . self as intervening in a social system - as a part of a network of relationships - and not as a single resource." (p.30). All the networks in which the family is involved need to be examined.

In order to assess and intervene effectively in a family where a child has been sexually abused, an ecological framework is essential. Bronfenbrenner (1977) outlines four levels of analysis in an effort to provide new methods of gathering and ordering data where human development is concerned. His approach is an ecological perspective where the environment is conceived topologically as a nested arrangement of structures, each contained in the next. These four levels are: 1) a microsystem, 2) a mesosystem, 3) an exosystem and 4) a macrosystem. Belsky (1980) took Bronfenbrenner's four levels of analysis and revised them for the purposes of examining the area of child maltreatment. Belsky (1980) includes ontogenic development, the background factors that individuals bring into the parenting role.

A framework such as the one Belsky (1980) developed provides the social worker with an ecological view of the family. A considerable amount of information can be methodically gathered and organized into a framework that

gives structure to the intervention. An analysis of the data can assist the social worker in formulating methods of intervention and it can indicate areas where immediate attention must be focused. As Belsky (1980) notes, this ecological framework can also serve as a guide for future empirical enquiry.

I A Framework for Assessment

An assessment from an ecological perspective of a family in which a child has been sexually abused can be organized using Belsky's (1980) four levels of analysis. These levels of analysis are pertinent whether the child sexual abuse is family or non-family. Following is a description of these four levels.

Ontogenic Development: This refers to what the individual parents bring with them to the parenting role. It is becoming apparent that the experience of or exposure to sexual abuse as a child has serious implications for individuals as adults. Sexual Assault Centre (1981B) states that about one-third of all child sexual abuse offenders were molested as children themselves or saw this as a model (eg. father sexually abusing sisters). The

article also notes that a large majority of sexual offenders were physically abused during childhood and adolescence. Corsini-Munt (1980) found that more than half (56%) of the children's parents in her study reported sexual abuse of themselves as children. Goodwin, McCarthy and DiVasto (1981) found that 24% of mothers of sexually abused children had incidents of prior family child sexual abuse. Although the statistics in the studies differ, it is clear that experience of or exposure to sexual abuse as a child has implications for adult behavior. The fact that these adults were sexually abused has implications for their repeating these experiences as adults. As well, their ability to respond appropriately to their child will depend on their experience with disclosure as a child. If, as a child, the parent was made to feel responsible for the abuse they may have difficulty responding in a supportive manner to their child's disclosure.

Many victims of child sexual abuse never told anyone about their victimization. Their child's disclosure will bring back unresolved issues which will further compound the crisis of disclosure. It is important for the social worker to be aware of these possibilities in order to intervene effectively. Thus, asking parents whether or not they were

sexually abused as children becomes a standard part of the assessment.

Attitudes toward sex and one's own sexuality are formed in childhood and adolescence. It is important to explore the parent's attitudes regarding sex and their beliefs regarding children. Many of the parent's attitudes and beliefs will stem from their experiences as children and adolescents, and exploration of this will assist the social worker in identifying areas where factual information is required.

The Microsystem: This refers to the family setting, the immediate environment. Much of what takes place in the family setting is dependent on the parents' ontogenic development.

It is important to know how the victim is viewed in the family setting. If the victim is identified as a troublesome child who has always caused problems in the home, her disclosure may be considered to be an attempt to draw some attention to herself. The parents ability to believe and support their child in this situation is questionable.

Finkelhor (1979) reports that girls whose mothers are absent or sick run a particularly high risk of abuse.

Finkelhor further notes that having a stepfather increases a girl's chances of being sexually abused, not just by the stepfather, but by persons outside the family as well. Therefore, it is important for the social worker to be aware of the family constellation. Finkelhor (1979) also found that when the parents' marriage is unhappy, rates are also high. The social worker must become attuned to the family's patterns of communication in order to assess the family.

The Exosystem: This system is made up of the social structures, both formal and informal, that impinge upon or encompass the immediate settings of the individual and family. These can include the world of work, school, daycare, church, peers, social circle, extended family, etc. These systems can respond to the disclosure of child sexual abuse in a supportive or rejecting way. A clear understanding of the support systems available to the family is important. Co-workers may view the victim's parent as negligent and irresponsible for allowing the abuse to occur. The extended family may provide the emotional and physical support the family needs to get through the crisis. The victim's teacher at school may provide the understanding and support a child

needs to get through the crisis of sexual abuse and not be further victimized by the school system.

It is important for the social worker to be aware of how the family views their exosystem. Support from the formal and informal social structures can be elicited with encouragement or facilitation from the social worker.

The Macrosystem: This refers to the cultural values and belief systems that foster child sexual abuse through the influence they exert on ontogenic development, the microsystem and the exosystem.

One factor to be considered at this level is society's attitudes towards children -- the notion that they are their parents' property and have no rights. Sgroi (1978) notes that child sexual abuse is a crime that our society abhors in the abstract but tolerates in reality. This becomes obvious when we see new programs being established to deal specifically with child sexual abuse while child prostitution and "Kiddie Porn" are becoming big business. Densen-Gerber and Hutchison (1979) note that the sexual use of children has become a multimillion dollar industry and view it as an international issue.

The family's cultural background is another factor to be considered at this level. The values and attitudes adhered to by the family which stem from their cultural orientation will affect their view of child sexual abuse.

There is no way to identify a child sexual abuse offender by his outward appearance. When a child discloses sexual abuse by a member of the community who is well liked and respected, there is a tendency to ignore the child's allegations. This tendency to assume that the report is a fabrication is shown by professional and non-professional people alike. As Topper (1979) notes, this denial has interfered with the development of effective intervention.

An assessment from an ecological perspective can alert the worker to the many systems in which the family is involved. Because child sexual abuse is a crime as well as a family problem, concern must also be directed to the new systems in which the family will be involved. The impact of involvement with police, medical personnel, lawyers and judges as well as social services must be recognized.

To be effective, all the resources and helping professionals must be coordinated and work together in responding to the abuse. In viewing the child sexual abuse from an ecological perspective,

it becomes clear that effective intervention must encompass consideration of the impact larger systems exert on the victim and her family. In this practicum, the ecological perspective served as the guiding orientation for the intervention to be described in Part Two.

PART TWO

THE PRACTICUM

Chapter Six

The Method of Intervention

I Introduction

The method of intervention carried out in this practicum was crisis intervention with victims and their families in cases of non-family child sexual abuse.

The majority of the literature discusses treatment of cases of family child sexual abuse, with little attention being paid to cases of non-family abuse. A number of treatment programs have been developed to treat cases of family child sexual abuse. (For example see Giarretto, 1982; Sgroi, 1982). Sgroi (1982) notes that treatment of non-family child sexual abuse should occur and should involve the whole family. Porter, Blick and Sgroi (1982) state that it is extremely difficult to engage the family of a victim of non-family abuse in treatment. The following is a model of treatment for non-family child sexual abuse cases based on crisis theory and crisis intervention. As Herman (1981) notes, disclosure of child sexual abuse initiates a profound crisis for the whole family. It is proposed that if the victim and family are seen while they are in an active crisis state, effective intervention can take place and that the majority of families will engage in and benefit from such treatment.

The method of intervention will now be described beginning with a discussion of crisis theory.

II Crisis Theory

Crisis has been defined as an "upset in a steady state" (Golan, 1978, p.61). Crisis theory is based on the belief that brief, skilful intervention that provides the client with relief from stress and the possibility for growth will be adequate in a number of situations. These situations are ones where the causes of the crisis are mainly external to the individual or family. A brief process that helps to reduce the stress and assists the individual to use appropriate coping skills is required. This approach differs from the ongoing treatment required for individuals or families who need to change their behavior and attitudes (Golan, 1978).

Early intervention in a crisis situation is important because of the willingness shown by people in crisis to reach out for and accept help (Rapoport, 1965). Golan (1978) stresses the importance of people in crisis having rapid access to the social worker. She further notes that there should be no waiting lists and that the initial social worker involved should provide the entire crisis intervention service.

A change in workers during crisis intervention may further compound the crisis for the individual or family. If the person(s) in crisis must wait to be seen, maladaptive resolution of the crisis may occur. Without purposeful intervention, people in an active crisis state will do whatever is necessary to relieve the intense stress they are experiencing. This relief may be in the form of alcohol or drug abuse, running away from the situation, blocking feelings about the situation or blaming oneself for the crisis, which can result in suicide or attempted suicide. Therefore, early crisis intervention is necessary to assist individuals or families to relieve the stress and to develop healthy coping mechanisms.

Golan (1978) describes two types of crises, the anticipated crisis and the accidental crisis. An anticipated crisis is one that occurs during an individual's developmental life course, such as adolescence or getting married. Although these events are anticipated, the stresses involved with the transitions may precipitate a crisis. An accidental crisis is one where there is little or no warning, such as the sexual abuse of a child or an earthquake.

Components of a Crisis Situation

Five components of a crisis situation are outlined by Golan (1978). These are: the hazardous event; the vulnerable state; the precipitating factor; the state of active crisis; and the state of reintegration or crisis resolution. Each of these components of a crisis situation will be briefly described.

The Hazardous Event. This is the stressful event that precipitates the initial threat to a person's coping abilities. As noted earlier, this event may be anticipated or accidental.

The Vulnerable State. This is a state of upset in response to the hazardous event. Golan (1978) notes that individuals respond to the hazardous event in their own way. The hazardous event may be perceived as a threat, loss or challenge. A threat to an individual's needs or sense of well-being may cause great anxiety. The response to the loss of a person or ability may be depression or mourning, whereas perceiving the hazardous event as a challenge may stimulate some anxiety, hope and excitement (Golan, 1978). Individuals respond to the hazardous event using their usual coping skills. If these are ineffective, others are called forth, ones not ordinarily used. If these fail to reduce

the stress, the individual may begin to feel helpless, depressed and hopeless (Golan, 1978).

The Precipitating Factor. This is the event that moves an individual from a vulnerable state into a state of active crisis (Golan, 1978). Crises can be precipitated by two different etiological processes (Golan, 1978). These are the exhaustion crisis and the shock crisis. In an exhaustion crisis the precipitating factor is the "last straw". There may be an accumulation of stressful events that lead up to the precipitating factor and although the event that precipitates an active crisis state may appear to be minor, it is all that is needed to throw the individual into an active crisis state. The individual becomes exhausted and cannot cope any further. A shock crisis is one where there is no forewarning and no time to draw on available coping mechanisms. The individual will be completely overwhelmed immediately, unable to assimilate the impact and will enter a state of emotional shock (Golan, 1978). In the shock crisis the hazardous event, vulnerable state and precipitating factor are combined and as a result of one highly stressful event the individual enters an active crisis state immediately.

The Active Crisis State. Tension is at its highest point in the active crisis state and the individual or family is in

a state of disequilibrium (Golan, 1978). In this state psychological and physical turmoil along with preoccupation with the events leading to the state of crisis are followed by a period of readjustment and remobilization as the individual becomes aware of his/her situation (Golan, 1978). An individual's usual coping mechanisms are not effective at this point, having been impaired or reduced. It is at this point that the decision is made whether or not to use crisis intervention (Golan, 1978). Golan (1978) notes that Caplan estimated that a person can only remain in an active crisis state for four to six weeks.

Reintegration or Crisis Resolution. At this point in the crisis situation an individual's anxiety lessens and some reorganization of the individual's functioning abilities occurs (Golan, 1978). This reorganization can lead to an adaptive or a maladaptive resolution of the crisis. An adaptive resolution of the crisis increases the individual's self-esteem and provides a broader base of coping abilities to be drawn upon in the event of another such crisis. Golan (1978) states that a maladaptive resolution of the crisis results in the use of defense mechanisms such as projection, introjection and denial. Others are blamed for the individual's problems which in turn provokes hostility toward the person in crisis (Golan, 1978).

To assist individuals and families to an adaptive resolution of a crisis Golan (1978) uses Rapoport's (1970) crisis-oriented treatment goals. These goals are divided into two levels. The main goal of crisis intervention is to enhance the individual's or family's ability to cope with current problems in living (Golan, 1978). In order to achieve this the goals at a minimal level are:

1. Relief of symptoms.
2. Restoration to precrisis level of functioning.
3. Some understanding of the relevant precipitating events which led up to the state of disequilibrium.
4. Identification of remedial measures which the individual or client can take or that are available through community resources.

Two additional goals are recommended:

5. Connecting the current stresses with past life experiences and conflicts.
6. Initiating new models of perceiving, thinking and feeling and developing new adaptive and coping responses which can be useful beyond the immediate crisis situation (Golan, 1978, pp. 71-72).

At the minimal level the individual or family return to their precrisis level of functioning. This is an adaptive

resolution of the crisis. The individual or family have some understanding of what led up to the crisis and are put in touch with resources to help with the current problems.

The additional goals outlined above go beyond the immediate crisis situation. Attainment of these goals will assist the individual or family to look at how the present situation connects with past situations. Further, new methods of responding to crises or in fact preventing crises from occurring are discussed. Achievement of the additional goals still falls within the crisis intervention process and does not become ongoing treatment.

Crisis intervention is a brief, intense process that has a beginning, middle and an end. Golan (1978) notes that crisis intervention can be utilized in an ongoing treatment situation where a crisis has occurred. Once crisis resolution is achieved, the casework continues as before, although the individual or family may have gained new insights into their coping abilities as well as new skills in dealing with stress.

Phases of Treatment in a Crisis Situation

Treatment in crisis situations consists of three phases -- formulation, implementation and termination (Golan, 1978). A brief description of each will be presented.

Formulation Phase: The focus in this phase is on the crisis. Clients are encouraged to talk about the crisis and their feelings as a result of the crisis. Golan (1978) notes that at this point the aim is to elicit reactions to the crisis. The client and worker identify the most pressing problems and set up an agreement to work together.

Implementation Phase: This is the longest phase of crisis intervention. During this phase the worker obtains a more complete understanding of the history and background of the client and the crisis. The client's strengths and weaknesses are identified as are the available support systems. The client's methods of dealing with past crises are examined and work toward the goals specified in the formulation phase takes place. This phase is aimed at helping the client regain a sense of self-control and self-esteem (Golan, 1978).

