

MOTHER-DAUGHTER RELATIONSHIPS IN
CHILD SEXUAL ABUSE:
SYSTEMIC PRACTICE WITH INDIVIDUALS
AND DYADS

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BY

ROSEMARY ANNE SIEMIENIUK

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of the University of Manitoba in partial fulfillment of the
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I wish to dedicate this degree to my mother Mary Siemieniuk. I have accomplished what only she could dream of...

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CHAPTER ONE

INTRODUCTION

The purpose of the practicum is to integrate theoretical knowledge with practical experience in the area of child sexual abuse. Child sexual abuse was chosen because of a desire to expand upon the knowledge base acquired from previous social work experience and to employ this information to develop therapeutic techniques to enhance healthy change in families. Family therapy with a focus on structural intervention (Minuchin and Fishman, 1981) was preferred because of the inclination toward a more comprehensive look at dysfunctional families. Structural intervention appears to be an active problem solving approach that explores family interactions and the patterns that are created to produce or maintain problems. Certain aspects of the structural perspective such as focusing on the present, clarifying interactions, building on strengths and identifying areas (these areas include hierarchy, subsystems, boundary, family cohesion and changing patterns of interaction) help to identify the problems that may require intervention. Also, the structural view seems less judgemental and less negative (Koch and Jarvis, 1987; MacKinnon and Miller, 1985). This perspective also encourages the therapist to focus on strengths and capacity for growth in both the individual and the family system.

The clinical experience concentrated on identifying the issues associated with the mother and daughter relationship in an incestuous family. This dyad was chosen

because it has been identified as an important link which can enhance future family health. Judith Herman (1981) states that "Just as healing in incestuous families begins with the restoration of the mother - daughter bond, prevention of incest ultimately depends on strengthening that relationship..." (p. 207). Other authors such as Anderson and Mayes (1982), Hoorwitz (1983) and Cammaert (1988) speculate that the strength of this relationship would predict the future functioning of the family. The mother has been identified as the centre of attention because of her role as the protector and caregiver. Often, after the disclosure, she may be the only adult ally for the child. Not all authors have identified the mother as a positive source of help for healing and growth. There are perceptions presented by certain clinicians (Reposa and Zuelzer, 1983; Furniss, 1983; Machotka, Pittman and Flomenhaft, 1967;) that attempt to explain how the mother may influence and support the process of sexual abuse. These authors indicate that the mother may collude in either overt or covert ways with the father to set the child up for the initiation and perpetuation of the abuse. It is important to recognize this "blaming" stance because it can impede therapy and add further to the victimization of the mother.

James and MacKinnon (1990) have presented an argument to dispute the viewpoint of the colluding mother. They suggest that to assume the above stance would be to agree that mothers are solely responsible for the protection of their children. This belief may shift the focus of accountability away from the perpetrator and onto the mother. They add that there is an assumption made that, in order to prevent the abuse, the mother must be continuously involved with her children.

James and MacKinnon (1990) believe that under other circumstances this over-involvement would be considered dysfunctional. To challenge the notion of the mother colluding against her child, two additional points are presented by James and MacKinnon (1990): first, "the myth of the colluding mother" ignores the fact that a high proportion of incest situations are brought to the attention of the authorities by mothers (James and MacKinnon, p. 76); second, "why is it the mother's, rather than father's responsibility to protect the daughter from her own father's sexual abuse of power? Should not men be taking responsibility for their own sexuality, individually and collectively?" (James and MacKinnon, p. 76).

Others such as Larson and Maddock (1986) and Barrett, Skyes and Byrnes (1986) present a view that diverts the focus of attention away from the mother and incorporates aspects of the structural perspective. These authors suggest that there are problems that occur within the interpersonal transactions of the family and in the network of the system. This perspective considers that incestuous behaviour is a result of many factors working together which create stress and the potential for dysfunctional relationships. Barrett, Skyes and Byrnes (1986) state that "intrafamilial sexual abuse is attributed to and maintained by a variety of interconnecting systems, family, individual and societal" (p.68). The key to this stance is its comprehensive look at the influences upon the family and the dysfunctional relationship patterns rather than its concentration on and blaming of one member.

A concensus exists among clinicians that the mother and daughter relationship can be the key to enhancing change for a healthier family environment (Anderson

and Mayes, 1982). Intervention aimed at strengthening the mother and helping to clarify the issues between mother and daughter may increase the mother's ability to protect her child from further abuse.

This practicum began with individual mother and daughter sessions in order to explore the presenting problems, to gather more information regarding family history and structure, and to form hypotheses about treatment needs. Mothers and daughters were then brought together in order to facilitate open communication, to address the issues regarding boundaries, to reduce and alleviate blame, and finally to build on the strengths of both parent and victim in order to help ensure the safety of the child in the future.

A second component that went beyond dyadic work was involvement of some mothers in a mothers' group. The group experience for the mothers gave them the opportunity to meet with others who shared their difficulties and to establish new relationships in order to reduce some of the isolation and frustration they were experiencing. Also, the women had access to a safe and secure environment where they could express their various feelings including anger, betrayal and loss.

Prior to engaging in the therapeutic process, four learning goals were established:

1. To further develop assessment skills in order to be able to address issues pertinent to the sexually abused child, the non-offending parent and the relationship between the two.
2. To demonstrate this knowledge in a counselling capacity with individuals

and with dyads. An emphasis was placed on learning and using the structural family therapy framework.

3. To develop insight and skills to identify the interactions, transaction and patterns of how sexual abuse occurs in families, and what changes would be required to protect the child from further abuse. Therapy would also focus on reducing the psychological impact of the abuse on the victim and non-offending parent.

4. To become involved in a group experience where mother's issues are shared. As well, this experience would supplement other knowledge in the area of sexual abuse and family violence. It was hoped that the group process would provide the student with an opportunity to develop skills in co-facilitating a group.

CHAPTER TWO

LITERATURE REVIEW

There are many theories offered that attempt to explain incestuous behaviour in families. In reviewing the information regarding systemic theories of incest, a number of themes became apparent. The theories of boundary disturbance, intergenerational transmission and role reversal are used in order to understand how incest may be conceived and maintained within the family. This chapter will attempt to define more clearly how the above concepts fit within the incestuous family and will help to identify problematic areas within the mother-daughter dyad.

As one begins an exploration of these ideas, it is difficult to ignore the importance of the mother and daughter relationship. The structure of the incestuous family is chaotic and often this can be exhibited by the disrupted nature of the mother and daughter dyad. It has been suggested by Judith Herman (1981), that the health of the family can be determined by the potential to improve the quality of this particular relationship. Treatment with this pair may be essential if the family is to attempt to resume healthy functioning. Therefore, in order to re-establish appropriate hierarchies, limits and bonding within the family, one must explore the theories of boundary, intergenerational transmission and role reversal along with their effects on the mother-daughter relationship. In addition, the chapter will demonstrate that in order to enhance the work done with both individuals and dyads, one should also consider including the mother in group therapy. It has been

speculated (Sgori, 1987) that the group experience can provide a supportive and nurturing milieu to help mothers cope with the issues affiliated with sexual abuse of their children.

A Systemic View of Incest

Every family is composed of a variety of organizational characteristics and interactional patterns. When these become problematic a "symptom" is produced that alerts professionals and other invested community members to the need to stop or change these patterns. The mother and daughter relationship is an intricate part of the family dynamics and a breakdown in this relationship may be symptomatic of a larger problem. It is important to consider how the symptom functions in the incestuous family and what has been found in the literature that has implicated the mother and daughter in the maintenance of the symptom. Hoffman (1981) views sexual abuse as a symptom of family dysfunction. She states that incest is "a product of a dysfunctional family system and that if the family organization becomes more normal, the symptom will automatically disappear"(p.263).

David Will (1983) appears to define incest as an effect of a dysfunctional family and suggests that the dysfunction has a purpose. He perceives incest as being a chronic pattern of coping and that its nature is to reduce tension within the family. Will (1983) states "it is used to reduce tension by helping the family avoid facing conflicts that are seen as having catastrophic consequences" (p.231). The family is already dysfunctional in their behaviours so additional conflict may threaten the existing interactions and could initiate other forms of coping that may be experienced

as destructive. The consequences of the tension that the family fears may be the potential to break apart, which in turn initiates the fears of abandonment and loss. It is suspected that each member of the incestuous family is dependent on the other for the gratification of their physical and emotional needs. If a member were to leave or be removed, then a concern is generated regarding the ability of the family to survive without that resource (Larson and Maddock, 1986). Gutheil and Avery (1977) and more recently Reposa and Zuelzer (1983) substantiate this notion by identifying that incest may be a defence mechanism against the pain of separation.

James and MacKinnon (1990) express some concerns regarding the theories of Gutheil and Avery (1977) and Reposa and Zuelzer (1983). They question the suggestion that the family members collude to maintain incest to avoid the pain of separation and feelings of loss. There are two myths that are inferred as a result of this theory. The first myth regards collusion between the members especially the mother. The second myth suggests that "incest is presumed to prevent adolescent separation" (p.78). James and MacKinnon (1990) state that incest, most of the time, will begin when the child is between the ages of five to ten years. This suggests that prior to puberty the incest has been occurring for some time. They also state that it is often during adolescence that the child will report the abuse. The adolescents' need for outside relationships, their developing knowledge and the fear of pregnancy may contribute to the desire for disclosure (James and MacKinnon 1990). James and MacKinnon (1990) question the idea that all members contribute equally to maintain the incest. They fear that the notion of collusion will divert the responsibility for the

incest away from the perpetrator, rather than making him accountable for his actions. Also, if "family members may be seen to participate equally, either overtly or covertly in bringing about the incest"(p.81), then the child may be held responsible for their own abuse and not given the protection they deserve (James and MacKinnon, 1990).

Cammaert (1989) explores the view that incest is symptomatic of family dysfunction and she adds another facet. Cammaert (1989) associates symptomatic behaviour with the tendency in the literature to blame the mother for creating or maintaining the incest. She reviewed this literature and found that incest can be symptomatic of stress but that the mother is often identified as the source of the stress or that she is often inadequate in her ability to alleviate it. Cammaert (1989) found some theories that suggest that the mother may facilitate or maintain the abuse in order to reduce the stress within the family or the marital relationship. She argues that gender bias may have interfered with the clinician's thoughts regarding the source of incest behaviour. In this sense, the mother, rather than the perpetrator, becomes the focus of attention. MacKinnon and Miller (1985) support Cammaert (1989) in this view that there is often a shift in the clinical focus which can lead to blaming the mother for the abuse. They state that "therapists are left with messages that mothers, and not fathers, are to be held responsible for fathers' sexual actions...it is left to mother to control men and protect their children from them" (p.96). Cammaert (1989) cites an article by Machotka, Pittman and Flomenhaft (1967) that identifies mothers as the cornerstone of family pathology. This suggests that in some way, by direct or indirect actions, the mother is responsible for the dysfunction in the

family. Cammaert (1989) continues on this theme to state that this concept is perpetuated because of "four ideas held by many clinicians" (p.311). They are:

(1) she [the mother] is the cornerstone of a pathological family (2) she is psychologically disturbed herself (3) she does not fulfil her roles as wife and mother because she is a poor sexual partner; she reverses roles with her daughter and deliberately leaves home through work and (4) she is collusive in providing opportunities for the incest to occur, pushing both husband and daughter into it and then turning a blind eye (p.311).

Cammaert (1989) attempts to refute the idea that mothers collude in maintaining the incestuous patterns of the family. She believes that there are more realistic explanations of the role of mothers within the family system. Cammaert (1989) argues that the status of women in our society and the inequality of relations between men and women have created a dependency by women on their husbands to the detriment of themselves and their families. As a result, Cammaert (1989) states that because of this situation mothers may be unable to effectively protect their children from sexual assault. Responsibility for the protection of children remains with the mother but she is not to be held solely accountable for the incest.

Haugaard and Repucci (1989) present a systemic view regarding incest as a symptom of family stress and this idea appears to be the most popular in the literature. Instead of focusing on individual problems, a wider view is presented that explains behaviour in terms of interactions. Thus, incest serves the function of maintaining the rules, boundaries and behaviour patterns already within the family.

This does not imply that the function is beneficial but it is used to keep the system and behaviours consistent to maintain balance.

An example is formulated by Haugaard and Repucci (1989) and it suggests how incest operates in the family. They state "that the father turns his sexual and emotional attention to his daughter in order to distance himself from his wife and reduce the tension within the parental relationship" (p.110). Haugaard and Repucci (1989) explain that the tension that threatens the marriage may be reduced between the spouses.

Conte (1986) and Larson and Maddock (1986) provide additional information that alleviates blame and considers the incestuous relationship from the family's viewpoint. All of these authors agree that incest serves a function within the family. Imposing meaning from external sources may create difficulties when searching for an effective treatment approach. Each individual family has their own motivations and purposes for the incest which may not always be apparent to the outside observer. Conte (1986) adds that incest is symptomatic of a dysfunctional system and that each member in some way "contributes to the development and maintenance of the problem" (p. 115). He also observes that each member may also contribute to "the belief that the problem (symptom) may not in itself have significance...have a meaning within the family which is not readily apparent in the behaviour" (p.115).

Larson and Maddock agree with Conte (1986) but add that the meaning of the incest may be derived from four particular patterns of interaction between the family members. They identified these as: the "affection-exchange process", the

"erotic-exchange process", the "aggression-exchange process" and the "rage-exchange process" (p.33-37). Larson and Maddock (1986) define the affection-exchange process of incest as a "father's engaging in a quasi-courtship process with their daughter in a misguided attempt to show affection and feel emotionally close" (p.33). This type of incest occurs because there may be a "lack of healthier, more normal forms of physical nurturing and affection available to family members"(p.33). Erotic-exchange process occurs when everyday interactions are sexualized: "The family appears to be bonded largely through its projections of eroticism into language, physical appearance, clothes, recreation and humour" (p.35). Larson and Maddock (1986) add further that sexual intercourse may or may not take place. The aggression-exchange process occurs in families where anger and hostility cannot be expressed in appropriate ways: "Aggression based incest families used sexualized anger to deal with their frustration and disappointment over various aspects of their lives" (p.36). Finally, in families where rage expression is the form of incest behaviour "the perpetrators acts out his/her existential rage upon a family member who is least threatening and resistant, typically a younger child" (p. 38). According to Larson and Maddock, "this is not focused anger, but a primitive expression of high energy affect resulting from longstanding frustration" (p.38). Larson and Maddock state that the affection-exchange process is the most common type of behaviour and rage expression as the most pathological.

Throughout the literature there is a consensus that the mother and daughter are part of an interaction pattern that is dysfunctional. In the past the mother has

been identified as having a greater role in the dysfunction than the father. It appears that more clinicians are challenging the blaming stance and expanding the theories to include all members as sharing the responsibility for incest.

Boundary

The concept of "boundary" is explored throughout a great part of the literature. The "boundary" of a family may be defined as the set of rules used to identify who is allowed to participate in a given activity within the family and how this activity is carried out (Minuchin and Fishman, 1981). Recently, clinicians have expanded the concept of boundary to include layers such as those identified by Larson and Maddock (1986). These authors present the idea that boundary disturbances can occur in four possible areas. Larson and Maddock (1986) list the areas as: "between the family and the social environment, between adult and the child generations, interpersonal role boundaries between family members and the intrapsychic within the family members" (p.28-30). The boundary disturbances that may affect the mother and daughter relationship are those between the adult and child generations and the interpersonal boundary between family members.

Within the incestuous family, the boundary between family and society may be quite rigid. Larson and Maddock (1986) explain that the family will create a strong boundary to protect themselves and the secret by insulating themselves from social feedback. The information that the family fears are the attitudes and values regarding sex related concerns. These may challenge the family's belief system and their rationalizations for the dysfunctional behaviour (Larson and Maddock, 1986).

Alexander (1985) refers to a system as "open" or "closed". These terms indicate how much interaction is allowed between the family and its environment. An incestuous family is defined by Alexander (1985) as being minimally open. The family does not isolate themselves completely because they have some basic needs that the social environment must meet. Larson and Maddock (1986) and Alexander (1985) all agree that because the family members isolate themselves, they must rely on each other to meet all of their own needs for "emotional support, reality testing and perception checking" (Larson and Maddock, 1986, p.28). Eventually the resources become depleted as the members become exhausted and the system becomes disorganized and chaotic with a fear of a potential breakdown.

A second layer of boundary, identified by Larson and Maddock (1986), concerns that which separates the adult and child generations. As family members exclude themselves from outside contacts with groups such as peers and friends, they must rely on each other to obtain gratification of their various emotional and physical needs. It appears that the children are required to facilitate the parents desires "regardless of age or developmental stage" (p.29). Larson and Maddock (1986) report that a parallel shift of responsibility occurs. Children begin to assume tasks that are appropriate to adults and parents abdicate certain important responsibilities "in order to compete with their children for limited emotional resources" (p.29). As the hierarchy in the family becomes displaced a chaotic atmosphere begins to permeate the household. Trepper and Barrett (1986) describe this process as the

blurring of boundaries within the family and between the generations. They state that each member becomes over involved with the other so that the roles, power, rules and hierarchy of individuals are indistinguishable. Haugarrd and Repucci (1988) portray four examples of family structure where the blurring of boundaries renders the family vulnerable to incest. In each case the family has created a context where there is confusion as to who belongs to the parental subsystem and sibling subsystem. Also, there appears to be a lack of responsibility displayed by the parents. Haugaard and Repucci (1988) identify a power imbalance created because of the difference in the authority of one parent over another. As the non-powerful parent aligns with the children, a blurring of boundaries takes place between child and parent. They add that either parent can potentially align with a child. The concern with this alignment is that it may result in over involvement with children. According to Haugarrd and Repucci, "this over involvement blurs the boundaries between the two subsystems, making it easy for the sexual boundary to be blurred also" (Haugaard and Repucci, 1988, p.124). For example, overinvolvement may occur when a child is pulled into the parental subsystem in order to fill in a void created by the physical or emotional absence of the other parent.

In her 1981 study, Herman found examples of blurred of boundaries between mother and daughter. She states that many of the mothers could not fulfil their parental roles due to illness, disability or child bearing. As a result, the daughters were required to perform many of the mothers' duties and, in order to keep the family together, the daughters obliged. These daughters began to receive special

attention from the fathers and often perceived this attention as their only source of affection. With the special position in the family and the need for attention, the daughters were often vulnerable to undesired advances by the fathers. Herman adds that, "under these circumstances, when the fathers chose to demand sexual services, the daughter felt they had absolutely no option but to comply" (p.83). The confusion of responsibilities and roles, the search for gratification of needs, the desire to exhibit loyalty to the family, and the disturbance in hierarchy all contribute to the blurring of generational boundaries.

In addition to the information presented on boundary issues, MacKinnon and Miller (1985) describe the boundaries around the various subsystems in the family. These subsystems are comprised of individuals involved directly or indirectly in some type of interactional behaviour. Their description states:

From a structural point of view, the family in which the father is sexually active with a daughter could be described as exhibiting an enmeshed father-daughter subsystem, a disengaged mother-daughter subsystem and a rigid external family boundary. The family would lack the ability to assert clear and consistent role and generational boundaries. Lacking a strong marital coalition, the parents would also be ineffective in maintaining a parental coalition (p.94).

A third area identified by Larson and Maddock (1986) is the interpersonal role boundaries between family members. In the incestuous family it may be presumed that each member is overly dependent on the other for the maintenance

of the existing behaviour and that any attempt at autonomy would be threatening. There are members in the family, usually a parent, who, through influence and power, are able to control the less powerful members. Those who find support and nurturance within the family give up their autonomy. The family becomes a conglomerate of "diffused personal boundaries" in which "the perception of each member's survival is dependent on the other members" (Larson and Maddock, 1986, p.30). Individuals lacking in self-esteem and self-differentiation become enmeshed and are unable to pull away. Koch and Jarvis (1987) describe the enmeshment that may occur between mothers and daughters as "symbiotic". This term sums up the over involved quality of this relationship within incestuous families. Koch and Jarvis (1987) define "symbiosis" as "a relationship in which two individuals are overly dependent upon each other to the detriment of both individuals in which neither can function adequately without the other" (p.96). They present a theory to describe the formation of this problem. It begins with the mother's lack of self-worth which she has developed by way of her own personal experiences. In order for the mother to find meaning for herself and self worth, she will attach to someone who will be significant in her life. The most convenient person is usually her daughter.

The relationship then fluctuates from excessive closeness to alienation, and a compromise becomes difficult and threatening. The insecurities that each person carries with them will feed the difficulties. This will be an unstable relationship because the daughter can never meet all of her mother's needs or expectations and the mother will be continuously threatened by the daughter's attempts at

independence. Koch and Jarvis (1987) suggest that, in order for treatment to be successful, one needs to be aware of the symbiotic nature of the mother and daughter relationship. Koch and Jarvis (1987) surmise that "the mother's ability to offer appropriate protection from possible future abuse is dependent on her ability to perceive her daughter as a separate individual who is deserving of and in need of protection"(p.94).

Finally, Larson and Maddock (1986) identify yet another area of boundary disturbance, the intrapsychic boundary. The authors state that this boundary has been structured within the individual in some maladaptive way. This distortion in meaning and interpretation of situations may not fit with how the outside environment views a similar situation. Therefore, conflicts are created and the family must react in order to protect itself. Denial has been recognized by Larson and Maddock (1986) as a mechanism activated during times of crisis. They present an example describing the conflict mothers experience when sexual abuse is disclosed by a child. On one level, the mother cannot acknowledge the abuse because of her own personal experiences; the pain is too deep. As a result, denial is engaged to protect herself from the overwhelming experience acknowledgement can bring. Taken a step further, Larson and Maddock (1986) state that the denial "enables families to engage in exquisitely distorted thought patterns which lead in turn to indicate rationalizations of symptoms or problem behaviours" (p.31). If this continues, the authors add that the patterns become ingrained and create resistance to change during treatment.

The distortion in the adult and child generations and the interpersonal boundary are the areas affecting the mother and daughter relationship. The disruption creates confusion within the child regarding her roles and responsibilities in the family. Children in these families perform adult tasks but are unable to meet their own needs for security and safety. It has been concluded that "parents abdicate some of their important adult responsibilities in order to compete with their children for limited resources" (Larson and Maddock, 1986, p. 29).

Intergenerational Transmission

Intergenerational transmission is a theory employed to explain how incestuous families may be created. The authors presented in this section speculate that many parents bring the experience of incest into the new family from their family of origin. The past experience is comprised of values, feelings and attitudes that sanction this dysfunctional behaviour.

Haugaard and Repucci (1988) and David Will (1983) believe that the early experiences of the parents within their own incestuous families affect their personality development and in turn affect the structure of the families they create. David Will (1983) states that "another clue to the importance of family transactional patterns in the genesis of incest is the tendency for such patterns to be replicated from one generation to the next" (p.230). He adds further that the victims will become parents and form a family in which further incest may occur. The spouses will choose partners similar to those of their own parents and in turn will recreate rules and structures resembling those they are familiar with. Haugaard and Repucci

(1988) suggest that different patterns may occur in the new families as parents attempt to resolve or master old issues. One pattern that may emerge can be connected to the inadequate nurturing of the parent as a child and how this deprivation is carried on into the next generation. Haugaard and Repucci (1988) offer additional support to this theory by citing the arguments of Parker and Parker (1986) that the neglect of parents as children will be a risk for the next generation. They also suggest that past neglect has created substantial anger and that this anger may be played out toward the new generation of children. This anger may be expressed in the form of incest.

Cooper and Cormier (1982) present the notion that incest is transmitted from one generation to another either through the mother or the father. They explain that if the mother was a victim, she will have incorporated certain values about power and a negative sense of herself. She may also lack the knowledge to cope appropriately with anger or nurture and protect her children adequately. The father also may transmit the pattern from one generation to another. Cooper and Cormier (1982) state that the father himself may have been a victim or a witness to incestuous behaviour. In both cases, the risk to the second generation is assessed as high if there has been prior exposure to incestuous behaviour and a lack of nurturance in the family of origin.