Termination Phase: The worker must assess the client's readiness for termination. Golan (1978) notes three kinds of termination reactions -- the client who agrees that it is time to end, the client who is afraid of termination and wants ongoing treatment and the client who needs ongoing treatment. An important aspect of this phase of treatment is a review of the progress made and tasks accomplished

during the crisis intervention process. Golan (1978) notes that often crisis intervention is terminated with the understanding that the client will return if necessary. Many times clients will decide that no further help is needed and will terminate the intervention on their own (Golan, 1971).

Chapter Seven

Design of the Practicum

I Introduction

The design of the practicum will be detailed in this Chapter and divided into areas of the setting, the clients and the intervention.

Before beginning to describe the design of the practicum I would like to explain a discrepancy that arose regarding the definitions of child sexual abuse.

The definition of family child sexual abuse that I used in this practicum included offenders who were parents or parent figures and people who were related to the child. The definition of non-family child sexual abuse included those offenders who were known but not related to the victim as well as strangers. These definitions differed from the ones used in the Agency where I conducted this practicum. The categories used by the Agency were family and "third party" child sexual abuse. Family child sexual abuse included offenders who were living in the victim's home. Third party abuse included anyone not living in the same home as the victim. Therefore, a child's natural father if not living in the home, as well as a neighbor, could all be included in the third party child sexual abuse category.

The Children's Aid Society of Winnipeg intervenes in family child sexual abuse but not in cases of third party abuse. This reflects their mandated role to protect children as well as the perception that victims of third party child sexual abuse are not at risk. The cases of third party abuse wanting intervention are referred to the agency where I did my practicum.

As a result of these differing definitions, I dealt with cases which were not strictly non-family child sexual abuse. (For example, in one "third party" case the grandfather was the offender.) Crisis intervention was provided in all cases.

II The Setting

This practicum was conducted at the Child Protection Centre, a part of the Children's Hospital at the Health Sciences Centre, from March to July, 1984. The Child Protection Centre is a diagnostic and treatment facility for abused and neglected children in Manitoba. Dr. Kathryn Saulnier, my practicum advisor, provided on-going supervision. Ms. Brenda Gravenor, Senior Therapist at the Child Protection Centre and a member of my practicum committee was my contact person at the Centre.

Initially I saw families at the Child Protection Centre after they had been referred by the medical personnel at the S.C.A.N.-Gyne (Suspected Child Abuse and Neglect - Gynecology) Clinic. There was often a waiting period of up to a week between the referral and the family's appointment with me. After a few of these families did not keep their appointments with me, it became clear that the intervention must begin at an earlier point. As a result, I began to attend the S.C.A.N.-Gyne Clinics each week. This approach proved to be effective as I was able to connect with families while they were in an active crisis state.

During the practicum I attended weekly meetings of the Child Sexual Abuse Committee. This interdisciplinary committee had representatives from the Child Protection Centre, medical doctors and psychologists from Children's Hospital, Children's Aid Society, police and the Child Guidance Clinic. The purpose of these meetings was to review cases of child sexual abuse and to discuss and coordinate intervention and treatment.

III The Clients

Fourteen families were seen during this practicum. Eight of these were female single parent families while the other six were two parent families. One native family was seen.

Information on labor force attachment was gathered from all fourteen families. Five of the single parent families were receiving Welfare. One of these mothers was disabled (heart problems) and could not work outside the home while one was a full-time student and one a part-time student. The other three single parents were employed full time. Of the six two parent families, five fathers were employed full-time and one was a full-time student. Four of the mothers worked part-time and one full-time.

Five of the fourteen families reported having problems with parenting while the other nine appeared to be doing well in this area. Three parents reported having been sexually abused as children.

Three families were seen only once. Two of these families reported having many problems above and beyond the sexual abuse of a child and did not return for further intervention. Both of these were single parent families and both mothers had reported being sexually abused as children. In one situation the mother insisted that her daughter had been sexually abused. However, both the daughter and the offender denied this. In the other situation the offender had admitted to the sexual abuse but the mother was resistant to any involvement.

The third family that only came to one session had appeared to want the intervention but never followed through. All three of these families were seen at the S.C.A.N.-Gyne Clinic and then were later referred to me. This waiting period apparently caused these families to adapt to the crisis in their own way making crisis intervention inappropriate. Phone calls were made and appointments arranged, but not kept. After a number of attempts to connect with these families, the information sheet on child sexual abuse that was developed for this practicum and a list of resources were mailed to them. (See: Appendix A).

Four families were seen twice each and three of these completed the crisis intervention in the two sessions. The other family was referred to the Children's Aid Society as the offender was a foster son and the victim's parents were not prepared to have him leave the home.

The remaining families were seen from four to ten times each.

Eleven female and three male victims of child sexual abuse were seen. Their ages ranged from three to twelve years with the majority (eight) of the victims being between four and six years old. The sexual abuse ranged from one incident of touching the genitals to three years of abuse

that had started with kissing and touching the genitals and carried on to regular anal and vaginal intercourse and involvement with the offender's homosexual friend. One child reported attempted vaginal penetration. Seven children reported being forced to perform fellatio on the offender. Two of the three male victims had fellatio performed on them and four of the female victims reported having cunnilingus performed on them.

Six of the victims were not yet in school. Of the remaining eight victims, half were doing well and half were failing their grade.

All of the offenders were male. There were only twelve offenders as one fourteen year old boy had been named as the offender in three cases. Of these twelve, five were under the age of seventeen and the remaining seven offenders were adults. Three of the offenders admitted to the sexual abuse. The boy accused of abusing three children admitted to abusing two of them. One of the offenders had left the country by the time the sexual abuse was disclosed. Only one offender was charged.

IV The Intervention

Treatment of non-family sexual abuse included all members of the victim's family wherever possible. The goals of treatment were:

1. Have the victim's parents
   - believe and support the victim,
   - reassure the victim that he or she is not to blame for the sexual abuse,
   - protect the victim from further sexual abuse by the offender.
2. Help the victim express her feelings about the sexual abuse.
3. Provide the victim and her family with factual information on child sexual abuse.
4. Help the parents understand the victim's reactions to the abuse (eg. pulling down other children's pants) and develop ways of handling these reactions.
5. Provide the victim and her family with information on the prevention of child sexual abuse.
6. Assure the victim and her family that they are not alone, that other children are sexually abused.

The impact of the crisis and the method of intervention used in this practicum will be outlined within the framework of the three phases of treatment in crisis situations.

Formulation. This first phase of treatment was usually completed in the first interview. The parents were seen alone if possible to give them an opportunity to express their feelings about the sexual abuse. This was a new experience for most parents and they were uncertain about what to do.

If the sexual abuse had not been reported to the police, parents were encouraged to do so. (Although this was not an issue with any of the parents I saw, if the parents had not reported the abuse to the police, I would have been legally obliged to do so.) If the sexual abuse had been reported, this experience was discussed, and in general terms, I explained what the parents could expect to happen.

Parents were also encouraged to arrange a medical examination for the victim if one had not been done. This was seen as important, so that the child and parents could be reassured by a doctor that the child had not been physically damaged or to ensure that any needed medical attention was provided.

The impact of the family's involvement with the police and medical personnel was discussed.

Parents were encouraged to talk about the sexual abuse and their feelings. During these discussions, many parents expressed feelings of anger at the offender and feelings of

guilt about not having better protected their child. Parents were reassured that these reactions were normal.

Early on in this phase I explained how important it was for the parents to believe and support their child and that their reaction to the sexual abuse would either help or hinder their child's ability to cope with this situation.

Many parents had reacted with anger at the time of the disclosure and were reminded to assure the victim that their anger was directed at the offender and not at the victim.

Some parents initially questioned whether or not the child was partially to blame for the abuse. Parents were assured that the child is always an innocent victim in child sexual abuse.

Parents also had to deal with their own feelings of guilt about the sexual abuse. Parents often felt that they were to blame for the abuse. These parents were urged to put the responsibility for the sexual abuse where it belonged, with the offender. The guilt parents expressed most often was in terms of not having better protected their child. This became an opportunity to motivate parents to work on prevention methods for the future protection of all of their children.

Many parents felt that their child who had been sexually abused had been "ruined". These parents were helped to evaluate the sexual abuse and their reactions to it in order to help them see that their child had not necessarily been damaged for life. The medical examination often helped relieve parents of some of these feelings. Parents were assured that most children were not permanently scarred by an incident of sexual abuse if it was handled properly by their parents and professionals.

Once the parents had calmed down somewhat, we discussed what they had been doing to deal with the sexual abuse and what had been useful. Other problems present in their lives (eg. heavy demands at work, financial difficulties, etc.) were reviewed.

In this first phase, an assessment from an ecological perspective began. As this assessment is detailed in Chapter Five of this practicum report, it will not be outlined here.

During the first interview parents were asked to complete a Child Sexual Abuse Questionnaire and a Child Behavior Profile. Ideally, these questionnaires were completed before the discussion began.

The Child Sexual Abuse Questionnaire was developed by Dr. Kathryn Saulnier and I in order to measure the parents'

level of knowledge concerning sexual abuse. The questions were based on common misunderstandings about sexual abuse in the general population. This questionnaire assisted in indicating areas that needed to be included in the educational component of the intervention.

The Child Behavior Profile was adapted from the one used by the Harborview Medical Centre in Seattle, Washington (Berliner, 1984). This form was useful in outlining the impact of the sexual abuse on the child and provided me with information on the parents' perception of their support system and their ability to cope with stress.

These forms are further described in Chapter Nine and can be found in Appendix B.

Whenever possible, the victim attended the last part of this session so that she would know I was aware of the situation and would be working with her and her family for a period of time.

An agreement to work together was developed and we discussed areas that would be addressed in the following sessions. A rough estimate of the number of sessions was established.

Following this first phase, intervention included both individual meetings with the child and with the parents as well as meetings with the whole family when possible.

Implementation. During this phase of treatment the assessment was completed. For some families this assessment was done in depth whereas with families who were seen briefly, the assessment was not as detailed. The issues discussed with the parents differed from the work done with the children and will be outlined separately here.

Working with Parents. All parents were asked if they had experienced sexual abuse as a child. If the parents had not been sexually abused, the treatment carried on. Where a parent had been sexually abused as a child, discussion of how this was handled took place. I asked parents about the sexual abuse (eg. what took place, who the offender was) and whether or not they had told anyone. In these situations I had to assess how able these parents were to support their child.

During this phase of treatment, other problems the parents or family were experiencing were also discussed. Other ways of dealing with these problems were reviewed and together we tried to put them into some order to be worked on.

Most parents believed that their child was not to blame for the sexual abuse but some felt angry and betrayed because their child had not told them about the abuse immediately. I had to make sure that these parents understood the coercion

used by the offender to make the child keep the secret. This was often difficult for parents to understand. It was important that the parents recognized that the threats and promises were very real for the child although they may have seemed ridiculous to the parents.

An important part of this phase was assisting parents to respond appropriately to their child when she talked or asked questions about the sexual abuse. Parents needed assistance and direction in discussing the sexual abuse with the victim and with other family members. As the parents learned more about child sexual abuse they became more comfortable in discussing the situation. I acted as a role model and with some parents roleplaying situations helped them to be more open in their discussion.

Parents learned to talk to their child about the abuse if the child wanted to talk about it. Some children wanted to talk about the abuse quite often while other children refused to discuss it at all.

As many children experienced sleep disturbances due to the sexual abuse, parents were encouraged to make bedtime relaxing and to assure the child that they were nearby. Some children were in the habit of sleeping with their parents. These children had to be gently but firmly moved

back into their own beds. Bedwetting was a common reaction to the sexual abuse. The parents learned to have the children change their own beds or at least remove the soiled sheets and put them in the laundry area. Other regressive behaviors (eg. thumb sucking, return to a favorite blanket, whining and wanting to be treated like a baby again, etc.) were exhibited by these children. As they began to feel more secure and confident many of these behaviors subsided.

Parents were encouraged to talk to their other children about the sexual abuse in order to explain the upset in the family. Some siblings may have been aware of the abuse but did not tell. I stressed the importance of making sure that the siblings knew the offender was responsible for the sexual abuse so that they would not blame the victim or themselves.

The discussion of whether or not to tell the extended family about the sexual abuse was left up to the family. However, it was pointed out to the parents that the victim may tell them on her own. Where the extended family was seen as supportive, families were urged to discuss the problem with them.

Preventive methods were often introduced early on in this phase. I explained how an assertive child could lessen her chances of being sexually abused. Talking about preventive

methods was often encouraging for the parents and an indication that things were getting better. Introducing the topic early in the implementation phase gave families an opportunity to practise these methods.

I outlined the value of teaching their children that their body was their own, that it was special and that the child can say no to uncomfortable touch. Many parents borrowed my copy of It's My Body, (Freeman, 1982) to read to their children. Parts of the Parent's Resource Booklet, (Hart-Rossi, 1983) were made available to parents along with Freeman's (1982) book. An Information Sheet on child sexual abuse plus a list of resource materials were also provided. (See: Appendix A).

Issues such as knowing the babysitter (some parents were provided with information on adolescent offenders and guidelines for hiring a babysitter), knowing who is supervising their child's activities, noticing and questioning changes in their child's behavior (sleep disturbances, stomach aches, headaches, not wanting to go certain places, etc.) and noticing and questioning the source of the child's extra money, candies, toys, etc., were discussed. As parents came to understand the dynamics of child sexual abuse some identified clues they had missed in their child's behavior. This understanding also helped many parents to see where they should concentrate on prevention with their other children.

Working with Children. Some parents were so overwhelmed by the sexual abuse that they were not able to provide their child with an opportunity to express her feelings. Working with these young children was often done using play. Children expressed their thoughts and feelings through play. Many children expressed anger, fear and confusion about the sexual abuse and its aftermath.

Anatomically correct dolls enabled the children to show what had happened to them. The children readily engaged with these dolls and they became an important part of our work together.

Using different play materials I learned a great deal about some of these children. Children showed how they thought their parents should treat them and what they thought should happen to the offender. Some children used drawings to express their feelings about themselves and their families.