Gelinas (1983) offers an in depth analysis of how the process of transmission takes place. In summary, Gelinas (1983) states that the mother may have been a parentified child. Through a process of initiation and exploitation, the mother, as a

child, maintains the roles and responsibilities of an adult. As she assumes this position, her own mother may begin to relinquish her role. Eventually, with this mature responsibility but immature knowledge, and with other intervening variables, the child may become involved in an incestuous relationship with her own father. However, Gelinas (1983) states that within the second generation the victim is at risk in a "different relational context" (p.325). Gelinas (1983) adds that "when the relational imbalances of her family of origin remain unfaced and untreated she is at risk for contributing to a family structure which will repeat the incestuous family constellation and in which her husband will sexually abuse one or more of their daughters" (p.325). In this family the mother will assume a new role as the mother of the victim and wife of the offender. In addition, the mother's lack of nurturance creates a situation where she may be unable to nurture her daughter. The mother becomes so needy that she is unable to pick up on the cues provided in order to identify trouble within her family. The mother is unable to protect because she has not learned this skill from her own past.

Cooper and Cormier (1982) offer another suggestion regarding intergenerational transmission. They state that once the taboo of sexual abuse has been broken it is much easier to continue to break it within succeeding generations. The barrier has been crossed and it would be difficult to replace this deterrent.

Role Reversal

This pattern appears to be the most studied feature of sexual abuse in families (Koch and Jarvis, 1987). Cammaert (1988) describes this situation as

occurring when the oldest daughter is given most of the household responsibilities. These chores become "internalized and generalized until the daughter is meeting all of her father's needs including the sexual ones" (p.310). Sgori and Dana (1987) support this definition and add that, in the process of the role reversal, the mother and daughter begin to behave like siblings. The hierarchy is not respected by either individual. As the change takes place, the other children begin to see that the mother has difficulty setting limits and meeting other role responsibilities. They begin to treat her as a peer rather than a mother (Sgori and Dana, 1987). These authors further state that a rivalry and competition is set up between the mother and children for the father's attention.

Gelinas (1983) describes the process of parentification of the daughter: the daughter assumes the responsibilities of an adult while the parents abdicate this role. The daughter internalizes the responsibilities of the caregiver/nurturer and then develops an identity around this. Gelinas (1983) states that the daughter allows this to happen because of loyalty to her parents. As a result she begins to meet their needs to the exclusion of her own.

Finklehor (1978) and James and MacKinnon expressed in the clinical literature. While accepting that the mother may be in some way responsible for aspects of the marital breakdown, Finklehor (1978) states that clinicians have drawn attention to the pattern of role reversal as contributing to the incest. Finklehor (1978) clarifies this point by adding that the breakdown in the mother and daughter dyad is one aspect. This feature, combined with a defect in the relationship between

father and daughter as well as the marital relationship, creates a situation where the family is vulnerable to incest.

Herman (1981) challenges this notion of the collusive mother who abdicates her role to her daughter and then sets her up to be abused. She describes how most of the mothers in the incestuous families she studied relinquished much of the responsibilities to their daughters because they were ill, disabled or hospitalized due to disability, illness or pregnancy. Herman (1981) states that "economically dependent, socially isolated, in poor health and encumbered with the care of many small children, these mothers were in no position to challenge their husbands' domination or to resist their abuses"(p.78).

Role reversal challenges the hierarchical structure that allows for the setting of limits regarding inappropriate behaviour. The role reversal can be a result of the blurring of boundaries within the family (Myers, 1985). In treatment, the focus should be to restructure the positions in the family so that the mother assumes her role as a parent and allows the daughter to experience childhood.

The dynamics explored do not conclusively explain the creation and maintenance of abuse. Boundary, intergenerational transmission and role reversal are a few dynamics that have been examined in order to determine how they fit into the pattern of incest. The evidence necessary to verify this information is not extensive and is riddled with many questions. There is a need to continue to explore this area and to provide evidence to support more effective treatment modes.

Treatment of Mothers and Daughters

During the exploration of common themes within the sexual abuse literature, one can not ignore the continuous references to the importance of treatment for the mother and daughter dyad. There has been a suggestion made that the strength of the relationship between the mother and daughter may determine the future of family health (Herman, 1981). Herman (1981) states that, in order to bring the family together, the restoration of the mother and daughter relationship must be the first step. Giarretto (1978), as cited in Herman's "Father-Daughter Incest", state that "the essential nucleus is the mother and daughter. As soon as the mother communicates to her daughter that she wasn't to blame, then the repair process has begun" (p.145).

It is recommended in the literature that a variety of treatment approaches should be considered for the mother and daughter (Sgori and Dana, 1982). Individual therapy can be used to explore some of the personal and intrinsic problems expressed by them. In dyadic work, the focus becomes the relationship between mothers and daughters. Hoorwitz (1983) identifies the purpose of dyadic work as fostering "an alliance between them" in addition to helping "the mother play protective and nurturing roles toward the daughter..."(p.521).

Sgori and Dana (1982) stress the importance of bringing the two together in a session to discuss their relationship. Porter, Blick and Sgori (1982) provide some guidance regarding the areas to be discussed. They suggest that the therapist help mother and child explore the reasons for the communication breakdown between

them, as well as determine what prevented the mother from being a supportive resource for the child. If it has been determined that there is a problem with roles, Porter, Blick and Sgori (1982) state that this conflict must be addressed. It is important for the daughter to use the dyadic sessions to express her many feelings such as hurt, anger and betrayal. Meanwhile, the mother may express many of her feelings such as anger, jealousy, confusion, guilt and alienation. Sgori and Dana (1982) further state that at some point in dyadic therapy the mother must help the child understand clearly that the child was not at fault and that her mother will protect her from further abuse. They add to this the importance of ensuring that the daughter understands that both parents failed to protect her. When the mother is ready to assume responsibility for protecting the child from further abuse, a critical point has been reached and the potential for positive change is created (Sgori and Dana, 1982).

Anderson and Mayes (1982) consider dyadic counselling as the most effective means of resolving conflict between family members. During the dyadic sessions, the authors recommend that the focus of intervention should be the mother and helping her identify to herself and her daughter that the responsibility for the sexual abuse remains with the father. The mother must be able to tell her daughter that disclosure of the sexual assault was appropriate and that she is not blamed for either the abuse or the disclosure. Anderson and Mayes (1982) and Hoorwitz (1983) suggest that the child be encouraged to express to her mother the feelings of betrayal and the suspicion that the mother knew of the abuse, and that the child be permitted

to observe the mother's reaction to this information. Since the concern may be the mother's inability to provide appropriate protection to the child, another issue for treatment would be to have the mother recognize her role as a parent and protector of her children. She may not have learned how to provide protection to her child and it may be necessary to assist the mother to identify the appropriate behaviours associated with this task. In conjunction with this acknowledgment, it is recommended by Anderson and Mayes (1982) that the mother apologize to the child "for her inability to effectively carry it (her role) out in past circumstances" (p.41). Hoorwitz (1983) adds that the dyadic sessions can be used to establish new rules of behaviour within the family and in the relationship between the mother and daughter.

Cammaert (1988) emphasizes the importance of focusing on the mother's strengths. She believes that treatment should be aimed at building on the skills already present within the mother. It is felt by Cammaert (1988) that the focus should be upon strengthening the mothers' skills as a protector and enhancing the development of behaviours that are conducive to increased independence and self-worth. Cammaert (1988) also recommends group treatment as a supplement to the other treatment modalities. This medium can enhance dyadic work because it may increase the mother's awareness by incorporating information about the dynamics of sexual abuse. Also, with peer support provided, the mothers can be gently confronted regarding their responsibility for the protection of their children. The group process may continue to stress the innocence of the daughter within the

incestuous family and the need for the mother to "begin resuming an emotional relationship as mother to her daughter..."(p.319). Herman (1981) provides information regarding the point at which the therapist can begin to assume that healing has begun. Herman (1981) states:

The relationship is restored when the daughter feels that she has access to her mother, when she can turn to her mother with her problems and especially when she is sure that her mother will take immediate protective action if her father attempts to renew sexual contact or harasses her in any way (p.148-49).

It has been recommended that exposure to more than one form of treatment can be beneficial to the family. The treatment that takes place during individual and dyadic work can be enhanced when mothers are encouraged to also attend group therapy.

Group Treatment

Sgori and Dana (1982) agree that more than one form of treatment is necessary in order to meet the mother's need for emotional support, guidance and nurturance. They suggest that group work will expose the mothers to peers outside of their families, and that it could provide the opportunity for these women to address their issues with women who share similar experiences. Sgori and Dana (1982) add that the feelings of shame and stigma created by, and associated with the sexual assault of their children could be minimized by participation in the group. Peer support and confrontation may assist the mother in recognizing the reality of the incestuous situation. It can help her identify the role she played during the incest

with a goal of encouraging her to gain some insight into how to function better in the future. The authors also state that a group atmosphere offers an opportunity for mothers to develop and strengthen many skill areas that have been weak. It is also a safe place to experiment with their new knowledge.

Herman (1981) states that the group experience is more beneficial than other modes of therapy because the results may be more rapidly attained. She also feels that the results would be more complete than those from individual therapy alone. A sense of belonging is created within the group setting because they are sharing very personal and private information. Herman (1981) identifies three advantages to the group experience: "1) they provide comfort and practical help in a much more complete way than any counsellor...possibly can; 2) they provide mothers with a new, constructive social network, bringing her out of her seclusion in the home 3) they build self-esteem"(p.146).

The focus of the group experience can vary. Damon and Waterman (1986) suggest that the goals of treatment in the mothers' group should focus on helping the mothers accept that the sexual abuse really happened, provide them with information regarding the dynamics of sexual abuse, assist the mothers in protecting their children from being reabused, deal with their own abuse and help the mothers become more nurturing and positive toward their children.

Sgori and Dana (1982) list twelve treatment issues to work on in order to meet the above goals. They state that trust must be established between members in order to facilitate the ventilation of feelings. It is helpful for members to share

their past histories of abuse and to be nurtured by other members in a way that they never were in their childhood. As this process takes place, the self-esteem of these women will hopefully increase because of acceptance and the similarities found among the group. Confronting and working through the denial is another area recommended for exploration. Feelings of anger, conflicting loyalties, and of jealousy are encouraged because resolution can begin with their expression. A final area Sgori and Dana (1982) identify as important is the need to encourage and improve communication because it is a major area of dysfunction within the incestuous family. Mothers are encouraged to take the responsibility of improving the communication with the children in the family. The group environment can be a supportive and safe place for the mothers to continue in their efforts toward healing and growth.

CHAPTER THREE

PRACTICUM SITE AND PROCEDURES

The site chosen to fulfil the practicum requirement was the Community Resource Clinic located in the downtown core area of Winnipeg. This clinic is affiliated with the Faculty of Social Work and the Psychological Services Centre at the University of Manitoba. The Community Resource Clinic began its services in March 1990. It is a training centre primarily for students of social work and psychology. The mandate of this clinic is to provide therapeutic intervention to families who are having child and family related problems and living in the core area. There is special consideration given to providing services to Native clients.

There is no fee charged and client participation is voluntary. This student has worked in the field of child welfare where mandates are more rigid and often intrusive because the focus of intervention is the protection of the child. In such child welfare settings, the opportunity to examine family issues in depth, and to provide treatment to all family members is not feasible. The service is crisis intervention and case management. Any therapy that is required would be referred to specific agencies. The practicum at the Community Resource Clinic provided the opportunity to develop a relationship with the client without the complications of the worker carrying an authoritative role. A child welfare social worker carries a powerful mandate that sanctions the removal of control from parents and permits intrusion into the family's private life. This role would often create hostility, anger

and resistance to any change or intervention that was required. Much time was spent with families in attempting to reduce this resistance and obtain cooperation. This was an imposed service where the clients have little, if any, choices regarding assistance. Child welfare referrals are different from those clients who voluntarily come for help. Many times the clients are forced by the legal system or child welfare to attend therapy. The external threat imposed upon the clients encourages resistance. It appears that the client will react to the pressure in a negative manner and may then attempt to avoid complying with the social worker. When this occurs, the client is sometimes viewed as problematic or labeled as difficult and resistant. Child welfare becomes involved with clients who are often multiproblem families with rigid and inflexible patterns of coping, and who are afraid of change. These clients have the ability, through their actions, to intimidate and create feelings of inadequacy and rejection for the therapist. This in turn may lead the therapist to become resentful and therefore not as committed to overcoming the resistance and to creating an atmosphere of acceptance and help. The Community Resource Clinic has a mandate to treat all clients. However, those who refuse treatment are respected and not pushed to comply. The child welfare social worker is notified of their non-compliance and it is the social workers responsibility to follow through on this concern with the client. It is important to recognize the reasons for resistance and to overcome them in a manner that may interest the client to return for further assistance. The client will then have accomplished their goals and have addressed child welfare expectations.

In a therapeutic context, the atmosphere can be slower, more relaxed and more respectful of the clients concerns. This may reduce the client's anxiety and help them feel more comfortable when addressing difficult issues. Parents can be given more control and choices regarding what will occur within the sessions. The exploration of problems can occur at a pace that is comfortable for the client.

The experience of serving as a therapist provided the time both to explore the issues in depth, and to examine these issues as problems within the interpersonal relationships between family members. Also, there is more emphasis on examining the family's strengths rather than their weaknesses. Therefore, this can encourage a more successful outlook for re-establishing family health.

Referrals were made to the Community Resource Clinic by Child and Family Services agencies within the centre city area of Winnipeg. Occasionally a referral was accepted from agencies serving Native communities in Northern Manitoba who sought in depth assessments and specialized treatment.

Intakes were received by one of the many students practising at the clinic and then the referral was placed on a list. This student and her primary advisor, Dr. Barry Trute, reviewed this list and selected specific clients who were appropriate for the practicum. The criteria used to select clients were as follows:

- (1) The family would have experienced a sexual assault disclosure within the last two years.
- (2) The presenting problem would include difficulties occurring between the mother and daughter within these incestuous families.

(3) The daughters would range in age from approximately nine to sixteen years of age. The clients could be self-referred or be referred by the child welfare agencies.

Once the families were selected based on the above criteria, they were contacted and an appointment was arranged to begin the intake process. This initial meeting provided further information about the presenting problem and the suitability of the case for the practicum. Initially, five referrals were chosen. During the four month practicum, there was an addition of two cases which increased the caseload to seven. The caseload then decreased when three of the original seven withdrew from the program. The remaining four cases continued therapy until the termination date in September 1990. One of the seven families terminated their involvement after one month and another family discontinued the service after three months. One of the mothers from the original five discontinued her involvement after two months. The reason for the early termination of therapy will be discussed later in this report.

The original five referrals were composed of two mother and daughter dyads, two individual mothers and an adolescent. All of the children experienced sexual abuse by a family member. Two of the girls were abused by step-fathers, two others by brothers and one by a natural father. The daughters ranged in age from nine to sixteen. All male perpetrators were out of the home except for one. This particular perpetrator remained at home and as a result, the victim was removed from the home and placed with her brother and sister-in-law. All of the families, with the

exception of one, had Child and Family services involvement during the time of therapy. All of the mothers had experienced some form of physical or sexual abuse in their childhood. Four of the families were of Canadian decent and one family had immigrated from Portugal about 12 years ago. It is important to mention the ethnic background of this family because it was an influencing variable in therapy. The experience with this family provided insight into how the cultural values of an individual or family can be overlooked or misinterpreted.

Once the families were seen at intake, the student and her faculty advisor met to clarify the problems experienced by the dyads and to form a plan of intervention. A hypothesis was developed regarding the most troubling aspect of the family structure. The exploration of this structure was facilitated by examination of aspects of hierarchy, boundary, alliances, coalitions, triangles and themes such as "loyalty", "pursuer-distancer" and "protector versus controller". Supervision occurred on a weekly basis in order to track the progress of the student utilizing this form of therapy.

Dr. Barry Trute was the faculty advisor and provided primary supervision especially in the area of family therapy. Supervision occurred on a bi-weekly basis with audio and video tape assessments. Dr. Trute also observed this student during family sessions and shared his views regarding areas of improvement, weakness and strengths. A personal log recording specifics of case proceedings and notes on relevant readings was completed. The practicum committee members were Dr. Barry Trute, Dr. Harvy Frankel and Enid Britton. Professor Elizabeth Hill was available

on a temporary bases to assist with issues regarding children and mother/daughter relationships. Dr. Harvy Frankel provided primary supervision during Dr. Trute's absence. Dr. Frankel also shared information regarding techniques of family therapy and was available to attend the family sessions as a consultant. Ms. Enid Britton was one of the leaders in the mothers' group and provided this student with supervision during the group process.

Clients were seen either weekly or bi-weekly depending on the nature of the problem and the intervention required. The term of the practicum was four consecutive months, beginning in May and terminating in September 1990.

First Phase of Practice

This student began to observe and participate in sessions with the primary advisor prior to the four month practice block of the practicum. With the help of the primary advisor, the area of study was generalized to couples and families. These initial sessions were used to introduce the student to the techniques of family assessment and to basic intervention principles. The experience provided useful information regarding the issues that all families must face in order to cope with difficulties. It also introduced the student to a practice which focused on transactions rather than on individual treatment. Various skills such as the ability to create clinical questions in a relational context, to attend to family of origin issues and to build on client social and psychological strengths were learned.

Measures

One of the tools that was routinely used to help develop a more

comprehensive understanding of the family was the genogram. The genogram was helpful in identifying relationships, past history of abuse, intergenerational issues and other significant patterns and relationships. A family assessment was completed in all cases by gathering data about how the mothers and daughters perceived the problems in their relationship and how they interacted with one another. Additional information was gathered regarding their personal and family history and their experiences with problems and solutions.

Depending on each family's clinical situation, specific empirical assessment and service outcome measures were used. The measures could support or add more information to assist in the exploration of the areas of dysfunction. The measures were given as soon as possible, first in the initial contact with the family and then again at the point of termination. The clinical measures routinely employed were:

- (1) The Family Assessment Measure III (Skinner and Steinhauser, 1981)
- (2) The Beck Depression Inventory (Beck and Beck, 1972)

The Family Assessment Measure III is an evaluation tool used to support the clinician in assessing the family and in developing a hypothesis regarding the dysfunction. There are seven areas of family dynamics that are explored. They are: Task Accomplishment, Role Performance, Communication, Affective Expression, Involvement, Control and Values and Norms. A questionnaire is distributed to the members to be filled out. They are scored and these scores are placed on a graph. The graph gives a visual evaluation of family functioning. When a post measure is taken the graph can display whether any improvement has taken place. There are

three scales that can be used: the General Scale, the Dyadic Scale and the Self Rating Scale. For this practicum the General Scale was employed. It has since been suggested that the Dyadic scale might have been more appropriate because it focuses on the relationships between two individuals in the family rather than on the entire family unit. However, the General Scale offers response-style checks such as social desirability and defensiveness. The dyadic scale does not. The General Scale measures the interaction of all family members. The norms used for scoring were Adolescent-Normal and Adults-Normal family. The Family Assessment Measure III was employed with two of the dyads and with one individual.

The Family Assessment Measure III was developed by Skinner, Steinhauer, and Santa Barbara to measure specific concepts of a theoretical model of family functioning. This measure was developed from two previous attempts and its strength is its ability to differentiate information about separate areas of family functioning. It can assess the family from three perspectives using the General Scale, the Dyadic Scale and the Self-Rating Scale. Preliminary analysis of the Family Assessment Measure III was conducted on 475 families that were tested at various health settings in the Toronto area. Validity and reliability estimates were quite high for example when the coefficient alpha was employed the scales showed high scores. The overall ratings were .93 for the General Scale, .95 for the Dyadic Scale and .89 for the Self-Rating Scale. These scores indicate that the questions on the scale were being answered consistently among all interviewees and that the questions were addressing the concepts they were designed to address. Their overall ratings are

higher than the subscale ratings due to a larger population base. A multivariate comparison was used to determine whether the Family Assessment Measure III could be employed as a diagnostic tool. The statistics show that it is very reliable. The areas of control, values and norms, affective expression, role performance and involvement account for 84% of the between group dispersion. Therefore, the above areas have been found useful in predicting family dysfunction because they will report problems in this area (Skinner, Steinhauer and Santa-Barbara, 1983).

The second measure employed was the Beck Depression Inventory developed by Aaron T. Beck. The shortened scale was utilized in this practicum. The brief version originated from a study of 598 patients at the Philadelphia General Hospital and the Hospital of the University of Pennsylvania. It is a thirteen item questionnaire and each item contains four statements that range in severity. When the items are added, the total score can be compared to established ranges in the degree of severity of depression. Also, each item measures a separate feeling such as pessimism, guilt and work difficulty. This feature can assist in isolating particular symptoms of depression. It was discovered that, in order to obtain a high correlation with the original Beck, a minimum of 13 items are necessary. The brief version of the Beck has a correlation of .96 with the original and a .61 correlation with "clinical depth of depression ratings"(Beck and Beck, 1972, p. 84). Four of the six clients filled out the Beck Depression Inventory.

CHAPTER FOUR

TREATMENT OF MOTHERS AND DAUGHTERS

The impact of sexual abuse upon the relationships in the family can be destructive. It can be especially detrimental to the bond between the mother and daughter. The trauma that may potentially result from the abuse and from the consequences of disclosure can leave the mother and child feeling depressed, alienated, confused and angry. In addition, the child appears to suffer the most because they are left without the support and protection of an adult ally. Intervention aimed at resolving the issues of inadequate communication and problem solving, restoring consistent and clear boundaries and clarifying age appropriate expectations could enhance the relationship and increase the child's sense of security and stability. In the practicum, the goal of intervention was to address these issues in order to begin to alleviate the stress associated with the abuse and to strengthen the relationship between the non-offending parent and child.

Bonnie Bear

One of the biggest challenges of this experience involved working with a sixteen-year-old sexual abuse victim who will be referred to as "Bonnie". Bonnie came into therapy on a weekly basis from May until September 1990. She had been sexually abuses on a number of occasions by her brother. Her family did not attend therapy because Bonnie no longer lived with them. Instead, she lived with her

brother and sister-in-law in rural Manitoba. Prior to her placement with this extended family, Bonnie was in foster care--a hospital and a residential treatment facility. Bonnie was removed from her parents' care because they were assessed by the local child welfare agency as being unable to appropriately protect her from further victimization by her brother. Also, her parents did not believe Bonnie about the sexual abuse. She was referred to the Community Resources Clinic when she moved out of the area serviced by the Manitoba Adolescent Treatment Centre.

There were eleven members that comprise Bonnie's family (see Appendix A). The children range in ages from fifteen to approximately thirty-five. Bonnie could not recall the ages of the four oldest siblings. Both Bonnie and her brother, Carl, stated that a split occurred in the family between the four oldest and five youngest children. Living in the family home were the parents, Mr. and Mrs. Bear, two sisters and two older brothers. The four oldest siblings live out on their own, and three of them have spouses and children. Bonnie stated that she was not very close to these older brothers and sisters. She also added that she was not close to her mother. Mrs. Bear had a history of extensive hospitalization, apparently due to stomach troubles and mental health problems. Bonnie added that an aunt also had emotional difficulties which resulted in a "nervous breakdown". There is one surviving grandparent but Bonnie did not have very much contact with her. There is some extended family in rural Manitoba.

The split that occurred between the siblings seemed to be related to Mrs. Bear's health. The four oldest children remembered their mother as healthy and

attentive to their needs. At a point sometime after Carl left but while the youngest five children were still at home, Mrs. Bear became quite ill. It seemed that this illness influenced Mrs. Bear's ability to parent. Bonnie stated that her relationship with her mother changed after Mrs. Bear was hospitalized for the first time. Carl described the four oldest siblings as being very close, however, the younger children were more distant from each other. Carl also recognized that Mrs. Bear's illness occurred at a difficult time because the younger children still required extensive nurturance. Mr. Bear was described by Bonnie and Carl as uninvolved with the family life. They indicated that his perceived responsibilities included work outside of the home and the assurance that the child care role was transferred to the older sisters, Sara and Rita. Bonnie remembered Sara and Rita as extremely abusive and inconsistent in their discipline. They were very aggressive with the younger children and, if they disobeyed, Sara and Rita would administer physical punishment. Bonnie found their methods frightening but was unable to tell her mother because she perceived Mrs. Bear to be too ill and unable to respond to Bonnie's complaints.