I read It's My Body (Freeman, 1982) to the children and we practiced saying 'no'. Children enjoyed this as well as deciding who they would tell if anybody tried to touch them again.

Termination. In the first interview a rough estimate of the number of sessions had been agreed upon. As the intervention progressed through the implementation phase,

the schedule was adjusted according to each family's needs. Reminders of the number of sessions left helped most families look forward to termination. This was especially important with the children.

During the termination phase, the progress made and the goals reached in the crisis intervention were discussed. The important points about child sexual abuse were reviewed. Parents were encouraged to continue work on preventive methods and to make sure that all the children in the family knew they could say no to uncomfortable touch. Celebration good-bye tea parties were held with some of the children.

At termination of the crisis intervention, some families were referred to other resources to receive ongoing help with problems they had. Parents were told that they could call me if they needed further assistance, but the progress they had made was emphasized and they were encouraged to handle the situation independently.

Where appropriate, families were referred to a follow-up session for sexual abuse victims and their parents. These groups were provided by the Child Protection Centre on each Tuesday of the month. The female victims' groups were divided into three age categories and all the boys attended one group together. These sessions included having the

parents and victims view a film on personal safety together. The point was made that we are careful when we cross the street or handle a sharp knife, so we also must learn to be careful where touch is concerned. The parents and children were then separated into groups where the children learned more about prevention of child sexual abuse and talked about or expressed through art work their feelings about the sexual abuse and its aftermath. Parents were presented with information about the prevention of sexual abuse. This group also discussed ways of helping the children resolve the abusive experience.

Although much of the information presented to the victims and parents just repeated what I had done with these families, the groups were seen as beneficial for two reasons. The victims and their parents saw that they were not alone, that other families had been through the crisis of sexual abuse too and were learning to cope with the problems it caused. Also, parents had an opportunity to meet other parents and talk about how they were helping their child to resolve the abusive experience. If parents connected with each other a new support system for these families was made available.

Follow-up phone calls were made to families approximately one month after termination. Client Feedback

Forms were mailed out to families. This form was developed to provide feedback on the usefulness of the service. The form is discussed further in Chapter Nine and can be found in Appendix C.

In the next chapter, I will illustrate how this method of intervention was used with five families I saw during my practicum.

Chapter Eight

Case Illustrations

I Introduction

All the families I worked with were very interesting and their circumstances were different. The five cases I have chosen to illustrate show the diversity of circumstances involved and the flexibility of the crisis intervention approach.

In the first four cases illustrated, the families were all relatively well-functioning when the sexual abuse occurred. The duration and extent of the sexual abuse, the victim's relationship to the offender and the parent's stability at the time of disclosure affected the family's ability to adaptively resolve the crisis.

In the first two cases illustrated, the parents were able to help their child resolve the crisis and had confidence in their ability. These cases differed in the extent and duration of the sexual abuse and the relationship of the offender to the victim. Where the sexual abuse had just started and the offender was a neighbor, the crisis intervention was very brief. In the other case, where the sexual abuse had gone on for some time and the offender was

closely related to the victim the crisis intervention was longer term.

The third case involved a healthy family system but the victim was very young and unable to name the offender. The family was supportive and assisted the victim to an adaptive resolution of the crisis.

The fourth case also involved a healthy family system but the crisis was complicated by the offender's place in the family and resulting issues of divided loyalty. The victim also had a number of problems which were exacerbated by the sexual abuse.

The fifth case illustrated here is one where the family system was not healthy at the time of the sexual abuse.

Some of the families seen in this practicum were referred to other resources for ongoing treatment but had resolved the crisis of the sexual abuse at least at a minimal level prior to the referral.

Each case will be described first in terms of family composition. The sexual abuse and the disclosure will be outlined. Treatment will be detailed within the framework of the crisis intervention phases of treatment. An assessment from an ecological perspective will also be included.

CASE 1 - Crisis Intervention in a Healthy Family System - - A Very Brief Intervention

The Jones Family. This family consisted of Jack, age 40, and Mary, age 39 and their daughter, Sue age 7. Sue was the only child and this the only marriage for both parents.

The Sexual Abuse. Sue had told her parents that the man next door had "tickled her pee-pee" and exposed himself to her. Sue could only recall two incidents. The abuse had occurred at the neighbor's house, upstairs in a bedroom. The offender had warned Sue not to say anything about their "game" to his wife.

The Intervention. Mr. and Mrs. Jones had reported the sexual abuse to the police who had suggested they take Sue to the S.C.A.N.-Gyne Clinic at Children's Hospital. Sue wanted her parents present during the medical examination which produced no conclusive evidence of the sexual abuse. After the medical examination, Sue colored in the Play Room while I met with her parents.

Formulation. Mr. & Mrs. Jones were a quiet couple and presented themselves in a calm manner. After I explained the purpose of our meeting they agreed they would like to know more about sexual abuse and how to help Sue resolve this crisis.

This couple was very upset about the sexual abuse and angry at the offender. Mr. and Mrs. Jones had been friends with the neighbor and his wife and Sue had spent a good deal of time at their house playing with their dog.

Sue's parents had believed her immediately and appeared to have dealt with the disclosure very well.

Mr. and Mrs. Jones completed the Child Sexual Abuse Questionnaire and the Child Behavior Profile together. In completing the Child Sexual Abuse Questionnaire the Jones' were surprised to learn that some children who have been sexually abused may show an unusual interest in the genitals of other people or of animals. They had not noticed this with Sue. They were relieved to hear that most children are not permanently scarred by an incident of sexual abuse if it is handled properly by the parents and professionals.

Assessment. My assessment of the Jones family is brief as the parents and child appeared quite stable and not overwhelmed by the abuse.

Neither Jack nor Mary reported having been sexually abused as children. They described their childhoods as being relatively trouble free, with no abuse of any kind.

This couple felt they had a good marriage and were supportive of each other and discussed their differences

easily. They discussed the limits they set for Sue and described her as a pleasant child who was easy to care for.

The Jones' answers on the Child Behavior Profile indicated that they felt they had a happy family and that they and Sue were capable of handling stressful situations. Mr. Jones was employed full-time and stated that he enjoyed his work. Mrs. Jones worked part-time outside of the home and Sue was doing well at school.

This family's support system of kin and friends appeared to be quite stable. Sue had wanted to tell both sets of grandparents about the sexual abuse and her parents had agreed with this. The Jones' kept in close contact with the grandparents whose response to the news of the suxual abuse was supportive.

Mr. and Mrs. Jones described Sue as a healthy, happy, somewhat shy seven year old. She had friends at school and in the neighborhood. Since the sexual abuse Sue had had minor sleep disturbances -- difficulty falling asleep and a couple of bad dreams. Mr. and Mrs. Jones were encouraged to make bedtime relaxing and to assure Sue that they were nearby.

Implementation. Mr. and Mrs. Jones were quite calm throughout the session. They were counting on the police to charge the offender. I explained the possibility of the

offender denying the abuse in which case it would be unlikely that charges would be laid. The Jones' found this frustrating.

Mr. and Mrs. Jones were interested in learning more about child sexual abuse and preventive methods. We agreed to meet again to discuss these issues and the parents were given the Information Sheet on Child Sexual Abuse, the List of Resources and the book It's My Body, (Freeman, 1982).

Toward the end of the session Sue joined our meeting. She sat on her father's knee where she appeared to be quite comfortable. Mr. and Mrs. Jones were able to tell Sue very clearly that they believed her and that she was not to blame for the sexual abuse or for the upset following her disclosure. Sue was shy and spoke very little. It was clear that she was comfortable with her parents and looked to them for support.

In our second session Mr. and Mrs. Jones reported that the offender had denied the sexual abuse and no charges were to be laid. As the offender was involved in a youth group, this couple felt the organizers should be informed about his sexually abusing their daughter. I suggested that Mr. and Mrs. Jones should discuss this with the police to see if they could do this without being slanderous. The offender was seen as innocent until proven guilty in court.

The family had read It's My Body (Freeman, 1982) a number of times and Sue had practised saying no. She had enjoyed the book.

Termination. This family had returned to their precrisis level of functioning and had learned about child sexual abuse and some preventive methods. We agreed that they would be fine on their own and I referred them to the follow-up group for sexual abuse victims and their parents. I left it up to the Jones' to contact me if they felt the need.

A follow-up phone call was made about a month after termination. The Jones' had missed the group session as Sue had been ill that day. They were interested in attending the next one and were informed of the date and time. Mrs. Jones stated that Sue was no longer experiencing problems with sleeping. She was not talking about the sexual abuse and became upset when her parents mentioned it. They had decided not to push the issue which I felt was a good idea.

CASE 2 - Crisis Intervention in a Healthy Family System - A Brief Intervention

The Allan Family. This family consisted of Fred, age 21 Linda, age 25 and Linda's sons Harold age 7 and Donald age 4. This was Fred's first marriage and Linda's second. This couple had been married less than a year and Linda had been divorced for two years.

The Sexual Abuse. Donald had been sexually abused by his natural father while visiting him every other Sunday. He could not remember when the abuse had started or how long it had been occurring. Donald said his Dad had made him "suck his dink" and that his dad had "sucked my dink for a long time". Donald also stated that his dad had "put poo in my dink and my bum" that he had used his finger to do this and had taken the "poo" from the toilet. Donald complained of a sore mouth because of having to suck his dad's penis.

The Intervention. Approximately a year prior to this disclosure Harold had refused to go for anymore visits with his natural father because he had been punched by him. Donald continued visiting his father. About six months prior to the disclosure of the sexual abuse the daycare centre that Donald attended contacted Linda and told her that he was becoming very aggressive and disruptive. About a month prior to the disclosure the daycare centre again contacted Linda as Donald had been masturbating at the centre and was pulling down other children's pants and sucking some boys' penises. Linda contacted a psychologist at Children's Hospital who had previously seen Harold. The psychologist suggested that limits be set with Donald concerning his behavior and that he be encouraged to talk about what was bothering him. A month

later Donald told Linda and Fred that he didn't want to visit his dad anymore because he undressed in front of him and sucked his penis. Linda again contacted the psychologist who referred her to the S.C.A.N.-Gyne Clinic. This family was referred to me by the doctor at the Clinic. The doctor also gave Linda a referral for Donald to see the psychologist. The sexual abuse was reported to the police.

Formulation. I met with Linda alone initially. In this first interview she expressed her anger at her ex-husband and her feeling that he had sexually abused Donald to get back at her. Linda blamed herself for allowing Donald to visit the offender as she knew he was "perverted" although she never thought he would sexually abuse their son. Linda cried quite freely in this session.

Donald wanted to talk about the abuse at home, but whenever he did Linda became upset and started to cry. She stated that Fred had been talking to Donald and that this was working well.

Assessment. Linda was managing a store and was under a great deal of stress at work and had no opportunity to take time off work. She was constantly thinking about the abuse which was interfering with her employment. Fred was going to University full-time. Linda described him as being very supportive and understanding about the sexual abuse and her feelings.

The Child Sexual Abuse Questionnaire was completed. Linda had a basic knowledge about sexual abuse but had thought that all offenders were insane.

Linda reported that neither she or Fred had been sexually or physically abused as children and although she was aware that her ex-husband had been physically abused as a child she did not know if he had been sexually abused.

Linda's mother had committed suicide when Linda was six years old. Her grandfather had cared for Linda and her two sisters until her father remarried when she was twelve. Linda stated that she was very close to her grandfather who left when her father remarried and died shortly thereafter. Linda never got along with her stepmother and married the offender when she was eighteen to get out of the house.

Linda's marriage to the offender was described as abusive, both sexually and physically. She stated that Fred had been a close friend throughout her separation and divorce from her first husband and that they married a year after her divorce.

This marriage appeared to be stable and Fred and the children reportedly got along well. Fred and Linda were taking a parenting course together which was proving beneficial.

The Child Behavior Profile was completed. Linda's answers indicated that her family had a good support system. Linda was close to her sister in Vancouver who had provided valuable information and emotional support to Linda at the time of disclosure. Linda had no contact with her father and stepmother and little contact with her other sister. Fred's family was a support to this couple and were very caring toward the children. Linda felt that they would do whatever they could to help out.

The impact of the sexual abuse on Donald was evident in his behavior at the daycare centre. He had also become afraid of being alone and was having nightmares, stomach-aches and headaches. Linda also noted that he had become very "clingy" with her and Fred and avoided contact with other adult men.

As Linda calmed down we drew up an agreement to work together for another three or four sessions. The goals of the intervention were to have Linda express her feelings about the abuse and her ex-husband and to help her return to her precrisis level of functioning; to assist Linda to respond appropriately to Donald; and to provide educational and preventive material and information. It was agreed to wait until after the crisis intervention to have Donald see the psychologist.

Implementation. I saw Linda for two more sessions on her own which was followed by a family meeting at their home. By the second session Linda was much calmer and felt that she was coping well at work and managing much better at home. Linda had stated that she had always been able to handle stressful situations and was concerned that she was having so much difficulty with this one. We discussed how this differed from her past experiences and how she had never imagined anything like this happening to her sons.

Linda and Fred had believed Donald from the beginning. Linda had had to explain that when she became angry and cried when Donald talked about the sexual abuse, she was angry at the offender and not at Donald. Harold had been told about the sexual abuse. He had teased Donald when Donald had continued to visit their father. Linda thought that Harold felt badly that Donald was receiving special attention from their father and so had berated Donald about continuing the visits. When Harold learned of the sexual abuse his attitude changed and he became quite protective of Donald.

Since the sexual abuse had stopped, Donald was having fewer nightmares, stomach-aches and headaches. He had been touching Harold's penis. I explained that it was common for children to re-enact the sexual abuse and that both Donald

and Harold had to learn that their penises were private and that nobody should touch them. Linda was provided with the Information Sheet and List of Resources as well as It's My Body, (Freeman, 1982). She purchased a copy of this book and the Parent's Resource Manual, (Hart-Rossi, 1983) as the boys had liked it so much.

Linda found that writing down her feelings about her ex-husband and the abuse helped. It was suggested that this could be put into the form of a letter that was not necessarily mailed to the offender.