The information that Bonnie shared regarding her family history was not extensive. Based on the information presented, an initial hypothesis was developed regarding boundary issues in the family. The boundary around the family appeared to be quite rigid. It seemed that the family did not allow outside information to infiltrate the existing structure. Their strong religious beliefs may have also helped to maintain the rules about who participated with the family and what role they were allowed to assume. When Bonnie disclosed the abuse, the family pulled together to

deny the allegations. Since Bonnie did not cooperate with them and deny or recant her story, she felt that she was rejected by her family. It appeared that the family was not flexible enough to cope with the additional stress that the disclosure of sexual abuse would create. Carl provided another example that suggests the rigidity of the boundary around the family. He stated that the family had always solved their problems without the help of others and that this was the desired method of coping with difficulties. Carl added that the family was very private. It was suspected that the privacy and need for secrecy was used as a method to keep the children under parental control. Because Bonnie left the family, she appeared to be no longer emotionally connected to her parents or to the remaining members. Bonnie stated that she did not wish to return home to her parents and that she had physically disconnected herself from specific family members such as her father and her abusive brother. Bonnie also stated that she was not ready to pursue an indepth relationship with her mother. Bonnie seemed quite angry at her parents because of the pain created by the lack of support, protection and nurturance.

Through Bonnie's description of family life after her mother's illness, it appeared that the home situation was very chaotic. Bonnie experienced herself becoming lost and confused by all of the activity and inconsistency within the family. She stated that the most difficult time for her occurred when she was not able to emotionally access her mother and was expected to listen to her abusive sisters. Bonnie described Mrs. Bear as being so ill at times that, when Bonnie asked for advice or help, she would disregard her. Bonnie stated that she would approach her

mother while she was sick in bed and describe to her mother the concerns about her sisters. Mrs. Bear would not acknowledge these concerns because she was preoccupied with her physical needs. After many efforts to engage her mother without success, Bonnie gave up and withdrew, telling herself to cope with the difficulties on her own.

The intergenerational boundaries between the mother and older daughters appeared to be distorted. A possible result of the child care responsibilities placed upon Sara and Rita due to Mrs. Bear's illness could be a confusion of hierarchy in the family and the parentification of the older daughters. The job of caring for the other children would continuously shift from Mrs. Bear to her daughters depending on Mrs. Bear's emotional and physical health. Again, Mr. Bear would not become involved with the children and preferred to remain out of the home. The parental subsystem was quite diffused because it allowed some of the children to carry out inappropriate parenting and caretaking tasks. There is some evidence provided by Bonnie that indicates the possibility of tremendous stress between the parents as a result of the illness. There was also some concern that Mrs. Bear may have displayed suicidal tendencies. Bonnie alluded on several occasions to her mothers' having expressed suicidal thoughts to her and to one incident when Mrs. Bear requested that Bonnie bring a knife to her. Bonnie believed that she had intended to cut her wrists. This incident was never discussed among the family and as a result some confusion remains regarding exactly what happened. Also, the family was split between those who believed, and those who did not believe that Mrs. Bear actually

attempted suicide. It was hypothesized that the circumstances surrounding the possible suicide gesture may be indicative of the patterns that created dysfunction in the family. It was evident that there was no stable hierarchy in control of the family and this lack seems to have created frustration and chaos within the family. The lack of a strong hierarchy may have left the younger children feeling insecure because the rules regarding punishment and loyalty were confused. The child who disclosed the abuse was required to leave the family, while the abuser remained at home to continue to terrorize the other family members, including the parents. Bonnie described how her brother would threaten to physically harm her parents when he was angry. It appeared that all members felt powerless to control what was happening to them.

A hypothesis could be offered regarding the sexual abuse in this family. The sexual abuse may be an expression of the chaotic nature of the family dynamics. The roles of the parents and children were unclear, the boundaries appeared confused and the family seemed physically and emotionally isolated. Also, there appeared to be some reliance upon each other for meeting the needs of individual members. This combination could potentially create an environment for dysfunctional patterns of interaction. To speculate further, using Larson and Maddock (1986) typologies, this may be an example of the aggression-exchange process. This process describes the perpetrator's use of violence and anger as an expression of frustration over other aspects of their life. Larson and Maddock (1986) add that "an adolescent male may sexually exploit his younger sister in retaliation for what he perceives as

abandonment or rejection by his father..."(p.36). Perhaps Bonnie was selected as the victim because she was the most withdrawn and was seen as less likely to disclose because of the silence imposed upon her by inaccessibility to a helpful adult. The learned response for Bonnie was that no one would listen to her problems or help her.

There were several issues that became apparent during the treatment process. One was the perception by the student that Bonnie was in a state of denial and would withdraw and not deal with the sexual abuse. Initially, Bonnie's behaviour was interpreted as denial because she did not wish to discuss her problems related to the sexual abuse. It was recognized later that her denial was an attempt at maintaining some control and self-protection in the sessions. Based on the content presented by the adolescent, it was assumed that her method of coping with troublesome feelings was to withdraw and ignore them. Efforts were made to engage her in discussion, but the harder she was pushed to disclose, the more Bonnie would withdraw. This silence was very uncomfortable and, as a result, a stronger and more confrontive approach was employed. From the beginning Bonnie stated that she was not comfortable expressing herself verbally and this discomfort was evident many times during the sessions. Her behaviour was interpreted as a way of maintaining control within the sessions. She was very effective in her use of this method because she kept this student struggling and chasing her to engage in therapy. Bonnie was sending the message that she required more time to establish a trusting relationship with the student. It was eventually understood that she needed to do this at her own

own pace, which was a very slow one. Throughout the time together, it felt as though the engaging phase was never completed. This experience emphasized the importance of proceeding at the clients pace in order to develop trust and a positive working relationship prior to diving into deeper problems.

Loyalty and abandonment were two other themes that emerged during therapy. Mrs. Bear was perceived to be caught in a struggle of conflicting loyalties between the victim and the perpetrator. Bonnie was very angry at Mrs. Bear because of her support of the perpetrator. Bonnie's anger could be understood because her lack of support resulted in Bonnie, rather than the perpetrator, leaving the family home. In therapy, Bonnie was gently assisted to recognize the difficulty Mrs. Bear was experiencing. In a family session with Bonnie's older brother Carl, he helped Bonnie to understand some of the struggle her mother appeared to be confronting. He added that "it is difficult to separate one child from another even under circumstances where you know one is wrong. You can't say one is more guilty or you love one more than the other".

Bonnie was struggling with similar concerns. She was caught between being loyal to the family or to herself while she decided what direction to take should she be required to testify against her brother. Bonnie recognized the difficulty she was facing. If she chose to testify against her brother, she would risk losing her parents and family and, if Bonnie chose not to testify, she would betray herself.

Two messages were received from her struggle. Bonnie's deliberations seemed to indicate that she was still somewhat connected to her family and that,

despite Bonnie's lack of self worth, there was a sense that she maintained some self respect. Some time was spent on helping Bonnie decide what course of action was most important to her and on helping her to feel comfortable with the final decision. Bonnie preferred to wait until the final moment to decide. It appeared that this process was too taxing for her. The end result was that she did not have to choose because her brother pleaded guilty.

Abandonment appeared to be another key element that created difficulty for Bonnie. There were some very important times when Bonnie required her mother's support, but when Mrs. Bear was unavailable to her. In order to cope with this perceived disinterest, Bonnie learned to withdraw and to deny her needs and her pain. Bonnie developed a sense that what she had to say was not important. This conclusion was further affirmed by her quiet way of speaking. The quietness appeared to be a method of controlling the session. It may be hypothesized that the use of her voice reflected her sense of self importance. During the session an attempt was made to emphasize the validity of her information, but it often appeared as though this attempt was sabotaged because repetition of her statements was required in order to hear what was said. When she was angry, Bonnie would not repeat herself, instead she would comment that the statement was not important. There were efforts made to encourage her to continue, but often she would lose interest and change the subject. Bonnie's difficulty in expressing herself was a very frustrating experience for the person listening to Bonnie. The sessions were beginning to focus on encouraging Bonnie to express herself more clearly so that the

tendency to disengage with her would not interfere with the therapy.

It appeared that communication within Bonnie's family was either indirect or non-existent. According to Bonnie, members would not clearly indicate to each other their fears, expectations and feelings. Messages were described as passing through others rather than being communicated directly to the individual they were intended for. It seemed that Bonnie had carried these experiences with her to the therapy session but that the student was unable to recognize Bonnie's style of communication until a problem occurred in a therapy session. Bonnie presented quite depressed during a session and stated that she was stupid and a failure. A number of specific questions were asked by the student who then concluded that Bonnie was suicidal. Based on past experience with suicidal teens, the student immediately responded with questions regarding her potential for a suicidal gesture. Also, Bonnie's sister-in-law was informed of the concern for suicidal behaviour. This resulted in Bonnie leaving the room quite angry. The potential for suicide was never resolved and, therefore, a concern was generated regarding the validity of the student's assumption. In consultation with the supervisor, it was learned that the issue could have been one of communication and not suicide. The intensity used to confront the suicidal subject left no room for the exploration of other possible problems. This incident challenged the rigid and over-focused style of the student. It appeared that the real issue was one of trust and of the need to be consistently aware of whether this trust has been established with the client.

In order to rectify the situation, Bonnie was invited back to therapy to resolve

this difficulty. Bonnie did come back and an attempt was made to clarify the conflict that arose from the last session. The incident resulted in the need to re-establish trust and to show Bonnie that she was heard and understood.

Another theme which became apparent was the chaos within the family and the violence that often erupted. It appeared that the more silent and withdrawn members of the family became lost and forgotten while the more aggressive members expressed themselves physically and violently. An incident occurred during a session where this observation became embarrassingly clear. A genogram of the family members was completed and all but one was accounted for on the map. In a state of confusion, a question was raised regarding this member. The reply indicated that the person in question was the one sitting directly in front of the student. A few minutes after this point the session ended. After carefully pondering the incident, an idea materialized regarding Bonnie's place in the family. It seemed that Bonnie's needs were neglected because of all of the activity and confusion in her family and because she had not attempted to make demands upon her parents to resolve these issues. Therefore, the hypothesis presented to Bonnie was that the oversight in the previous session may be indicative of her place in the family. Bonnie agreed that this incident reflected her feelings of alienation and isolation in the family.

During the sessions with Bonnie, it was obvious that she was struggling with feelings of guilt created by the disclosure and that she needed to hear from her parents that what she had done was the right thing. It appeared that many other feelings, such as anger at her family and herself, depression, lack of self-esteem and

the inability to trust because of the betrayal and loss of self-control that may occur after sexual assault, were experienced by this adolescent. Sometimes the sessions would attempt to focus on strengthening Bonnie's self-esteem or encouraging her to express her anger by letting her know that it was safe to do this in therapy. The limit of our time together, complicated by the continuous re-establishment of the therapeutic relationship, only allowed sexual abuse issues to be explored in a preliminary manner.

Measures

Two clinical measures were employed to assist the assessment and therapeutic process with Bonnie. The tools utilized were the Family Assessment Measure III and the Beck Depression Inventory. Bonnie answered the questionnaire from the Family Assessment Measure III regarding her family of origin (see Appendix B). The social desirability and defensiveness scores were in the average range, therefore, it may be assumed that Bonnie was presenting the problems in her family without response style bias. As a result, the other scales can be viewed with confidence. The areas that show a weakness are Task Accomplishment, Communication, Affective Expression, Involvement, Control and Values and Norms. This measure corroborated the hypothesis that this family was extremely chaotic.

Each member of the family was in a different stage of individual development but, due to the mother's continuous illness and the absence of parental support and control, many of their needs did not appear to have been met. Rather than supporting and encouraging each other to explore and develop interests outside the

family unit, the family discouraged interaction with the social environment to the detriment of all the members. Also, it appeared in session and was supported by the measures, that the members were emotionally separated from one another and hindered rather than helped each other with personal growth. The scale validated the clinical perception that the family boundary was very rigid and that there was little flexibility.

Communication was problematic between the family members because people were ignored, forced to withdraw their concerns or pressured to keep quiet about existing problems. It was suggested by the Family Assessment Measure III that family members did not openly communicate their problems but resorted to dysfunctional behaviours, such as physical violence or suicidal gestures, to express themselves.

Roles were very confused. The children had been exposed to different sets of parenting styles because of the transition of responsibility from the actual parent to the parent substitute and then back to the actual parent. This change produced much confusion for the children when they were presenting concerns, seeking help or needing nurturance. This family did not create a nurturing environment. Also, solutions to problems appeared unclear. An example of this lack of clarity occurred when the children were told to seek answers within the Bible, which they could not understand, or else the problem was ignored.

The scale of Task Accomplishment helped to confirm that basic family tasks were not being adequately completed.

Bonnie completed the Beck Depression Inventory before and after therapy.