By our third session together Linda felt that her life was back to normal and that she was able to cope on her own. She was going to take Donald out of the daycare centre he was in as she had some serious concerns about what was happening there. Donald had been involving other boys at the centre in oral sex for approximately three weeks before they contacted her about it. They said they had waited so long to inform her because they felt he had seen it being done at home and would just get over it. Once she had removed Donald from the centre she was going to explain the reasons to the daycare centre board.

Linda felt that she and Fred were responding well to Donald and they had been practising saying no to uncomfortable

touch with both boys. She felt that her anger at her ex-husband would subside after the court hearing to stop his visiting rights. The offender had denied the abuse to the police so no charges had been laid.

Termination. The family meeting went well although Donald and Harold were very energetic and found it impossible to sit still. Half way through Harold went out to ride his bike. Donald explained to me what he would do if anybody tried to touch him and it felt uncomfortable -- he would say no and then tell his parents right away. Donald sat on his mom's knee during the last half of the session. Fred said that he felt things were pretty much back to normal and expressed his anger at the offender for upsetting his family so much. He had found the information on sexual abuse very interesting and was going to get some books out of the library to learn more about this area.

I left the family with the understanding that they could contact me if they felt the need.

A follow-up phone call was made approximately one and a half months later. Donald had been assessed by the psychologist and was reportedly doing well. Linda's ex-husband had contested the request to end his visiting rights which had created more problems for Linda. Her doctor had given her

a referral to see a psychiatrist and Linda felt that with some professional help she would be able to deal with her extreme anger toward her ex-husband.

CASE 3 - Crisis Intervention In a Healthy Family System Where the Victim Could Not Name the Offender.

The Ball Family. The Ball family consisted of Ted age 24, Jean age 25, Tom age 8 and Sally age 3. This was the first marriage for both Jean and Ted. Tom was Jean's son and Sally was Jean and Ted's daughter. This couple had lived together for a period of time before marrying approximately two years ago. The family was also caring for a foster child, Sam age 17.

The Sexual Abuse. While Jean and Sally were watching T.V. one day, Sally told her mother that a man had tied her hands with a skipping rope and had then "played" with her "bum and pee-pee" and had bitten her "bum". She also told her mother that the man had tried to put his "dinky" in her "pee-pee". Sally said this had happened in a bedroom and that the man was a friend's daddy who lived across the street. She only told her mom about this one incident.

The Intervention. The Balls reported the sexual abuse to the police who referred them to the S.C.A.N.-Gyne Clinic. Sally refused to have a physical examination. The family was referred to me and given a follow-up appointment at the Clinic.

Formulation. I met with Mr. & Mrs. Ball who were confused and upset about the sexual abuse. Sally had later told her dad that the offender looked like Michael Jackson and that he had put his penis in her mouth. Mr. & Mrs. Ball were also upset that the police had not gone over to charge the alleged offender.

The Balls were confused because what Sally had told them just did not seem to fit together. Only being three years old, Sally never went out of the yard on her own, but a few days prior to her disclosure she had been lost for about forty-five minutes. When she was found it was nowhere near the alleged offender's home. Also, the alleged offender was blonde, tall and thin and did not look at all like Michael Jackson. When her parents had questioned her further about the sexual abuse Sally had not wanted to talk about it.

Assessment. Mr. & Mrs. Ball completed the Child Sexual Abuse Questionnaire and the Child Behavior Profile. They were surprised to learn that most child sexual abuse offenders were not mentally ill and that some sexually abused children show an unusual interest in genitals. They hoped that Sally would not be permanently scarred by this incident of sexual abuse.

This family appeared to have a good support system. Although their extended families did not live in Winnipeg they maintained close contact with them and visited when possible. The Balls had a close friendship with a family that was ten or fifteen years older than them. This family had helped the Balls in many ways and Sally was especially close to them.

Although the family had experienced numerous recent changes (a move, Sally had stopped going to daycare and Sam had joined their family) the Balls did not feel that Sally had been adversely affected by these changes.

The Balls felt that they were able to handle stressful situations although they agreed that Ted was more able than Jean. They described their family as usually being happy.

Neither parent reported having been sexually abused as children. Mr. Ball described his childhood as stable and relatively uneventful. Mrs. Ball though had had a rather harsh childhood. Her father had been an alcoholic and beat her mother frequently until he left the family when Jean was twelve. Jean stated that this was very upsetting for her as she had been close to her Dad. Jean's older brother had been sent to prison for rape when Jean was fourteen and had been in and out of jail ever since. Recently, Jean's sixteen

year old brother disclosed that he had been sexually abused by a friend of the family for the past six years. Although Jean had never been personally abused, she had witnessed much violence in her home. Jean remains very close to her mother but seldom sees her father.

Ted was employed full-time but was hoping to get a job working in a group home for adolescents. He was interested in this area which was the reason the Balls were fostering Sam. Jean worked part-time at night so that they did not need a daycare for Sally. On Friday and Saturday nights when Ted was playing taped music at dances and Jean was working, Sam and his girl friend babysat Tom and Sally.

The Balls engaged in many activities as a family and appeared to enjoy each other's company. Both parents were involved in the child care duties but Mrs. Ball did most of the domestic work in the home. When Sam came to live with the family he would listen to Ted but not to Jean. His presence had put a strain on their relationship but they appeared to be working this out together. Sam had been doing very well with the Balls as far as his school work was concerned. He had no male friends that the Balls were aware of and spent most of his free time with his girlfriend. He often took Tom and Sally to the park and appeared to enjoy playing ball with Tom and his friends.

Sally and Tom shared a bedroom and Sam had one of his own which was in between the children's and parent's rooms. As Sam's eighteenth birthday was soon approaching Jean felt he would move out on his own at that time and she said she would be just as glad when he did. Although Jean felt that she and Ted were doing a good job in caring for Sam and were providing a needed resource, she found him very difficult to deal with.

Mr. and Mrs. Ball had noticed that Sally was having nightmares and had started to be afraid of the dark and afraid to sleep alone. They had been letting her sleep with them most nights. Mrs. Ball also noticed that Sally was afraid to be alone and had to be in the same room as she was all day.

As Sally had not come to the first interview we arranged a home visit so that I could meet her and Tom. We agreed that I would work with Sally through play and focus on her feelings about the sexual abuse. It was hoped that if Sally realized that the offender was responsible for the sexual abuse and that it was wrong, she would tell who he was. I also agreed to meet with Mr. and Mrs. Ball to assist them in responding to Sally and her reactions to the abuse and to provide information and material about child sexual abuse and its prevention. We decided to start off with three sessions and to negotiate for more if needed.

Implementation. The majority of this intervention took place in the Ball's home. I would meet with Sally for about one half to three quarters of an hour and then meet with her mother afterward. I will describe my work with Sally and then describe the intervention with the rest of the family.

Sally was a lively, verbal three year old girl. She thought the anatomically correct dolls were wonderful.

Over the 10 weeks that I saw Sally the majority of her play centered around a family of dolls doing family things together -- eating, cooking, the laundry, shopping and sleeping. At some point in each session she undressed all of the dolls and examined their genitals.

When Sally's follow-up appointment at the S.C.A.N.-Gyne Clinic came around I used the dolls to show Sally what the doctor did. Sally then agreed to be examined.

Over the weeks Sally showed how the man had put his penis in her mouth, vagina and between her legs, using the dolls. She said she had been scared but not hurt and that the man said it was a secret. She once told me about a man coming up the stairs at night, coming into her bedroom and trying to put his penis in her "pee-pee". She said he got "stuff" on him and had to get napkins to clean it off. She showed me the drawer in the kitchen where he got the napkins.

Afterward Sally said they went and watched T.V. She said the man was big like me, not big like Daddy or like Sam.

At this point I was convinced that the offender lived in the home or spent a lot of time there. Sally and I had two sessions at the Psychological Service Centre play room at the University of Manitoba. In her home, Sally insisted on playing in her bedroom. I thought that moving elsewhere might take some of the pressure off, but it seemed to put more on Sally. She ignored the dolls and was very controlled in her play. She asked if she could play with each toy before she touched it and then put it away before playing with another one.

I read It's My Body to Sally a number of times and she enjoyed practising saying no. I suggested that some time she would feel like telling somebody who had sexually abused her and asked her who she might tell. She said she would tell her mom or me.

I saw Sally at her house in the mornings and would often be there when Tom arrived home for lunch. Sally told Tom about what she and I did together and Tom asked me questions about it. He was very concerned about the sexual abuse and was protective of Sally.

After my time with Sally, I met with Jean. She was upset that Sally could not tell who the offender was and seemed to be questioning Sally about it quite often. I encouraged her to stop questioning Sally and to focus more on the preventive methods. Jean found this hard to do.

Jean and Ted had been trying to get Sally to sleep in her own bed. They left her bedroom and the bathroom lights on all night but Sally was still frightened.

Much of the educational information was discussed as a result of Sam's social worker's attitude toward sexual abuse. I had mentioned that Sam appeared to be the most likely person to be perpetrating the sexual abuse. Jean had told the social worker who had said that if it was Sam, it was probably just a case of exploratory sex play. This worker also felt that if it was Sam, he could be removed for a few weeks until the family got over it and then could return to live with them. The age difference, Sam's girl friend who was on the pill and the extent of the sexual abuse Sally had described were outlined to show that this could not be considered sex play. Jean, in turn, educated the social worker.

In discussions with the police it was agreed that the offender was someone in the home and most likely it was Sam. The police had interviewed everybody in the family except Sam.

Termination. In my last session with Ted and Jean, I again raised the issue of having Sam moved. Both Ted and Jean had been reluctant to do so because he had been through so many moves already and seemed to be doing well in their home. They agreed to discuss it further but felt it was somewhat unfair to move him on the basis of a suspicion.

We reviewed what had happened throughout the intervention and what we knew about the sexual abuse. I stated that in order to protect Sally I felt that Sam should be moved.

I saw Tom again and answered his questions about why I had been working with Sally. He had seen the "Feeling Yes, Feeling No" (1982) presentation at school and had taught Sally the song "My Body is Nobody's but Mine". Tom had also talked to Sally about uncomfortable touch.

In my last session with Sally we practised saying no to uncomfortable touch and deciding who to tell. I again suggested that Sally might feel like telling somebody about the sexual abuse someday and that she should tell her mom.

I told the family that they could call me if they needed to.

One week later Sally told her mom that Sam had been sexually abusing her and that he had threatened to beat up her and her mom if she told anybody. Sam was interviewed by the police and denied all the allegations. He was removed from the foster home within 3 days.

I met with Sally twice after the disclosure. She was very worried that Sam would come back and carry through with his threats. She wanted to be with Jean all the time and was prepared to go to work with her.

Sally seemed to be relieved that the secret was out, but needed considerable reassurance that she had done the right thing. During our last session, Sally, Jean and I had a tea party to celebrate the end of our work together.

CASE 4 - Crisis Intervention in a Healthy Family System Where There are Issues of Divided Loyalty.

The Peterson Family. This family consisted of Bill, age 35 and Helen, age 34 and their children, David, age 9 and Christine, age 2. This was the only marriage for both partners.

The Sexual Abuse. While he was playing a game with his teacher at school, David told her about the "dinky game" he played with his grandfather. David said that his grandfather had made him "suck his dinky" and that his grandfather had "sucked my dinky". This sexual abuse occurred when his grandfather had been babysitting him. David had been promised a trip to Burger King if he played the "dinky game" and did not tell anybody. David was not sure how long the sexual abuse had been going on.

The Intervention. The school reported the sexual abuse to the police who interviewed David at the school. The school then informed Mr. and Mrs. Peterson and suggested they see the psychologist from the Child Guidance Clinic who was working with David. This psychologist then referred the family to me.

Formulation. I met with Mr. and Mrs. Peterson and Christine while David was at school. Both parents were somewhat embarassed about the sexual abuse. These parents were upset but were very controlled and did not become emotional. Helen's father was the offender but both she and Bill had no trouble believing David and were very supportive of him. The offender had been interviewed by the police and had admitted to the sexual abuse.

Bill and Helen had not discussed the sexual abuse with David as they were not sure if that was the right thing to do. They had heard from the school what David had said his grandfather had done to him. They described David as being a bit hyperactive.

Assessment. The Child Sexual Abuse Questionnaire was completed, but as this couple had virtually no knowledge about child sexual abuse, we discussed a number of questions on the form prior to their answering them.

The Child Behavior Profile was also completed and indicated that the family had a good support system. Mr. and Mrs. Peterson felt that they were able to tolerate stress well although their son was not. In describing David's behavior on this form, his many problems became apparent -- academic problems, non-academic school behavior problems, aggressive behavior, excessive activity, speech problems, poor peer relationships, etc. David had also resumed bed wetting almost nightly about two months prior to his disclosure.

Christine was an active two year old girl who did not appear to have the problems David had. Bill and Helen had to watch David when he was with Christine as he could get quite rough with her.

Helen and Bill had grown up in Scotland. They married there and moved to South Africa for five years before moving to Winnipeg where they have lived for six years. Initially, neither Bill or Helen reported any kind of abuse as children although near the end of the intervention Helen told about a time when she caught her father peeping through the bathroom window when she was having a bath. Helen had been 15 or 16 at the time. Her father said he had been drunk and he apologized later.

This couple appeared to have a strong marriage and were very supportive with each other. They appeared to cope with David's behavior. Bill coached David's soccer team. He explained that once David was on the field he never wanted to come off so as coach he did not put David in until later in the game. Bill said that David was a good soccer player.

Helen's parents and two sisters and their families lived in Winnipeg. An aunt, her mother's sister, also lived here. When David disclosed the sexual abuse and the offender admitted it, Helen's mother left her husband. Grandfather had had a stroke a number of years ago that had left him partially disabled and, according to Helen, had changed his personality. He had become very bitter and was verbally abusive to his wife. Approximately three months prior to David's disclosure he had been laid off from his job as a security guard.

Bill had no relatives in Canada, but maintained close contact with his family in Scotland. Since moving to Winnipeg Bill had felt very much a part of Helen's family. He felt it was good that the children had extended family nearby.

Bill worked full-time and Helen worked part-time. They both enjoyed their jobs.

We agreed that we would meet two or three more times. I said I would work with David around his feelings about the sexual abuse. Our goal was to have the family well-informed about child sexual abuse and the preventive methods. Helen mentioned that her whole family had been very supportive which she appreciated.

Implementation. Our next session was a family one where at first David was too shy to come into the room. He finally came in and told me what his grandfather had done to him without being asked. He also told me he had had to "play pump" and that when he "pumped" grandpa's penis "stuff" came out of it. That was all he would say. During the rest of the session David crawled all over the furniture, tickled me and yelled very loudly. Bill and Helen said that he was upset about the abuse.

I contacted the psychologist who had referred David and was informed that he had epilepsy, was taking ritalin for his hyperactivity and displayed many autistic behaviors. He also had poor communication skills and was behind in school. The psychologist felt that she had a good relationship with David and suggested that she try to work with him around his feelings in her social skills group of which he was a member.

Bill and Helen read Come Tell Me Right Away (Sanford, 1982) and found it to be interesting and informative. They also read No More Secrets (Adams and Fay, 1981) and enjoyed it. As we discussed sexual abuse they became more comfortable in talking to David about it. He did not mention it very often but when he did they were prepared. They had read It's My Body (Freeman, 1982) to David and he had liked the idea that he could say no to uncomfortable touch no matter who was touching him.

The major problem for the Petersons came in dealing with Helen's family. Helen's mother had moved back in with Grandpa. She said she was in the spare room and only went back to take care of him because he was disabled. Helen and Bill felt that Helen's extended family had rallied to support grandpa and had abandoned them. Helen could not understand how her sisters, who also had children, could visit him.

We arranged to have a family meeting where I could explain more about child sexual abuse to the family. Helen and Bill thought this would be a good opportunity for people to express their feelings.

Our first meeting was short as Helen's sister's became lost and went home. At the second meeting Helen, Bill and Helen's mother, aunt and two sisters were present. The sisters

did not bring their husbands. After about a half hour people began to talk. Two hours later everybody had had an opportunity to express their feelings. Both sisters told Helen they understood how she felt, but they also felt that their father needed them too. Helen and Bill expressed their feelings very clearly. Helen's mother cried throughout the session and said she hated her husband and what he had done to the family, but she felt that it was her duty to help him out.

Each family member had made it clear how he or she felt about the situation. They were not in agreement on many of the issues but were glad it had been brought out into the open. Helen's sisters assured her that they had not abandoned her and said they would be available if she needed somebody to talk to. Helen's aunt also offered to help out in any way she could.

I encouraged Helen's mother to see a social worker at the Child Protection Centre to discuss her feelings about her husband and the sexual abuse, but she refused, saying that she was too embarassed to talk to anybody about the situation.

Termination. Helen tried a number of times to convince her mother to talk to a professional but she still refused.

At our last session Helen reported that she had talked to David's teacher. This was an improvement as Helen and

Bill were so used to having the "professionals" take over where David was concerned that they had assumed I would be in touch with his school and then let them know about it later.

David was doing worse in school. His vocabulary was not growing and he was angry so much of the time that his behavior was becoming uncontrollable. The psychologist from the Child Guidance Clinic had made a referral for David to see a psychiatrist. Bill and Helen thought this was good as his behavior at home was also becoming very difficult to control.

Bill stated that David had touched his genitals when he got out of the shower, and that Bill had explained to David about not touching other people's private body parts. Helen and Bill felt concerned that David would repeat what Grandpa had done to him. I explained that it is common for children to re-enact the sexual abuse and that they had to keep up the reminders about not touching other people's private parts and not letting them touch his.

Bill and Helen were somewhat resistant to termination. They had attended the follow-up session for victims and their parents and had met a social worker there. This social worker agreed to be the contact person for the Petersons and they felt better about having someone to call on if the need arose.

I contacted the Petersons approximately one and a half months after termination. David had been to see a psychiatrist who felt that he needed long-term treatment. David had refused to talk to the psychiatrist for some time so that he felt it would take a long time to develop a working relationship with David.

The offender was sentenced to six months in prison. Helen and Bill had not been to visit him and did not plan to go. Helen's mother and sisters saw the offender on a regular basis. Helen still found it difficult to understand their feelings toward the offender.

Helen felt that things were going well in the family and that David was enjoying his summer holidays.

CASE 5 - Crisis Intervention in a Multi-Problem Family.

The Brown Family. This family consisted of Joan age 32, and her children, Shirley age 12, Eric age 10 and Carol age 5. Joan had been married twice. She had been separated from Shirley and Eric's father, Brian, for nine years and from Carol's father, Alvin, for one year.

The Sexual Abuse. After seeing the "Feeling Yes, Feeling No" (1982) presentation at school, Shirley told her teacher that she had been sexually abused by her uncle. Shirley had

said that her uncle "sticks a finger up there". The teacher had then asked if "up there" meant her vagina and Shirley had said yes. She said he had also undone a button on her blouse when they were in the car, but that someone had come along and he had stopped.

The Intervention. Shirley's teacher reported the sexual abuse to the police who then referred Joan and Shirley to the S.C.A.N.-Gyne Clinic.

Formulation. I met with Joan while Shirley was being examined by the doctor. Joan was very upset about the sexual abuse. The offender was not Shirley's uncle but was a friend of the family. All of Joan's children had referred to him as "uncle". Joan had believed Shirley right away. The family had moved recently, to another part of the city that was far from where the offender lived. Joan stated that there would be no more contact with him. Joan was very disappointed in the offender but stated that because she had been sexually abused as a child, she understood what her daughter must be feeling. The following assessment was done during the first two sessions.

Assessment. Joan was the eighth of ten children. Her father had beaten her mother and older siblings but had not beaten Joan or her younger siblings. Joan stated that the

abuse had been very severe and had left one of her sisters deaf in one ear and one of her brothers with terrible scars covering his back. Joan described her mother as being able to hold her own when her father beat her. Even when Joan's brothers were old enough and big enough to step in they never stopped their father from beating their mother.

Joan had been sexually abused by her brother-in-law. When she had been in bed he had put his hands under the covers and touched her vagina and breasts. Joan was nine at the time. She told her mother and although they never talked about it, the sexual abuse had stopped. Joan stated that she had seen her brother-in-law put his hand inside his niece's diaper while he was holding her.

Joan's mother had died about two years prior to this intervention. Joan had never been very close to her mother. She felt close to her father and had almost no contact with her siblings. Joan felt that her father was a good support for her.

When she was nineteen years old Joan married Brian. He beat Joan quite regularly, but she thought this was normal, that it happened in all marriages. After three years of marriage Brian was convicted of raping a fourteen year old girl and was sentenced to four years in jail. After

serving two and one half years he was released and went back to live with Joan. The relationship only lasted for six months and then Brian left.

Alvin and Joan had lived together for approximately one year before they were married. Alvin had a severe drinking problem and he too beat Joan. Joan stated that she could cope with the beatings but could not stand his verbal abuse. Alvin constantly berated her and told lies about her to their friends. He never hit the children, but he teased and belittled them. Joan had taken the children and left him. They had been separated for about a year, but were now considering reuniting. Alvin had quit drinking. He worked from six p.m. to six a.m. and spent most of his free time at Joan's house.

Joan described her family's life as chaotic. She was working full-time and was not receiving any financial support for the children from Brian or Alvin. It was a constant struggle to make ends meet.

Joan also had difficulty disciplining Shirley and Eric. They had been given chores to do which were not excessive but Joan stated that they fought constantly. Joan felt that she yelled at Shirley and Eric from the time she got home from work until they were in bed. She also stated that she hit Shirley and Eric, but never Carol. Joan stated that Eric was

hit most often and that he was probably hit harder than was Shirley. Although she did not like hitting the children, Joan did not consider this to be abusive.

Joan completed the Child Behavior Profile. Her answers indicated that she felt she had a good support system, but not one that could help her with the children. Joan stated that her father was her main support. She also noted that she was not able to tolerate stress.

On the Child Behavior Profile, Joan noted that Shirley had found Alvin's leaving the family to be very difficult. Shirley had academic problems at school but otherwise Joan indicated no other areas of concern.

The Child Sexual Abuse Questionnaire was completed. Joan was relieved to hear that most children are not permanently scarred by an incident of sexual abuse if it is handled properly by the parents and professionals.

During the first interview, Joan asked if I thought it was possible that Alvin could have sexually abused Shirley. Joan suspected that he had and also thought he might have sexually abused Carol too. Joan could give no concrete reasons for her suspicions and Shirley had denied that Alvin had touched her, but Joan still believed there was reason to suspect him.

I suggested that Joan not have Alvin in her home until she was sure that he was not sexually abusing Shirley and Carol. The only way Joan felt she could keep Alvin away for any length of time was to start a fight with him and then he would walk out on her. After a lengthy discussion, Joan agreed to ask Alvin not to come around the house for awhile rather than start a fight with him.

Shirley came in for the last part of the interview. She understood that the offender was responsible for the abuse and did not think she would ever have to see him again. She stated that she could talk to her mom about the abuse. Shirley also stated that there was a teacher at school she could talk to if she felt the need.

We agreed to meet at least three more times. Our goals were to further educate the whole family about child sexual abuse and preventive methods. I agreed that I would talk to Shirley about the allegations Joan had made regarding Alvin's suspected sexual abuse.

Implementation. I met with the whole Brown family twice and saw each child individually, and Shirley twice individually. I met with Joan alone five times.

Shirley denied that Alvin had sexually abused her. She said that she liked Alvin and was sad that he did not live

with them anymore. Shirley had gone to visit him a couple of times with her friend. Shirley also said that if Alvin ever tried to touch her private body parts she would tell her mom right away.

When Shirley described the sexual abuse perpetrated by her "uncle", she stated that she had always had her clothes on and that he had once undone a blouse button and once had undone the button on her jeans. She explained that when they were playing he had put his hand between her legs and lifted her up that way. He had done this a number of times to her and it was uncomfortable. Shirley stated that if anybody touched her again and it was uncomfortable touch she would run away from that person and tell her mother or her teacher.

Shirley stated that most of the hitting in their house was done by her and Eric. She did not feel that her mom hit her much. Shirley stated that her mom's yelling bothered her more than the hitting.

Eric agreed that he and Shirley did most of the hitting in the house. They fought with each other, never with Carol. Eric also found his mom's yelling more disturbing than her hitting and felt that when he was slapped, he had deserved it. Eric stated that nobody had ever tried to touch his

private body parts but that if anybody did he would punch them and run away. With prompting, Eric said he would tell his mother, but gave the impression that he felt he could handle an offender on his own.

Carol stated that nobody hit her at home. When we talked about comfortable and uncomfortable touch, Carol could identify comfortable touch -- her mother or father giving her a hug and kiss. She could not identify uncomfortable touch.

Joan was given the information sheet on child sexual abuse and the resource list. Shirley read It's My Body to Carol but Eric did not want to listen.

All three children were verbal and not overly shy. They responded appropriately and seemed to be relatively happy. Shirley was the most nervous of all the children and seemed less sure of herself than Eric or Carol.

During the five sessions I saw Joan individually, we discussed three main issues -- the child sexual abuse, her relationship with Alvin and her inability to discipline the children without hitting them.

Joan felt that Shirley was doing well where the sexual abuse was concerned. The sexual abuse perpetrated by the "uncle" had not progressed too far by the time Shirley told

about it. Shirley had been given positive feedback when she did tell and appeared to be returning to her usual self very quickly.

Alvin had been staying away from the house although he phoned Joan at home and at work to bother her. Joan admitted that she did not want to resume living with Alvin. Although he had quit drinking, he had not changed many of the behaviors that had bothered Joan. Joan would not admit completely that her allegations of Alvin sexually abusing Shirley and Carol were her way of keeping Alvin out of their lives.

Joan stated that Shirley and Eric appeared to have a good understanding about sexual abuse from school where they had both seen the "Feeling Yes, Feeling No" program.

In our second session Joan agreed to implement a no-hitting rule in her home which included her. She had read a pamphlet that described the intergenerational effects of child abuse and was afraid she was beginning to behave like her father had. She did not like the violence that was evident in her home and realized she was setting a poor example for her children. Joan had no idea how to disapline her children without yelling at them or hitting them. In detail, I explained the practice of 'time-out' for the children where they went to their rooms for a specified period of time. Joan agreed to try this.

Joan knew she did not like the battering that she had been subjected to by her husbands but felt somehow that it was their right and that it was normal. She had adapted to the abuse and had her own little ways of getting back at the abusers (eg. Joan would start a fight with Alvin knowing he would walk out on her and remain away for a few days). Joan and I discussed assertive behavior and how it differed from non-assertive and agressive behavior. It was very encouraging for Joan to learn that there were other ways of behaving and that she could learn these ways.

In the last two sessions I had with Joan she voiced concern about Shirley. Joan reported that Shirley had developed some very irritating habits (giggling or blinking her eyes) which she felt were deliberate attempts to get on her nerves. I suggested that Shirley appeared to be a rather nervous child and that perhaps these habits were physical manifestations of her nervous state. Joan stated that she found herself picking on Shirley more than usual. When the family had had one full week with no hitting, it was Joan who broke the rule first by hitting Shirley.

I gave Joan the telephone numbers for Parents Anonymous and Al-anon and urged her to contact these groups as they would provide some needed support to her.

Termination. In termination of the crisis intervention it was recognized by Joan and I that she and her children needed help in areas other than the child sexual abuse. I referred the Brown family to a social worker who agreed to work with them. The areas of concern were the discipline methods used in the home and Joan's relationships with men, especially their abusive nature. Joan was very interested in attending a group for battered women.

The crisis of the child sexual abuse was the opening Joan needed to begin to talk about all of her problems. Early intervention in the crisis allowed Joan and I to engage when Joan was in an active crisis state and more able to reach out for and accept help.

Follow-Up. I contacted Joan a week after the referral. She stated that things were back to normal at home and that she had an appointment with the new social worker. Joan had not contacted Parents Anonymous or Al-anon.