The two scores indicated that Bonnie was in the severe depression category. In comparing the individual items from the two tests, all but three areas stayed the same. The three items that changed were self dislike, indecisiveness and fatigability. They each showed an improvement by one point. At the termination interview, when the post test was given, Bonnie expressed some concerns about how her life had no direction and how she felt that she could not contribute in any way. She was especially fearful of going back to school and failing once more. Bonnie stated that she did not know what to do because she was too "dumb" to do anything. This was a difficult session because it was the end of this student's involvement and it seemed to the student that little had been accomplished. These were complaints similar to those voiced at the beginning of the therapeutic involvement. What was even more important was this teen's obvious need to continue in therapy and to be given an indication of hope. It was important for the student to acknowledge that in cases like this, involving deep rooted problems emerging from complex family histories, progress in therapy would be a slow, long term process.

Mrs. Kelso

Mrs. Kelso was a thirty-three year old single mother. She has a nine year old daughter, Jane, who was abused by her sixty-five year old step-father, Mr. Kelso. The sexual assaults occurred over a period of approximately one-and-a-half years and involved fondling and intercourse. Mr. and Mrs. Kelso had lived together for three years and then married. Their marriage lasted approximately one-and-a-half years.

Mr. and Mrs. Kelso were divorced in the summer of 1990 (see Appendix C). Mrs. Kelso stated that there were marital problems prior to the disclosure and that this disclosure initiated the marriage breakdown. Mrs. Kelso did not discuss her childhood in depth, except to state that she had never been sexually abused. She did describe a history of unsuccessful relationships. Mrs. Kelso was a foster child until the age of sixteen. She then married Mr. Epp, Jane's natural father, and this union continued for eight years. Mrs. Kelso described Mr. Epp as physically and verbally abusive and he also suffered from an alcohol problem. When Mrs. Kelso discovered that she was pregnant, she left the relationship. The reason she gave for leaving was to protect Jane. Mrs. Kelso would have been concerned for the child's safety if she had remained with Mr. Epp. A brief amount of time elapsed before Mrs. Kelso became involved with Mr. Many. This common law union continued for four years. Mrs. Kelso stated that Mr. Many was a good surrogate parent for Jane and that it had been hard for her to terminate her involvement with him. Mrs. Kelso described the relationship as positive even though Mr. Many was involved in various affairs with other women. Mrs. Kelso left because she could not tolerate the circumstances any longer. Again Mrs. Kelso was on her own with Jane. This period was described as a happy time for them but also a lonely one for Mrs. Kelso. After many years of friendship, Mr. and Mrs. Kelso decided to live together. This decision was made by Mrs. Kelso after approximately three or four months of living on her own.

Mrs. Kelso and Jane were referred to the Community Resources Clinic by a local child welfare agency. The referral information stated that Mrs. Kelso required

counselling and support in coping with the sexual assault of Jane. Mrs. Kelso attended one session and decided that she did not require any help. Approximately four weeks later, Jane was apprehended because Mrs. Kelso continued her involvement with Mr. Kelso. Mrs. Kelso returned to the Community Resources Clinic after the apprehension in order to comply with the child welfare authorities.

The intervention with Mrs. Kelso was brief due to practicum time limitations. Mrs. Kelso requested a written contract from her social worker that outlined specific issues that needed to be addressed. This document would provide to the client a clear understanding of what was expected in order to have Jane returned to Mrs. Kelso's care. The contract was signed by the social worker and by Mrs. Kelso. It would be utilized as an evaluation tool at the end of therapy to determine if Mrs. Kelso had complied with the expectations.

Mrs. Kelso attended approximately ten sessions in total. One session was devoted to working with Mrs. Kelso and her daughter to achieve two different goals: the first, to open up a discussion regarding the abuse and the placement of responsibility; the second, to facilitate a session with Mrs. Kelso and Jane in order to observe their interaction and determine if this mother would be ready to have Jane return home sooner. The goal of this brief intervention was to assess Mrs. Kelso's ability to protect her child in the future. The child welfare social worker outlined criteria required to satisfy the goal of securing the return of Jane. Prior to the development of the contract, the child welfare worker, Mrs. Kelso and the student met to negotiate the conditions for therapy. One concern that became

obvious was that the visits with Jane might be used as leverage to encourage Mrs. Kelso to attend therapy. The position taken by child welfare was to discontinue visitation between Jane and Mrs. Kelso if Mrs. Kelso refused to comply with the expectations of the child welfare worker. This was not acceptable. A counter position was taken to help the child welfare worker understand that lack of visitation could be detrimental to their final goal of returning the child home. An agreement was finally reached that allowed visits to continue despite Mrs Kelso's response to therapy. This situation proved how easily one can lose sight of the importance of maintaining a strong mother and daughter relationship when mandates interfere.

Unfamiliar with the role of therapist and confused about the reasons for Jane's continued placement in foster care, the student temporarily lost sight of the importance of the relationship. This distraction resulted in Jane returning home a little later than was necessary. The confusion resulted from the question of who actually had the authority to decide whether or not the mother was able to protect her child. It appeared that Mrs. Kelso had taken some steps toward insuring Jane's protection when she returned home. Mrs. Kelso had completed divorce proceedings with the perpetrator and discontinued her involvement with him. This action should have alleviated the protection concerns. In consultation with the supervisor, it was determined that the therapist had no real reason to keep the child in foster care and that Jane's remaining out of the home was creating more difficulties for her. This information was shared with the social worker and, as a result, Jane was returned home to her mother's care.

In the process of advocating on behalf of the client, the relationship between the therapist and the client was enhanced. Initially, Mrs. Kelso was uncertain about trusting the therapist. There was a fear that an alliance had been created between the child welfare social worker and the therapist against the mother. Empowering Mrs. Kelso to speak on her own behalf, helping to clarify the confusion, and supporting her rights to visitation with Jane as well as respecting the child welfare agency's mandate, helped to establish in Mrs. Kelso's perspective the therapist's neutral stance. Mrs. Kelso could feel confident that the therapy would remain objective and that her needs would be respected and addressed and her disclosures would remain confidential. Any information to be shared with the social worker would be approved by Mrs. Kelso. All of this activity was used to promote confidence in Mrs. Kelso herself, in the therapy process and in her ability to regain control over her life. This also helped to break the resistance toward therapy.

Initially Mrs. Kelso was skeptical and admitted to coming for therapy because it was required. After the negotiation for continued visitation with Jane, Mrs. Kelso became aware that she could gain something from counselling. The feeling of getting something out of therapy was an important element in turning resistance into co-operation and growth. Mrs Kelso felt more open to discuss personal issues that had created conflict in her life.

Throughout the sessions, Mrs. Kelso was continually encouraged to ask questions and to state her displeasure and confusion. Mrs. Kelso stated that this was something denied to her in the past.

In order to begin to hypothesize on the function of the sexual abuse, a description of the dynamics in Mr. and Mrs. Kelso's marriage will be presented. Mrs. Kelso stated that the relationship with Mr. Kelso was beginning to deteriorate prior to the marriage. The two of them married hoping that this would stabilize their situation. Immediately after the marriage, Mrs. Kelso noticed a change in Jane. She had regressed in her behaviour and displayed temper tantrums with other babyish mannerisms. Mrs. Kelso interpreted this as a method of getting her attention away from Mr. Kelso because Jane was jealous of the relationship. Both Mr. and Mrs. Kelso began to focus on Jane and labelled her a problem. Rather than attempt to resolve their own issues, Mr. and Mrs. Kelso allowed Jane to become the centre of attention. At some point Mr. Kelso and Jane developed a "cross generational coalition". The adult and child boundary was crossed and a sexual relationship developed between the two. Perhaps the sexual abuse served the function of reducing the tension in the spousal subsystem. This hypothesis was difficult to confirm without access to all members involved.

Mrs. Kelso could not recall any indicators to alert her to this dysfunctional activity. Apparently the assaults would occur when Mrs. Kelso was not at home. Mrs. Kelso stated that she did not suspect anything because of her complete trust of Mr. Kelso. Mrs. Kelso described how careful she was in selecting this partner because of her past history with an abuser and philanderer. So, for Mrs. Kelso, the betrayal of trust was a very serious issue.

There is information in the literature (Herman, 1981) that supports the fact

that often mothers are unaware of the sexual abuse of their children. There may be many reasons for this to occur, one of which may be that some mothers implicitly trust their partners and do not expect the assault to happen. This may also be a reflection of the mother's inability to judge and select appropriate partners.

It appeared that within this relationship a pattern may have been created between Mr. and Mrs. Kelso. The pattern can be described as that of dominant spouse and passive spouse (Haugaard and Repucci, 1989). Mr. Kelso was identified by Mrs. Kelso as the dominant partner and Mrs. Kelso would relinquish most of her control and independence to him. Many times she would suppress her beliefs that something was amiss and give in to Mr Kelso's assurances that all was fine. Mr. Kelso would also verbally abuse Mrs Kelso by telling her that she was stupid and that her decisions were worthless. She developed a mistrust of herself and became dependent on Mr. Kelso for decisions and attention. Mrs. Kelso also felt that she had become very dependent on the relationship and spent most of her time maintaining it, while she simultaneously, isolated herself from friends and family who might have been more supportive. As a result, Mrs. Kelso attended to the needs of her husband but neglected herself and her daughter. This dynamic may have encouraged a situation where both mother and child were vulnerable to abuse.

The initial area of family structure that appeared problematic was the boundary around the parental subsystem. It was discovered that the rules regarding privacy were not very clear. Mrs. Kelso said that Jane often walked into the parental bedroom while Mr. and Mrs. Kelso were sharing an intimate moment. No rules were

established regarding closed doors or knocking before entering a room. Also, Jane had access to pornographic movies because they were not locked away, and it is assumed by Mrs. Kelso that Jane may have viewed them on more than one occasion. When the sexual abuse disclosure was made, Mrs. Kelso assumed that Jane invented her story after having watched the pornographic movies. As a result, Mrs. Kelso refused to believe Jane and accept Mr. Kelso as the perpetrator. It required intensive work with Mrs. Kelso to help her to understand that a movie was not at fault. A discussion ensued regarding how Jane was at risk for abuse partly because of the lack of boundaries and the lack of respect for privacy. In therapy Mrs. Kelso required education regarding the dynamics of the abuse and the parent's responsibility to protect the child from further harm. Some of the work with Mrs. Kelso centred on establishing appropriate guidelines around privacy and educating her about the need to respect this privacy.

One of the personal issues Mrs. Kelso struggled with was that of loyalty. This struggle was very pronounced during the time of Jane's disclosure and the investigation. She had difficulty believing her child and continued to expose Jane to Mr. Kelso in hopes that all would resolve itself. Mrs. Kelso was also receiving advise from her church to maintain the relationship with Mr. Kelso. When the child welfare authorities discovered what Mrs. Kelso was doing, Jane was apprehended. Mrs. Kelso was caught in the middle. To be loyal to either side meant the loss of support and love from the other. This was a difficult choice to make and a very painful reality to face. During therapy, Mrs. Kelso was gently challenged on her

belief that Jane was fabricating the abuse from a pornographic movie. Mrs. Kelso began to realize that Jane could not make up such an indepth account of sexual abuse without having direct knowledge.

An exploration of the relationship between Mr. and Mrs. Kelso helped this mother understand how Jane was discredited by her role as a problem child. Once Mr. Kelso was out of the home it became easier for Mrs. Kelso to clarify some of the confusion surrounding the sexual abuse. It was suggested that if Mr. Kelso could convince Mrs. Kelso that Jane was a trouble maker, then Mrs. Kelso would be reluctant to accept Jane's complaint as reality. Instead the complaint could be framed in such a manner that Jane would be disregarded because her motive would be perceived as creating problems in the relationship. Once Mrs. Kelso began to understand the dynamics that were occurring at home, she was able to focus all of her energy on becoming a stronger parent so that the child could return to her care as soon as possible.

One of the areas that was important to address was Mrs. Kelso's lack of social support and networks. Mrs. Kelso relied heavily on Mr. Kelso and the church, both of which betrayed her when she needed them the most. Part of the therapeutic process focused on facilitating the development of support in the areas left vacant. Some ideas and information were shared regarding how to access more support. The isolation imposed upon Mrs. Kelso had limited her ability to acquire information or establish peer networks. A situation was created where Mrs. Kelso was immersed in the relationship with her husband and, as a result, seemed to be out of touch with

Jane's emotional needs. With more support available to Mrs. Kelso, it was hoped that the need for the involvement of outside agencies would diminish. It was better to promote the support of natural helping networks such as friends, neighbours and family because they may be more consistent and less threatening.