I telephoned Joan again about a month and a half after termination. She had seen the social worker a few times and had been referred for family therapy to begin in the fall. The group for battered women was to start in the fall. Joan stated that Alvin had stopped pestering her as much as he had been and that the children were enjoying their summer.

Chapter Nine

Evaluation

I Evaluation of Questionnaires Used in this Practicum

In this section I will further describe the methods of evaluation and their usefulness in this practicum. I will begin with the Child Sexual Abuse Questionnaire and the Child Behavior Profile and end with the Client Feedback form.

Child Sexual Abuse Questionnaire. As noted earlier, this questionnaire was useful in ascertaining the parents' level of knowledge regarding child sexual abuse and helped to indicate where education was needed. I also found that this questionnaire was a useful tool in helping parents to start talking about the sexual abuse. The structure which the questionnaire provided for this initial discussion allowed me to express my ideological orientation regarding child sexual abuse.

Many parents found it very difficult to answer many of the questions on the form. They were not pushed to do so, but were encouraged to try. With some parents many of the questions were discussed before they completed the entire form.

The question most often answered incorrectly was the statement that most children are permanently scarred by an incident of child sexual abuse. The other question most frequently answered incorrectly was the statement that most sexual abuse offenders are mentally ill or mentally retarded. Only one parent thought that many children make up stories about being sexually abused. About half of the families answering the questionnaire did not know that children who have been sexually abused may show an unusual interest in the genitals of other people or of animals or may have sexual knowledge beyond their age. All other questions on the questionnaire were correctly answered by all parents.

The Revised Child Behavior Profile. The Child Behavior Profile was developed by Dr. Jon R. Conte (1984) in order to measure the impact of child sexual abuse on the child. In developing the scale, items from two previously established measures of child behavior were administered to a group of children not known to have been sexually abused. The items which best discriminated between the groups were combined with items reflecting symptoms reported in the clinical literature, and together form the 110 item scale. The psychometric properties of the scale are currently being tested and further refinements will be made.

This form is divided into four parts. The first part provides demographic information. The second part asks parents to identify the availability of supports and the quality of their social system. Parents are also asked to describe how well they and their child cope with stress. This section asks the parents about their support system in two different ways. Parents are asked if their family is usually under some kind of stress and whether or not they are happy.

This information was helpful in discussing the impact of the sexual abuse and how the parents perceived their ability to cope with it and the availability of supports they could call on. If parents could not identify any supports and felt that they were unable to cope with stress, they were probably having a very difficult time coping with the sexual abuse. The parent's stability and support system were identified as key factors for an adaptive resolution of the crisis for the victim and family.

The third part of the form asks parents to note significant events in the victim's life in the past year and to note whether or not the event was stressful for that child. These events involve losses and changes in the family and significant others. This helps to identify the recent upsets

in the family and can help to indicate how and how well the family is able to cope with stressful situations.

The last part of the form consists of one hundred and ten items which refer to the victim's behavior. This helps to indicate the impact of the sexual abuse on the victim. The greatest majority of the victims seen in this practicum had sleep disturbances such as nightmares, bedwetting, unable to go to sleep, etc. Many of the younger children displayed regressive behaviors such as thumb sucking, clinging to parents, acting like a baby, etc.

This form was useful in the assessment phase. Although it is very long, no parents refused to complete it.

Client Feedback Form. As noted earlier, this form was developed to evaluate the service provided. The form was mailed to nine families approximately one month after termination. It was accompanied by a covering letter signed by the Case Manager of the Child Protection Centre. This was done to reduce bias. Six families returned the completed questionnaires. The questions focused on the timing of the intervention, usefulness of the service, how easy the social worker was to talk to and whether or not the families had learned more about child sexual abuse and its possible effects.

The majority of parents indicated that they would have liked to have met with a social worker within three days of learning that their child had been sexually abused.

Most parents said they definitely would have requested this service if it had not been provided. I tend to think that with hindsight they would have requested the service, but at the time of disclosure the majority would not have known to have asked for help.

The majority of parents indicated that they found the service very helpful and the social worker very easy to talk to. The families were generally satisfied with the number of sessions they had with the social worker and felt that the service helped them to respond more appropriately to their child who had been sexually abused.

The majority felt that their understanding of sexual abuse and its possible effects was greater than before and they all agreed that all families where a child had been sexually abused should have an opportunity to meet with a social worker.

These evaluations indicate that crisis intervention is needed when a child discloses sexual abuse. Early intervention is indicated and providing parents and their families with educational and preventive measures and

information is beneficial. All families who were seen while in an active crisis state engaged in and benefitted from the intervention.

Qualitative comments provided by some of the parents can be found in Appendix C.

II Recommendations Arising From the Practicum

Child sexual abuse is a new area and there are many gaps in our ability to identify and treat the victims and their families. During my practicum and from my reading in this area, I have identified some areas I think need more input. These are discussed below.

1. There is a definite need for effective treatment of cases of non-family child sexual abuse. Although there are a large number of victims involved, treatment programs focus primarily on cases of family child sexual abuse and virtually ignore the victims of non-family sexual abuse and their families.

   I would therefore recommend that crisis intervention be provided by Hospital Social Services for all families where a child has been sexually abused. As demonstrated by this practicum,

families readily engaged in crisis intervention when they were seen at the Clinic, presumably in an active crisis state.

2. Interdisciplinary teams should be implemented in all areas to provide complete, coordinated and effective intervention into all cases of child sexual abuse. Intervention strategies upon disclosure should be improved to ensure that the victim is protected and that the many systems involved are working together in the child's best interest.

3. The need to educate social workers in the areas of child sexual abuse, rape and wife abuse must be recognized by the schools of social work, (Dietz and Craft, 1980; Berliner and Stevens, 1982). As Berliner and Stevens (1982) note, social workers must recognize the need to advocate on behalf of the child. These authors further state that social workers are able to view all the systems involved and must reach out to organize and educate these systems in an effort to improve intervention in cases of child sexual abuse (Berliner and Stevens, 1982).

As I found in my practicum, social workers in the field are also in need of education in these areas, which could be provided through in-service programs and workshops.

4. Few empirical studies have been done in this area. Much of the available information comes from adult women telling about sexual abuse in their childhood and from therapists' reports and case studies. There are many issues that need to be researched (eg. the impact of the sexual abuse on children at different ages and levels of development, the long term effects of the sexual abuse, the role child pornography plays in child sexual abuse, etc.).

Research also needs to be directed toward evaluating treatment programs for all the people involved (including the offender) in child sexual abuse. The effectiveness of prevention methods could be assessed.

5. Children need factual education about sexuality, family relationships and child sexual abuse. They need to know that they do have a choice in who can touch their bodies. This education can

help prevent some children from being sexually abused and can also help to clarify issues for children who are in the position of being potential child sexual abuse offenders.

6. Finally, I would like to recommend that all concerned adults become involved in more strenuous lobbying to stop the abuse of all children, but especially to stop the commercial sale of children and child pornography. Without a strong and fervent outcry from people who are concerned about children, second order change, change of the system itself, cannot be achieved.

III Skill Development Afforded by the Practicum

I was fortunate in this practicum to work in two different areas which both provided an opportunity for skill development. The crisis intervention outlined in this report was one area and the other involved co-facilitating a group. Both areas provided an opportunity to develop new skills and improve existing ones.

Although I have done crisis intervention work in the past, in this practicum the theory and practice were integrated as they never were before. Goals were clearly identified and

there was a purpose to each session. I was able to be flexible with the number of sessions but also recognize the phases of the intervention and the benefits of termination for the family.

Being a member of the Child Sexual Abuse Committee meeting each week showed me how valuable such an interdisciplinary team can be. Observing all the systems working together assisted me in helping clients to respond to them and in explaining to clients what and how important their roles are.

The experience of developing, implementing and evaluating a program was very valuable and interesting. The use of the Child Sexual Abuse Questionnaire and the Revised Child Behavior Profile added to the information from interviews and provided a richer assessment. I found it helpful to follow-up with families and to receive their feedback on the service provided. The use of these types of measures will be incorporated into my future practice.

I had the opportunity to further develop my skills in working with children. The value of play and make believe with children has opened up new areas of practise for me and will also be further implemented in my future practise.

The second area I worked in during this practicum was group. I co-facilitated a group with Dr. Kathryn Saulnier. The group was for female adolescent victims of family child sexual abuse. The rationale for this group and themes covered in each session are described in Appendix D of this practicum report. A fuller representation of the group experience was seen to be beyond the scope of this report.

The experience of helping to develop a model of group work and then acting as co-leader was very valuable. The focus of the group was on family rather than non-family child sexual abuse. This allowed me to have experience in both areas of child sexual abuse during this practicum.

Working with this group of victims provided me with new skills in dealing with members' intense feelings. The need to set limits early on in the group process was recognized and skills in dealing with members' acting out behavior were developed.

In this group many different methods were used (eg. group discussion, video taping, films, role playing, etc.). Using these different activities helped to keep the group together and to keep it moving forward. Through this experience I have developed a base that I can apply to future groups.

The experience of being a co-facilitator of a group was valuable. The use of co-leaders can make facilitating a group less of a burden. It also demands that the leaders be compatible and present the group with commonly shared values and beliefs. This need provided me with an opportunity to further clarify my own ideological orientation toward child sexual abuse.

In this practicum I developed many new skills and broadened my knowledge base in the area of child sexual abuse. This experience was challenging and personally rewarding.

Appendix A

Information Sheet

on

Child Sexual Abuse

and

List of Resources

Appendix A

Information About Child Sexual Abuse

1. Children rarely lie about being sexually abused.
2. Most sexual abuse offenders are family members or someone known to the child.
3. Most sexual abuse offenders are not mentally ill or mentally retarded. They are not usually criminals other than in the sexual abuse setting.
4. Without outside intervention, most offenders will continue to assault children.
5. Both girls and boys are sexually abused although girls appear to be victimized more often than boys.
6. Children who have been sexually abused may show an unusual interest in the genitals of other people or of animals or have sexual knowledge beyond their age.
7. Many children who were sexually abused feel guilty and feel that it was somehow their fault.
8. Most children are not permanently scarred by an incident of sexual abuse, if it is properly handled by their parents and professionals.
9. It is important for parents to unburden themselves of their feelings about the abuse so they can better support their child.

10. Teaching children about their bodies (that they are special and that they own them) is helpful in preventing child sexual abuse.
11. The child who is believed when he/she reports has the best chance of recovery.
12. Offenders often deny the sexual abuse or blame it on alcohol or drugs or the child. The truth of the matter is that the offender is always responsible for the sexual abuse and the child is always innocent.

Appendix A

Books and Pamphlets about Child Sexual Abuse

1. It's My Body - A Book to Teach Young Children How to Resist Uncomfortable Touch, by Lory Freeman.

   A Parent's Resource Booklet, to accompany It's My Body.

   To Order, write to: Planned Parenthood of Snohomish County,
   2730 Hoyt Avenue,
   Everett, WA 98201, U.S.A.

2. Come Tell Me Right Away - A Positive Approach to Warning Children About Sexual Abuse, by Linda Tschirhart Sanford.

   To Order, write to: Ed-U Press, Inc.,
   P. O. Box 583,
   Fayetteville, NY 13066, U.S.A.

3. The Silent Children: A Parent's Guide to the Prevention of Child Sexual Abuse, by Linda Tschirhart Sanford.

   To Order, write to: Ed-U Press, Inc.,
   P. O. Box 583,
   Fayetteville, NY 13066, U.S.A.

4. No More Secrets - Protecting Your Child from Sexual Assault, by Caren Adams and Jennifer Fay.

To Order, write to: Impact Publishers,
P. O. Box 1094,
San Luis Obispo, California,
93406, U.S.A.

5. "He Told Me No to Tell" - Parent's Guide for Talking to Your Child about Sexual Assault.

To Order, write to: King County Rape Relief,
305 S. 43rd St.,
Renton, WA 98055, U.S.A.

Appendix B

Child Sexual Abuse Questionnaire

and

Revised Child Behavior Profile

Appendix B

Child Sexual Abuse Questionnaire

Please read each of the following statements and circle TRUE or FALSE.

1. Many children make up stories about being sexually abused. TRUE FALSE
2. Children who have been sexually abused may show an unusual interest in the genitals of other people or of animals or have sexual knowledge beyond their age. TRUE FALSE
3. Most sexual abuse offenders are strangers. TRUE FALSE
4. Teaching children about their bodies (that they are special and that they own them) is helpful in preventing child sexual abuse. TRUE FALSE
5. Most sexual abuse offenders are mentally ill or mentally retarded. TRUE FALSE
6. The child who is believed when he/she reports sexual abuse has the best chance of recovery. TRUE FALSE
7. Ignoring an incident of sexual abuse because it is just a part of growing up is a helpful way to respond. TRUE FALSE

8. Many children who are sexually abused feel guilty and feel that it was somehow their fault TRUE FALSE

9. Most children are permanently scarred by an incident of sexual abuse. TRUE FALSE

10. It is important for parents to unburden themselves of their feelings about the abuse so they can better support their child. TRUE FALSE

11. Without outside intervention most offenders will continue to assault children. TRUE FALSE

12. Only female children are sexually abused. TRUE FALSE

Appendix B

Child Behavior Profile

In order to better help us understand your child, please answer each of the following questions about your child and family. When describing your child, please think about his/her behavior during the past month. Please try to answer each question. All information will be kept confidential. Select only one answer for each question.

The following questions apply to you. Please circle the best answer as it applies to yourself.

1. You are the child's:
    1. Mother
    2. Father
    3. Stepmother
    4. Stepfather
    5. Other, specify
2. Education: (circle one)
    1. None
    2. Grades 1-4
    3. Grades 5-8
    4. Grades 9-12
    5. Tech. or Voc. Training
    6. University Education

3. What is the appropriate yearly family income from all sources:

   1. less than $5,000.00
   2. $5,000.00 - $9,999.00
   3. $10,000.00 - $19,999.00
   4. $20,000.00 - $29,999.00
   5. $30,000.00 - $39,999.00
   6. over $40,000.00

4. How many people are dependent on this income?

   _____

5. Are you currently:

   1. Married
   2. Living as married
   3. Separated
   4. Divorced
   5. Widowed
   6. Never married

6. Please list the people living in your home:

Name	Age	Relationship to you

7. The following questions ask you to describe <u>your life</u> as you now see it. Circle the best answer to each question.

a. Are there adults you know whom you could call upon for help if you really needed it?

YES	NO	NOT SURE
1	2	3

b. If you needed to leave town quickly, is there someone whom you would trust to look after your house and belongings?

YES	NO	NOT SURE
1	2	3

c. If you had to leave town quickly, is there someone whom you would trust to look after your child(ren)?

YES	NO	NOT SURE
1	2	3

d. Have you engaged in a social activity with other adults outside your home in the last:

24 HOURS	WEEK	MONTH
1	2	3

e. Have you engaged in a social activity inside your home in the last:

24 HOURS	WEEK	MONTH
1	2	3

f. Have you talked with an adult who cares about you, and you care about, in the last:

24 HOURS	WEEK	MONTH
1	2	3

g. Are most of your contacts with other adults initiated

1. By you
2. By others
3. Sometimes by you and sometimes by others

h. Are most of your contacts with other adults:

1. Positive, supportive or pleasant
2. Neutral, neither positive nor negative
3. Negative, conflictual or aversive

8. The following questions have to do with the child you believe may have been sexually abused. Sometimes significant events in a child's life are important in understanding a child's behavior and emotional reactions. Following is a list of events. Please read through the list two times. As you read through the list for the

first time, please place a check mark in Column 1 beside any event which has occurred in your child's life anytime in the past year.

Whether any of the events listed are in fact stressful to a particular child is very much individually determined. Please read the list a second time and for each event which has happened in your child's life in the past year, if you believe that event has been stressful to the child, place an X in Column 2.

Column 1 Did it occur? (√)		Column 2 Was it Stressful? (X)
_____	Death of a parent	_____
_____	Serious injury/illness to child	_____
_____	Serious injury/illness to parent	_____
_____	Serious injury/illness to sister or brother of child	_____
_____	Change of schools	_____
_____	Family moved to new house or apartment	_____
_____	New infant or adult joined the family	_____
_____	Family income significantly decreased	_____
_____	Child's parents divorced or separated	_____

9. For each of the following statements, indicate whether the statement is true or not true by placing an (x) in the appropriate column.

		TRUE	NOT TRUE
a.	My family is usually under some kind of stress	_____	_____
b.	My child is behaving more or less like she/he always does	_____	_____
c.	I do not handle stress well	_____	_____
d.	I have close friends whom I trust	_____	_____
e.	I am able to tolerate stress and problems well	_____	_____
f.	My child is able to tolerate stress and problems well	_____	_____
g.	My child is usually not happy	_____	_____
h.	I am basically alone with no one to help or support me.	_____	_____
i.	Our family life is often hectic and chaotic	_____	_____
j.	I am usually happy	_____	_____

10. Thinking about the child you believe has been sexually abused, please put an (X) in the blank which most nearly describes how often each behavior or characteristic occurs for the child.

		Never	Rarely	Some-times	Often	Almost Always
1.	Academic problems	_____	_____	_____	_____	_____
2.	Agressive behavior (eg. yelling,hitting and breaking things)	_____	_____	_____	_____	_____
3.	Hangs around with a bad crowd	_____	_____	_____	_____	_____
4.	Can't fall asleep	_____	_____	_____	_____	_____
5.	Has concern for others	_____	_____	_____	_____	_____
6.	Excessive activity, restlessness, fidgity	_____	_____	_____	_____	_____
7.	Stubborn, negative obstinate	_____	_____	_____	_____	_____
8.	Doesn't do what told	_____	_____	_____	_____	_____
9.	Bullies other kids	_____	_____	_____	_____	_____

		Never	Rarely	Some-times	Often	Almost Always
10.	Moods change quickly	_____	_____	_____	_____	_____
11.	Easily frustrated or distracted	_____	_____	_____	_____	_____
12.	Nice or pleasant disposition	_____	_____	_____	_____	_____
13.	Temper tantrums	_____	_____	_____	_____	_____
14.	Doesn't listen	_____	_____	_____	_____	_____
15.	Has difficulty talking or communicating	_____	_____	_____	_____	_____
16.	Thinks a lot about or talks a lot about accidents or tragedy	_____	_____	_____	_____	_____
17.	Has difficulty waiting for his/ her turn	_____	_____	_____	_____	_____
18.	Blames others for what he/she has done wrong	_____	_____	_____	_____	_____
19.	Dizziness/faintness	_____	_____	_____	_____	_____

		Never	Rarely	Some-times	Often	Almost Always
20.	Spends time with friends or other children	_____	_____	_____	_____	_____
21.	Breaks household rules	_____	_____	_____	_____	_____
22.	Sets fires	_____	_____	_____	_____	_____
23.	Breaks into other peoples' homes	_____	_____	_____	_____	_____
24.	Feels guilty or badly after doing something wrong	_____	_____	_____	_____	_____
25.	Lies/doesn't tell the truth	_____	_____	_____	_____	_____
26.	Goes to the bathroom (soils) clothing during the day	_____	_____	_____	_____	_____
27.	Clings to parents	_____	_____	_____	_____	_____
28.	Afraid of the dark	_____	_____	_____	_____	_____
29.	Demanding, needs constant attention	_____	_____	_____	_____	_____
30.	Reluctant to go to school	_____	_____	_____	_____	_____

		Never	Rarely	Some-times	Often	Almost Always
31.	Avoids contact with peers	_____	_____	_____	_____	_____
32.	Overly concerned with what people say about him/her	_____	_____	_____	_____	_____
33.	Sexually active	_____	_____	_____	_____	_____
34.	Acts like a baby (e.g. uses bottle, whines a lot)	_____	_____	_____	_____	_____
35.	Has panic or anxiety attacks	_____	_____	_____	_____	_____
36.	Avoids contact with non-related adults	_____	_____	_____	_____	_____
37.	Afraid of being alone	_____	_____	_____	_____	_____
38.	Easily startled, overly sensitive to noises	_____	_____	_____	_____	_____
39.	Runs away, takes off	_____	_____	_____	_____	_____
40.	Depressed or very unhappy	_____	_____	_____	_____	_____

		Never	Rarely	Some-times	Often	Almost Always
41.	Withdraws from usual activities of friendships	_____	_____	_____	_____	_____
42.	Generalized fears (e.g. afraid of leaving home, or riding in car)	_____	_____	_____	_____	_____
43.	Tries to kill self	_____	_____	_____	_____	_____
44.	Involves younger children in sexual play	_____	_____	_____	_____	_____
45.	Kind, considerate, helpful	_____	_____	_____	_____	_____
46.	Overly concerned about cleanliness	_____	_____	_____	_____	_____
47.	Does not like his/ her body	_____	_____	_____	_____	_____
48.	Keeps anger or hostility bottled up inside	_____	_____	_____	_____	_____

		Never	Rarely	Some-times	Often	Almost Always
49.	Day dreams excessively, has memory loss, unable to concentrate	_____	_____	_____	_____	_____
50.	Major problems with police	_____	_____	_____	_____	_____
51.	Hurts self physically	_____	_____	_____	_____	_____
52.	Bizarre behavior, incoherent or loose speech and thoughts, sees or hears things which are not really there	_____	_____	_____	_____	_____
53.	Overly compliant, too anxious to please	_____	_____	_____	_____	_____
54.	Uses drugs or alcohol	_____	_____	_____	_____	_____
55.	Motivated	_____	_____	_____	_____	_____
56.	Walks in his/her sleep	_____	_____	_____	_____	_____

		Never	Rarely	Some-times	Often	Almost Always
57.	Afraid of adult men or boys	_____	_____	_____	_____	_____
58.	Talks about hurting or killing self	_____	_____	_____	_____	_____
59.	Stomach-aches, headaches	_____	_____	_____	_____	_____
60.	Places self in dangerous situations (risk taking)	_____	_____	_____	_____	_____
61.	Overly affectionate	_____	_____	_____	_____	_____
62.	Talks about doing violence (hurting others)	_____	_____	_____	_____	_____
63.	Overly emotional (cries easily, supersensitive)	_____	_____	_____	_____	_____
64.	Afraid of certain places	_____	_____	_____	_____	_____
65.	Nightmares	_____	_____	_____	_____	_____
66.	Thinks about or talks about the same thing over and over	_____	_____	_____	_____	_____

		Never	Rarely	Some-times	Often	Almost Always
67.	Non-academic school behavior problems	_____	_____	_____	_____	_____
68.	Difficulty making and maintaining friendships	_____	_____	_____	_____	_____
69.	Is able to relax	_____	_____	_____	_____	_____
70.	Minor problems with police (e.g. shop-lifting)	_____	_____	_____	_____	_____
71.	Shy or socially isolated	_____	_____	_____	_____	_____
72.	Very concerned with following family rules	_____	_____	_____	_____	_____
73.	Steals	_____	_____	_____	_____	_____
74.	Has good moral or ethical values	_____	_____	_____	_____	_____
75.	Loyalty to others	_____	_____	_____	_____	_____
76.	Periodically binge eats (eats to excess)	_____	_____	_____	_____	_____

		Never	Rarely	Some-times	Often	Almost Always
77.	Self critical	_____	_____	_____	_____	_____
78.	Does not finish things he/she starts	_____	_____	_____	_____	_____
79.	Wets bed at night	_____	_____	_____	_____	_____
80.	Responds quickly to directions	_____	_____	_____	_____	_____
81.	Is pleasant, nice to be around	_____	_____	_____	_____	_____
82.	Gets upset easily	_____	_____	_____	_____	_____
83.	Attends school regularly	_____	_____	_____	_____	_____
84.	Is irritable	_____	_____	_____	_____	_____
85.	Lots of pep, energy	_____	_____	_____	_____	_____
86.	Goes to the bath-room (wets) clothing during the day	_____	_____	_____	_____	_____
87.	Easily quieted	_____	_____	_____	_____	_____
88.	Fusses and frets	_____	_____	_____	_____	_____
89.	Slow to understand	_____	_____	_____	_____	_____

	Never	Rarely	Some-times	Often	Almost Always
90. Easy to take care of	_____	_____	_____	_____	_____
91. Uncontrolled, unruly, defiant	_____	_____	_____	_____	_____
92. Cooperative	_____	_____	_____	_____	_____
93. Tense	_____	_____	_____	_____	_____
94. Nervous	_____	_____	_____	_____	_____
95. Patient, calm	_____	_____	_____	_____	_____
96. Rational, logical, uses common sense	_____	_____	_____	_____	_____
97. Lethargic or lazy	_____	_____	_____	_____	_____
98. Loving, caring	_____	_____	_____	_____	_____
99. Antagonistic, hostile	_____	_____	_____	_____	_____
100. Conscientious	_____	_____	_____	_____	_____
101. Feels inferior	_____	_____	_____	_____	_____
102. Works hard	_____	_____	_____	_____	_____
103. Able to concentrate	_____	_____	_____	_____	_____
104. Dislikes parents	_____	_____	_____	_____	_____
105. Thinks others don't like him/her	_____	_____	_____	_____	_____
106. Seductive	_____	_____	_____	_____	_____

	Never	Rarely	Some-times	Often	Almost Always
107. Gets pushed around	_____	_____	_____	_____	_____
108. Lacks self-confidence	_____	_____	_____	_____	_____
109. Secure, confident	_____	_____	_____	_____	_____
110. Loss of appetite	_____	_____	_____	_____	_____

Appendix C

Client Feedback Form

Appendix C

Client Feedback

This questionnaire is given to you in order to evaluate the needs of a family where a child has been sexually abused and to evaluate the service you have been given by the Child Protection Centre in the Childrens Hospital.

Thank you for your cooperation. The questionnaire is anonymous and will be confidential.

Please circle the correct answer:

1. How soon after you learned that your child had been sexually abused did you meet with a social worker?

3 Weeks or more	2 Weeks	1 Week	4-6 Days	1-3 Days

2. When would you have liked to meet with a social worker after you learned that your child had been sexually abused?

3 Weeks or more	2 Weeks	1 Week	4-6 Days	1-3 Days

3. If this service had not been provided do you feel you would have requested such help?

Never	Probably Not	Maybe	Quite Likely	Definitely Yes

4. How helpful did you find this service?

Not at All Helpful	A Little Helpful	Not Sure	Helpful	Very Helpful

5. How easy was your social worker to talk with?

Very Hard	Hard	In Between	Easy	Very Easy

6. How satisfied were you with the number of sessions you had with your social worker? The number of sessions should have been:

Much Fewer	Fewer	The Same	More	Much More

7. Do you feel that these sessions helped you to respond more appropriately to your child that was sexually abused?

Yes Maybe No

8. My understanding of sexual abuse and its possible effects is:

Greater Since I Received Service	The Same As Before	I Feel More Confused About this Area

9. Would you recommend this service to a friend or relative whose child has been sexually abused?

Yes Maybe No

10. Do you think all families where a child has been sexually abused should have an opportunity to meet with a social worker?

Yes Maybe No

THANK YOU!

Client Feedback

This questionnaire is given to you in order to evaluate the needs of a family where a child has been sexually abused and to evaluate the service you have been given by the Child Protection Centre in the Childrens Hospital.

Thank you for your cooperation. The questionnaire is anonymous and will be confidential.

Please circle the correct answer:

1. How soon after you learned that your child had been sexually abused did you meet with a social worker?

   3 weeks or more | 2 weeks | 1 week | 4-6 Days | (1-3 Days)

2. When would you have liked to meet with a social worker after you learned that your child had been sexually abused?

   3 weeks or more | 2 weeks | 1 week | 4-6 Days | (1-3 Days)

3. If this service had not been provided do you feel you would have requested such help?

   Never | Probably Not | Maybe | Quite Likely | (Definitely Yes)

4. How helpful did you find this service?

   Not at all Helpful | A Little Helpful | Not Sure | Helpful | (Very Helpful)

5. How easy was your social worker to talk with?

   Very Hard | Hard | In Between | Easy | (Very Easy)

6. How satisfied were you with the number of sessions you had with your social worker? The number of sessions should have been:

   Much Fewer | Fewer | (The Same) | More | Much More

7. Do you feel that these sessions helped you to respond more appropriately to your child that was sexually abused?

(Yes) Maybe No

8. My understanding of sexual abuse and its possible effects is:

(Greater Since I Received Service) The Same As Before I Feel More Confused About this Area

9. Would you recommend this service to a friend or relative whose child has been sexually abused?

(Yes) Maybe No

10. Do you think all families where a child has been sexually abused should have an opportunity to meet with a social worker?