Another area covered was the continued protection of Jane. In therapy, Mrs. Kelso was assisted in developing a safety plan to protect Jane from further harm. This plan was also used to demonstrate to the agency that Mrs. Kelso was ready to resume parenting. Several sessions were spent discussing the abuse of Jane and its impact upon the child. This was followed by a session about how Mrs. Kelso could create an environment of safety. The importance of talking to the child about the abuse, of placing the responsibility for the abuse with the appropriate person, of redirecting the blame from the child to the perpetrator and of reassuring Jane of protection was emphasized. This material was also introduced into the dyadic sessions with Mrs. Kelso and Jane.

Mrs. Kelso identified some personal issues that may have contributed to her inability to protect Jane. She stated that her lack of self confidence, trust in herself and feelings of powerlessness resulted in situations where others were allowed to influence her decisions and actions. Some work centred around the building of Mrs. Kelso's self esteem by providing opportunities in therapy for her to take control and to resolve problems. This proved to be successful and Mrs. Kelso felt stronger and more confident of resolving her issues by the end of therapy.

An atmosphere of neutrality and safety was established in the therapeutic

sessions in order to facilitate the expression of feelings more comfortably. Mrs. Kelso was able to share her feelings of anger, initially projected at the church, the social worker and finally toward Mr. Kelso. Later she could admit to being angry at herself for failing to protect Jane, for allowing Jane to be hurt and for the disruption of their lives. Mrs. Kelso discussed her disbelief and denial at the disclosure, her shame and guilt for doubting Jane and for returning to Mr. Kelso and trying to protect him. She was able to begin to grieve the loss of stability and hope for a normal life with Mr. Kelso and Jane. In order to provide hope for the future, Mrs. Kelso was encouraged to explore how she could create change in her self and her situation to rebuild the lost trust and make the relationship with Jane stronger. Also, Mrs. Kelso was also helped to find a balance between fulfilling the roles of parent while still meeting her own needs without feelings of guilt and selfishness.

Many issues were covered during the brief encounter with Mrs. Kelso and Jane. At the end of the practicum, one more informal contact was made with Mrs. Kelso. Jane had returned home and was doing well. Mrs. Kelso had registered for assertiveness training and was attending a mothers group once a week to develop support and acquire more information regarding sexual abuse and its impact.

Measures

The Beck Depression Inventory and The Social Network were the evaluation measures employed with this client. Mrs. Kelso was given a pre and post test using the Beck Depression Inventory. The initial test indicated a total score in the minimal level of depression range. This coincided with the apprehension of her child and her

feeling of hopelessness and anxiety while she was unable to foresee her way through all of the confusion. Mrs. Kelso's post test showed improvement because her score indicated no depression. At the time Mrs. Kelso completed this test, her appearance and attitude had changed and seemed quite positive. The items on the scale that indicated a decrease in depression were dissatisfaction and self dislike. When Mrs. Kelso began therapy, she was feeling very angry with herself for having put Jane at risk. Mrs. Kelso stated that she had begun to develop an awareness of how others influenced her even though she was aware that they were wrong. Mrs. Kelso felt very humiliated and remorseful for having influenced such a disruption in her own and her daughter's life. Once she was able to gain control over herself and the situation, Mrs. Kelso felt more hopeful and began to create some positive changes in her life.

With this individual, one other scale was employed. This was the Social Support Network. It is a tool used to help identify the support resources available and those that are lacking. The scale is divided into categories that outline the extent of contact with professionals, friends and family. On a separate form, group support is explored. The three areas are divided further to obtain identifying information and to confirm the type of support that was given by those described. In reviewing Mrs. Kelso's inventory, it was observed that she had very few resources available to support her. She was deficient in the area of social activities. This was discussed with Mrs. Kelso in terms of the importance of getting out of the home and engaging in activity with others. Mrs. Kelso stated that her isolation was partly due to her relationship with Mr. Kelso. He was quite concerned about her participating

in any activities outside of the home. Using the Social Support Network, Mrs. Kelso was shown that she did not have many support systems and then she was encouraged to establish a stronger bond with those family members and friends with whom she had recently lost touch.

Dyads

Another form of treatment that was incorporated into this practicum was dyadic work with mothers and daughters. There were two sets of mothers and daughters, the Violet family (Mrs. Violet and Beth) and the Tony family (Mrs. Tony and Millie). Both client sets came into therapy seeking assistance with problems related to the sexual abuse of the daughters.

The Violet Family

The first dyad to be described is the Violet family. This family was composed of Mrs. Violet, a forty-three year old single mother, and five children: Jack who was twenty four, Fred who was twenty three, Mike who was twenty one and two daughters, eighteen-year-old Shirley and fourteen-year-old Beth (see Appendix D). The two daughters were living at home with their mother while the boys were living on their own. Mrs. Violet and her husband had been divorced for a number of years. Mr. Violet remarried and now resides in British Columbia. He has cut himself off both emotionally and physically from his original family. The oldest son, Jack, had assumed many of the parenting roles left vacant by his father's departure; these roles included financial and emotional support for Mrs. Violet while she was not

employed. The second oldest son, Fred, had been convicted and incarcerated for sexually abusing his sister, Beth. There was some unconfirmed suspicion that Shirley may have also been abused and that the other two brothers may have been involved. At the time of disclosure, the child welfare authorities requested that all the boys move out of the family home so that Beth's safety would be assured. Their departure from home put additional stress on Mrs. Violet because she depended on them to assist her after her husband left.

Beth and Shirley had a very conflictive relationship. One hypothesis regarding the reason for their conflict, that was clinically explored, questioned whether or not the daughters became involved in arguing to engage their mother and distract her from dwelling on her problems. Mrs. Violet had stated that she became very depressed when she reflected upon her life. This depression immobilized her to the point where she was emotionally inaccessible to her daughters. Also the depression seemed to interfere in daily routines such as going to work.

Beth and Shirley would begin an argument over an object that was missing or something that was said between them. Often, it would escalate until there was a physical confrontation between the sisters. The girls would call Mrs. Violet in to be the judge and to determine who was right. Often Mrs. Violet would try to avoid getting involved but the conflict would continue until she was engaged. Mrs. Violet found this frustrating and preferred to have the girls resolve the problems themselves. They would usually succeed in distracting her and, as a result gain, the desired attention in addition to dissipating some of her depression.

Sometimes Beth's behaviour could be interpreted as protective toward her mother. During the sessions, Beth would often make a gesture toward her mother that was perceived as helpful. When questioned about her actions, Beth agreed that she was being protective and helpful and did not want anyone to take advantage of or hurt her mother. An example of this protective behaviour related to Mrs. Violet's difficulty understanding the English language. The family was from Portugal and the cultural values, beliefs and language remain with Mrs. Violet. Beth assumed some responsibility as an interpreter and the link between the new and the old country. Beth spent a lot of time discussing how poorly other family members treated her mother. She stated that they should be punished in some way for taking advantage of her mother. It appeared that Beth used this position to get closer to her mother while at the same time attempting to establish an alliance with her against the other family members. This effort could be framed as a positive gesture because Beth was doing what she could to meet her needs and to find an ally in the family. Beth discovered how powerful developing an alliance could be with someone who she perceived as having some control in getting her needs met. This will be discussed at a later point in this description.

There appeared to be a split within the family between the boys and the girls. One of the major issues for Beth in the relationship with Mrs. Violet was the mother's continued involvement with Fred. Beth stated that she disassociated herself from him and expected her mother to do the same. Mrs. Violet's continued contact with Fred was perceived by Beth as belief that Fred was innocent and that Mrs.

Violet did not believe Beth regarding the abuse. Mrs. Violet was caught in a position of divided loyalties. She felt compelled to continue contact with both sets of children but Beth put pressure on her to forfeit her relationship with the boys. Mrs. Violet attempted to explain to Beth that this was a difficult thing to do because she was dependent upon their financial and emotional support. Mrs. Violet attempted to explain to Beth that she had a bond with the boys regardless of what they had done. This was a frustrating position for Mrs. Violet because she risked anger and harassment by her daughters or the loss of much needed support from her sons.

The establishment of alliances and the challenge to loyalties in the family appeared to be a pattern that occurred in other relationships. Beth appeared to be the most active person engaging in this behaviour. Beth attempted to try and align herself with her mother against other family members. During the dyadic therapy sessions, Beth was helped to understand the difficult position she was creating for her mother when she pressured her to take a side. Mrs. Violet was encouraged to share her frustration with Beth regarding this situation, and to describe what role she would rather assume. Mrs. Violet preferred a role of neutrality. A dialogue was facilitated between the two in order to resolve the reason why Mrs. Violet chose this position and how she could be supportive of Beth while continuing her contact with the boys. It seemed important to attempt to shift and neutralize loyalty positions within the family, especially with Beth and her mother. Beth stated that her mother did not believe her about the abuse and that she had been punished for creating the

disruption in their lives. One of the hypothesis considered regarding this situation was that Shirley and Mrs. Violet were both very angry at Beth for the disruption and that they were punishing her in their own way. In order to reduce the tension in the household, it seemed necessary to have Beth and her mother begin to discuss the consequences each had suffered as a result of the abuse and to encourage them to understand what it was like for the other person. Communication between them had been very open and comfortable prior to the abuse, but afterward it shut down. A session was spent discussing the abuse and what had occurred after the disclosure. Mrs. Violet and Beth were encouraged to express their feelings in an effort to clarify some of the misperceptions they had of each other. Mrs. Violet was able to state openly that she believed Beth and would try to be more accepting of such difficult information in the future. It was obvious while observing them in session and on tapes, that they enjoyed each other and were both struggling to regain some of the relationship that was lost because of the tension.

Another strain to the relationship occurred as a result of child welfare's over involvement with Beth. Beth had been involved with child welfare prior to the therapeutic contact. She was successful in establishing a strong bond with the social worker over and beyond that of her own mother. Rather than discuss problems or other issues with her mother, Beth would contact her social worker, get advice from her, and then pass this information on to her mother. The social worker had inadvertently disempowered Mrs. Violet and added to the conflicts at home. An example of this disempowerment occurred when the social worker and the daughter,

during the initial interview, described Mrs. Violet as being "weird". They provided information about an incident which seemed to confirm their perception. They stated that after the disclosure was made to the police, Mrs. Violet had cut off all her hair. Both the social worker and Beth stated to the student that Mrs. Violet was probably "crazy". This action was later explored in session with the mother and daughter. This incident was explained as a gesture, not of pathology, but of anger at oneself for perceiving to have failed at parenting.

From a structural perspective, the parental subsystem within the family had been challenged and replaced by a social agency. In order to correct this, the power and responsibility for parenting had to be shifted back to the mother, and the agency had to withdraw its intrusive involvement. It appeared that there was no real need for the agency to continue their services because the protection issues had been resolved when the perpetrator left home. The social worker was advised by the student that her actions may have taken on the parenting role to the detriment of the relationship between mother and child. This situation produced some questions about who would be the most appropriate case manager with this family. It had been suggested in case consultation that the student (or therapist) assume the responsibility for case management and have child welfare reduce their contact with the family. This was recommended because the potential for child welfare to become over-involved with the client appears to be high. This over-involvement can then create problems because the social worker may be unable to distance herself from the family and remain neutral when interacting with various family members. The

therapist may have an opportunity to be more neutral and objective when making assessments and case decisions because she is not responsible for the protection of the child.

Two incidents occurred that alleviated the emotional triangle between Mrs. Violet, Beth and the social worker. The most significant was the termination of the social worker's involvement with the case. Also, a meeting was established to include the mother and daughter, the social worker, the student with the student's supervisor acting in the role of consultant. The purpose of the conference was to determine the reason for therapy and to evaluate whether or not Mrs. Violet and Beth were committed to the process. Mother and child did not attend. The session was then used to help the social worker identify how she had contributed to the difficulties in the family. It was a very positive experience. The worker had not realized the difficulty she had created and added that this information would be helpful to her in the future.