(Yes) Maybe No

THANK YOU.

Dear Betty,

Just a short note to thank you for all your help and support. Although I would never have wanted this to happen, the understanding and the help given with such sensitivity served to bring a family that was somewhat floundering a lot closer together. We have a long way to go, but we sure got a good start with the help of Melanie Grace and your own. Thanks again

Client Feedback

This questionnaire is given to you in order to evaluate the needs of a family where a child has been sexually abused and to evaluate the service you have been given by the Child Protection Centre in the Childrens Hospital.

Thank you for your cooperation. The questionnaire is anonymous and will be confidential.

Please circle the correct answer:

1. How soon after you learned that your child had been sexually abused did you meet with a social worker?

3 weeks or more	2 weeks	1 week	(4-6 Days)	1-3 Days

2. When would you have liked to meet with a social worker after you learned that your child had been sexually abused?

I found that I talked to the worker just at the right time

3 weeks or more	2 weeks	1 week	4-6 Days	1-3 Days

3. If this service had not been provided do you feel you would have requested such help?

Never	Probably Not	Maybe	Quite Likely	(Definitely Yes)

4. How helpful did you find this service?

Not at all Helpful	A Little Helpful	Not Sure	Helpful	(Very Helpful)

5. How easy was your social worker to talk with?

we found ourselfs very comfortable in talking with the worker

Very Hard	Hard	In Between	Easy	(Very Easy)

6. How satisfied were you with the number of sessions you had with your social worker? The number of sessions should have been:

Much Fewer	Fewer	(The Same)	More	Much More

I think the number of sessions were good I think would of liked to have her at our home all the time.

7. Do you feel that these sessions helped you to respond more appropriately to your child that was sexually abused?

(Yes) Maybe No

8. My understanding of sexual abuse and its possible effects is:

(Greater Since I Received Service) The Same As Before I Feel More Confused About this Area

9. Would you recommend this service to a friend or relative whose child has been sexually abused?

(Yes) Maybe No

10. Do you think all families where a child has been sexually abused should have an opportunity to meet with a social worker?

(Yes) Maybe No

I think it really helps to have someone there to talk to about this. especially when you know they THANK YOU. really do care.

P.S.

I found the social worker (Melanie Grace) very easy to talk to and I know my daughter Jenifer just adored her and felt very comfortable with her. I think if it hadn't been this way she wouldn't of talked about it so easy and been at eased with herself. I would like to take this time to thank yours for all your help to get us through this time, and I would especially like to thank Melanie for her time and energye she spent with Jenny and the help she gave us.

Again Thank you.

Client Feedback

This questionnaire is given to you in order to evaluate the needs of a family where a child has been sexually abused and to evaluate the service you have been given by the Child Protection Centre in the Childrens Hospital.

Thank you for your cooperation. The questionnaire is anonymous and will be confidential.

Please circle the correct answer:

1. How soon after you learned that your child had been sexually abused did you meet with a social worker?

   3 weeks or more | 2 weeks | **1 week** | 4-6 Days | 1-3 Days

2. When would you have liked to meet with a social worker after you learned that your child had been sexually abused?

   3 weeks or more | 2 weeks | 1 week | 4-6 Days | **1-3 Days**

3. If this service had not been provided do you feel you would have requested such help?

   Never | Probably Not | Maybe | Quite Likely | **Definitely Yes**

4. How helpful did you find this service?

   Not at all Helpful | A Little Helpful | Not Sure | Helpful | **Very Helpful**

5. How easy was your social worker to talk with?

   Very Hard | Hard | In Between | Easy | **Very Easy**

6. How satisfied were you with the number of sessions you had with your social worker? The number of sessions should have been:

   Much Fewer | Fewer | **The Same** | More | Much More

7. Do you feel that these sessions helped you to respond more appropriately to your child that was sexually abused?

(Yes) Maybe No

8. My understanding of sexual abuse and its possible effects is:

(Greater Since I Received Service) The Same As Before I Feel More Confused About this Area

9. Would you recommend this service to a friend or relative whose child has been sexually abused?

(Yes) Maybe No

10. Do you think all families where a child has been sexually abused should have an opportunity to meet with a social worker?

(Yes) Maybe No

THANK YOU.

The most important role the social worker played was that of a listener. I found it very helpful to be able to sound off to someone about the abuse; it helped me release the anger and made me realize that it was in no way my fault. I would definately recommend this service to anyone whose child had been sexually abused. It helped me relate to my abused child more positively. I don't think anyone should have to go through this trauma without someone in the professional field to relate to and fall back on as the realities start to sink in. I appreciated the service very much

Client Feedback

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Thank you for your cooperation. The questionnaire is anonymous and will be confidential.

Please circle the correct answer:

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   3 weeks or more | 2 weeks | 1 week | **4-6 Days** | 1-3 Days

2. When would you have liked to meet with a social worker after you learned that your child had been sexually abused?

   3 weeks or more | 2 weeks | 1 week | 4-6 Days | **1-3 Days**

3. If this service had not been provided do you feel you would have requested such help?

   Never | Probably Not | **Maybe** | Quite Likely | Definitely Yes

4. How helpful did you find this service?

   Not at all Helpful | A Little Helpful | Not Sure | **Helpful** | Very Helpful

5. How easy was your social worker to talk with?

   Very Hard | Hard | In Between | Easy | **Very Easy**

6. How satisfied were you with the number of sessions you had with your social worker? The number of sessions should have been:

   Much Fewer | Fewer | **The Same** | More | Much More

7. Do you feel that these sessions helped you to respond more appropriately to your child that was sexually abused?

Yes Maybe No

8. My understanding of sexual abuse and its possible effects is:

Greater Since I Received Service | The Same As Before | I Feel More Confused About this Area

9. Would you recommend this service to a friend or relative whose child has been sexually abused?

Yes Maybe No

10. Do you think all families where a child has been sexually abused should have an opportunity to meet with a social worker?

Yes Maybe No

THANK YOU.

Client Feedback

This questionnaire is given to you in order to evaluate the needs of a family where a child has been sexually abused and to evaluate the service you have been given by the Child Protection Centre in the Childrens Hospital.

Thank you for your cooperation. The questionnaire is anonymous and will be confidential.

Please circle the correct answer:

1. How soon after you learned that your child had been sexually abused did you meet with a social worker?

   3 weeks or more | 2 weeks | 1 week | (4-6 Days) | 1-3 Days

2. When would you have liked to meet with a social worker after you learned that your child had been sexually abused?

   3 weeks or more | 2 weeks | 1 week | 4-6 Days | (1-3 Days)

3. If this service had not been provided do you feel you would have requested such help?

   Never | Probably Not | Maybe | Quite Likely | (Definitely Yes)

4. How helpful did you find this service?

   Not at all Helpful | A Little Helpful | Not Sure | Helpful | (Very Helpful)

5. How easy was your social worker to talk with?

   Very Hard | Hard | In Between | Easy | (Very Easy)

6. How satisfied were you with the number of sessions you had with your social worker? The number of sessions should have been:

   Much Fewer | Fewer | (The Same) | More | Much More

7. Do you feel that these sessions helped you to respond more appropriately to your child that was sexually abused?

(Yes) Maybe No

8. My understanding of sexual abuse and its possible effects is:

Greater Since I Received Service | (The Same As Before) | I Feel More Confused About this Area

9. Would you recommend this service to a friend or relative whose child has been sexually abused?

(Yes) Maybe No

10. Do you think all families where a child has been sexually abused should have an opportunity to meet with a social worker?

(Yes) Maybe No

THANK YOU.

Appendix D

Group Work with Female Adolescent Victims of Child Sexual Abuse

Introduction

Dr. Kathryn Saulnier and I developed a model of group work for adolescent victims of child sexual abuse. There were nine members in our group which ran from March - May, 1984, at the Psychological Service Centre at the University of Manitoba. Following is a rationale for group work with adolescent victims of sexual abuse and an outline of the themes covered in the group.

Rationale For Group Work

Helping professionals are becoming better able to identify child sexual abuse. Indicators in children are being recognized and appropriate questions are being asked. With the increasing numbers of victims being identified the need for effective treatment resources is also being recognized. Many child sexual abuse treatment programs recognize the value of groups for the victims. Ideally, groups for victims of child sexual abuse are one part of a comprehensive treatment program for the whole family. In reality, here in Winnipeg, the group is sometimes the only treatment a victim may receive. Berliner and MacQuivey (1982) describe the group for adolescent victims as being the one place where the victim and her personal concerns are central.

One main factor in choosing group treatment for adolescent victims of sexual abuse is recognition of the importance of the peer group for the adolescent. The need to belong and to be accepted and approved of by peers is a normal developmental part of adolescence. When children have been sexually abused they often experience a sense of being different than their peers. Blick and Porter (1982) note that victims of family child sexual abuse usually have a history of alienation and isolation from their peers and the community. The group is a safe environment where victims can express their feelings about the abuse, the offender and themselves with the knowledge that the other group members have experienced these or similar emotions.

Victims of child sexual abuse often have poor self-esteem. Many abuse victims feel guilty about the sexual abuse and blame themselves for having allowed it to occur. Blick and Porter (1982) report that these feelings of guilt and shame are often expressed in negative self-esteem. A group for victims of child sexual abuse reassures members that they are not alone, that others are suffering through the pains of child sexual abuse. Through identification with other victims and their situations, members can begin to believe that they are victims and are not to blame for the sexual

abuse or the disruptions upon disclosure. The responsibility of the offender is put into perspective. Through this learning experience and sharing process, victims can begin to develop a more positive self-esteem.

Many adolescent victims of sexual abuse are confused around issues of sexuality. The difference between a healthy sexual relationship and an abusive one is often hazy. Issues such as who to have sex with, when and why, need to be addressed as victims of sexual abuse often feel they have no choice in these matters. If the offender "paid" the victim (with money, favors or affection), victims often feel that they must provide sex in return for the attention of all boys or men. As a member of a group of victims, discussion around topics of sexuality can help to clarify many misconceptions and encourage members to look at value issues.

Blick and Porter (1982) note that many victims have poorly developed social skills. The group offers an opportunity for members to improve their social skills and to develop and maintain a relationship with peers.

Themes Covered in the Group

The Group consisted of twelve sessions with the first six focusing on the sexual abuse while the last six focused on improving coping skills. Following is an outline of the themes covered in each session.

1. Getting to know each other. In this first session the purpose of the group was outlined and individual and group goals were briefly discussed. The group leaders explained their ideological orientation regarding child sexual abuse. "Ice-breaker" exercises were used to get the members talking to one another and a puzzle exercise emphasizing the need for cooperation in order for the group to succeed was used.
2. Sexual abuse. This session began with a review of the goals that members had identified and the leaders had combined. The video "Child Sexual Abuse: The Untold Secret" (1981) was viewed. This video prompted members to discuss their own experiences.
3. Child sexual abuse offenders. This session focused on why some men sexually abuse children. Leaders identified myths and reviewed theories after the group had come up with a number of possibilities.

Members broke into partners and talked about what they would like to tell the offender and what they would like to ask him. This was shared with the larger group.

4. Victim's mothers. The reasons mothers might not intervene in the sexual abuse if they were aware of it was discussed. Reasons why some mothers stay with the offender were identified and the group discussed the notion that "any man is better than no man at all".

5. Impact of sexual abuse. In this session, the CBC 24 Hours documentary "Incest: The Family Secret" (1980) was viewed in parts. Afterward, discussion focused on how young many victims were, how many had tried to kill themselves, opinions about jailing the offender and the suggestion that incest be legalized. The notion of being a "survivor" vs. a victim was introduced.

6. Identifying feelings. The movie "Something About Amelia" (1983) was shown in this session. Members were asked to complete question sheets during the film. These questions focused on group member's perception of the events and emotions portrayed in the movie.

7. Expressing feelings. This session focused on the importance of being able to identify feelings and clearly label them. The group played "Feelings Charades".

8. Assertiveness skills. The distinction between assertive, non-assertive and agressive behavior was outlined as were the steps to being assertive. The group split into two teams and drew role play situations from a hat (e.g. resisting sexual advances, borrowing a friends top, saying no to a date, etc.). These role plays were video taped and then were watched and the assertive behavior identified.

9. Court. The focus in this session was on a court hearing where the offender had been accused of sexually abusing his daughter. The trial was role played with members taking the roles of victim, bailiff, judge, doctor, character witness and victim's friend. Leaders portrayed the crown and defense attorneys. Group members voted "guilty" or "not guilty" and indicated sentences they felt were appropriate.

10. Relationships with males. Each group member wrote down what she looked for in a male, what characteristics she considered important in a male friend. These were shared with the group. We viewed the film "Running My Way" (1982). This film was about teens dating and peer pressure to have sex. Discussion then centered on how you decide whether or not to have sex with somebody, will boys like you better if you do have sex, and will boys still ask you out if you don't. The film "When Jenny, When" (1977) was shown. This film was about a promiscuous high school girl who decided to stop being promiscuous.

11. Values clarification and sex education. In this session the group did the "Alligator River" exercise individually and then discussed it as a group. Members were encouraged to express their own opinions and to listen to other's opinions which may have differed from theirs. A discussion about our bodies and contraception was explicated using a plastic vagina model and a birth control demonstration kit.

12. Celebration, goodbye, evaluation. This session focused on saying goodbye and a review of the progress made in the group. A self-evaluation exercise was done. Through art work, a self-image exercise relating to future hopes and dreams was completed and explained by each member. The group had a party with fruit, cake and punch and leaders presented members with cards in which special sayings had been calligraphied.

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