One of the major challenges in working with this mother and daughter was keeping them engaged in therapy. Mrs. Violet and Beth were always reluctant to attend because they felt that there were no problems in their relationship. When Beth first came into the office with her worker, she stated immediately that she would attend only three sessions. Beth added that she was at the initial session because her worker convinced Beth to give therapy a chance. As a result, the issue was one of attempting to identify who was most concerned about the problem and what would be gained from the therapeutic process. In order to assess this, it was

necessary to consider Mrs. Violet's and Beth's perceptions of what constituted "therapy". The social worker was convinced that it was extremely important for mother and daughter to attend because she estimated that the conflicts were serious. The social worker was prepared to apprehend Beth if therapy was not pursued by them.

When Mrs. Violet and Beth attended their first session together, they were unclear about what it was they were suppose to do in counselling. Mother and daughter stated they would be interested in therapy if it helped the other, but they felt that there was nothing to gain for themselves. These attitudes created difficulty with the therapeutic process because Mrs. Violet and Beth would not come to their appointments. A meeting was arranged with Mrs. Violet, Beth and the student to discuss the value of therapy and to attempt to reengage them in counselling.

In consultation with the supervisor, it was determined that, in order to obtain co-operation, one must identify the member with the most power in the family. Even though the social worker's intervention created some disruption, Mrs. Violet was still recognized as the one with the most leverage. It was important to interest her first so that she could engage Beth and possibly Shirley. The advisor and the student discussed various methods of seeking the mother and daughter's co-operation to attend therapy. The method chosen was also perceived to be the most comfortable and most effective in achieving the goal. An appointment was arranged to meet at the family home and to discuss their commitment to therapy. Their home was selected as the site for the meeting because of the familiarity and control it allowed

the family. In this setting, the student was a guest and was required to abide by Mrs. Violet's expectations.

The meeting in their home seemed to be productive even though they declined the invitation to return for therapy. Mrs. Violet and Beth appeared quite comfortable as they openly discussed their feelings about the abuse and each other. Beth was able to tell her mother how she felt about Mrs. Violet's disbelief. Mrs. Violet reassured Beth that she believed her and would be less tempted to deny the truth in the future. Beth stated that she trusted her mother and would seek her support in the future. Mrs. Violet told Beth that the disclosure was necessary and that she was not responsible for the family breakdown. She added that the responsibility for the sexual abuse belonged to Fred. They began to negotiate new rules of behaviour and expectations to cope with future difficulties and to ensure protection for Beth against further abuse.

Prior to termination of the practicum, a letter was sent to Mrs. Violet and Beth and it stated that they would be welcome back to the clinic if they wished to pursue assistance with further difficulties.

Measures

The Violet family completed the pre-test on the Family Assessment Measure III (see Appendix E). This was the only evaluation used with this client. The post test was not completed because Mrs. Violet and Beth discontinued their involvement in therapy. There was some concern regarding the validity of the mother's pre measure. It was feared that her comprehension of English would not be very good.

Mrs. Violet had requested to have many of the questions explained to her. There was a fear that the explanation may have biased her responses.

The other two measures were not employed because of the language concerns and the difficulty of maintaining this family in therapy. Although there was some concern regarding the validity of Mrs. Violet's responses, it was discovered that her scoring indicated a fairly accurate perception of family functioning. This conclusion was reached in consultation with the faculty advisor after the family terminated therapy.

Beth's score was low on the desirability and defensiveness scale; therefore, it may be assumed that she was experiencing some anxiety. This anxiety may have influenced her to exaggerate the scores, thus presenting the difficulties at home as more severe. Mrs. Violet's score was in the average range, which indicated no response style bias. The problem areas identified by Mrs. Violet were Communication, Affective Expression, Involvement and Control. There was a "cross over" of scores that occurred in the areas of Affective Expression and Control. A "cross over" is a reversal in the normal pattern of family scores and draws attention to strong perceptions about family functioning. The daughter felt that most areas of family functioning were more problematic than did her mother. Unlike her mother, Beth did not perceive Affective Expression and Control in the family as being much of a problem. The Family Assessment Measure III profile supported clinical observations made in session. Mrs. Violet complained that Beth did not share enough information and feelings with her at home. If this were to occur more often,

Mrs. Violet felt that the problems could be worked out at home rather than with outside intervention. Also, Mrs. Violet was frustrated with the conflict between her daughters and she expressed a desire to have the girls find a more peaceful resolution to their problems. In the sessions, it was observed that Beth's behaviour contradicted Beth's statements about hating the conflicts with her sister. It appeared that Beth enjoyed arguing with her sister and was not about to alter this pattern. In addition, Beth felt that her sister deserved the constant harassment because she was to blame for the majority of problems at home.

The area of Control appeared problematic and Mrs. Violet was able to confirm this by indicating that she had difficulty keeping Beth at home. Beth felt that she did not need further control because her mother knew where she was when she was not at home.

Mrs. Violet and Beth both agreed that Communication was a problem. The subject of communication was explored during the sessions because Mrs. Violet and Beth agreed that they had stopped talking to each other after the disclosure of sexual abuse. Beth added that prior to the sexual abuse she would spend more time talking with her mother. The rating on the scale confirmed the observation that this was a problematic area.

Values and Norms were perceived as more of a problem by Beth than by her mother. One of the hypothesis developed to address this discrepancy concerned the traditional and generational differences between Beth and her mother. Beth believed her mother was old-fashioned and that Mrs. Violet could not understand what Beth

was going through. There may be conflict in the area of discipline and expectations because of the different value systems each has incorporated from the society in which they grew up.

The Tony Family

Mrs. Tony and Millie were involved in the most intensive contacts of all the cases in the practicum experience. They attended weekly sessions from May until September 1990. This involved twelve contacts which combined individual and dyadic work. A considerable amount of information was gathered during the therapeutic exchange. To expedite this report presentation, specific areas of the mother and daughter relationship will be focused upon.

Mrs. Tony is the single mother of fifteen year old Millie. Mrs. Tony has had three previous relationships, two of which were extremely abusive (see Appendix F). The biological father of Millie is remarried with another family of his own. Mrs. Tony had met this man when she was thirteen and had maintained a relationship with him until she was sixteen and became pregnant with Millie. They never married. At the time, Millie's father was physically abusive to Mrs. Tony and had a serious drinking problem. Millie knew of her father but until this past summer she had never met him.

After approximately one-and-a-half years after her separation from Millie's father, Mrs. Tony became involved with Bert. They were married for four years. Both Millie and her mother remember this as a stable and happy time. Bert was

described as a good parent to Millie and Millie stated that she could recall fond memories of this man. Mrs. Tony left him and she added in session that this was a mistake. Mrs. Tony stated that she became involved in drugs and alcohol at the time and blamed her actions during this period on the two addictions.

Mrs. Tony then became involved with Jedd for four years. This person was extremely physically abusive to Mrs. Tony and he sexually abused Millie. Mrs. Tony left Jedd immediately upon hearing about the sexual assault from Millie. Mrs. Tony and Millie made several attempts to escape from Jedd but he continued to pursue them. When Jedd found Mrs. Tony, he became violent and assaulted her once again. Mrs. Tony and Millie were extremely frightened of him because of his threats and violent actions. Jedd was finally incarcerated for having raped and murdered an eleven year old girl. Mrs. Tony continues to be afraid because of his threats to pursue her when he is finally released from prison.

During the therapeutic encounter, Mrs. Tony was involved with two men simultaneously. She described one of the relationships as strictly platonic. The other relationship was described as long term but with no direction. According to Mrs. Tony, these men appeared to be stable and not abusive.

Mrs. Tony's childhood was not very stable. She came from an abusive family where there was a history of alcohol addictions and violent behaviour. The violence was exhibited mostly by the male side of the family. There were seven children in her family and three different fathers. The five oldest share the same father who died in August 1989. Mrs. Tony's younger brother has a separate father who is also

deceased. Mrs. Tony's natural father has been described as an alcoholic and has spent five years in prison for manslaughter. Mrs. Tony was placed in foster care around the age of eight when her mother left the home. Mrs. Tony spent some time in the care of siblings but was mostly on her own. She stated that, to curtail the pain of being abandoned, she became involved in drugs and alcohol. Mrs. Tony continued this abuse until her behaviour was recognized as out of control. Apparently her mother returned when Mrs. Tony was fifteen but Mrs. Tony was already living with an older man.

After giving birth to Millie Mrs. Tony continued her drug and alcohol addiction. As the child grew older, Mrs. Tony would leave Millie to manage on her own. The memory Millie has of her childhood is of having to look after her self and wishing that her mother would spend more time with her. As a result, Millie stated that she felt resentment and anger towards her mother.

Prior to the beginning of therapy, Millie had moved out of her mother's home and into her grandmother's. Whether the move was deliberate or not, Millie's action immediately extended the problems between herself and her mother to include the grandmother. According to the structural perspective, a triangle had developed which involved Millie, Mrs. Tony and the grandmother. Rather than confronting the source of the problem, Millie would share her anger and disappointments regarding her mother with her grandmother. This sharing may have developed a coalition between Millie and her grandmother against Mrs. Tony. The coalition was strengthened by the historical difficulties that were never resolved between Mrs. Tony

and her mother. This alliance may be viewed as altering the hierarchy and power of authority from mother to grandmother. The reason for the move according to Millie was the conflictive relationship with her mother.

Millie felt that her grandmother would be a much more consistent and less intrusive parent. Mrs. Tony believed that her mother had consented to this move because she would have a second chance to parent and an opportunity to correct past parenting errors. Mrs. Tony also felt that her mother was competing with her in order to prove to Millie that the grandmother was the better parent. Mrs. Tony spent a lot of time describing how her mother had made her feel inadequate as a teenager and as a parent.

Reflecting upon the information Mrs. Tony provided, it appeared that Mrs. Tony and Millie carried a legacy. A pattern of neglect and abandonment, both emotional and physical, along with the blaming of the mother for these problems was suspected. Although the complaints were real, therapeutic intervention was required in order to begin to terminate the blaming process and to focus on discovering a resolution to the difficulties.

One might hypothesize that this may represent a transgenerational coalition. In this situation the shift of parental role to grandmother would result in Mrs. Tony being reduced a position of sibling with Millie. This hypothesis is supported by the fact that, at times during the dyadic sessions, Mrs. Tony and Millie would appear to be interacting as siblings rather than as a parent and child. For example, Millie would give advice to Mrs. Tony regarding moral obligations to her boyfriends and

would be involved in decisions regarding who Mrs. Tony was allowed to date. Mrs. Tony attempted to compensate for this loss of power by struggling to gain more control over Millie's life. Part of the resolution to this problem was to change the hierarchial order so that Mrs. Tony was back in charge. A beginning step was to try to interest Millie in returning home. The development of a contract was suggested and negotiated, however, Millie was reluctant to participate in this activity. Millie's living conditions at the grandmother's were comfortable and consistent. She was given plenty of freedom without the obligation of reporting her activities to her grandmother. Also, the rules that were established could be renegotiated between Millie and her grandmother. Millie stated that she knew what to expect when she broke her curfew or other rules. Often times, it appeared the punishment was very minimal. Millie felt this was appropriate and felt she would not have this flexibility if she were to return home.

A useful intervention to address this problem of a transgenerational coalition would have been to arrange a session with Millie, her mother and her grandmother. At that time, a shift in parental role could have been explored. However, it seemed that the triangle that was established may have been convenient for Millie because it helped diffuse the conflict between Millie and her mother and thus they were not forced into resolving their problems. At one point during the summer, Millie and Mrs. Tony lived together in the grandmother's house. This opportunity was utilized in therapy to identify and build on the strengths of their relationship. The arrangement at the grandmother's home appeared to be successful, therefore, the

reasons for this success were explored. Millie described the setting as neutral territory which meant that her mother did not have any control in this placement. Also, Millie indicated that since she was living with her grandmother she would follow only her grandmother's rules. Mrs. Tony consented to the arrangement and was satisfied that it had worked.

A discussion regarding their success at living together was facilitated in session. Afterwards, Mrs. Tony and Millie went home and they stated that they continued to talk about their relationship. The topics they had covered while staying together at the grandmother's included, the reason why the present situation would work out and what was needed to heal some of the tension between the two of them.

In an individual session with Millie an interesting insight developed that helped to clarify some of the anger she felt toward her mother. Millie shared her feelings about the sexual abuse and blamed her mother for not protecting her. The discussion took on a more generalized view of how Mrs. Tony neglected Millie during childhood by leaving her to cope on her own. Millie expressed anger at Mrs. Tony because of the perceived inconsistency in parenting. Millie stated that as a child she was left alone to cope when what she really needed was her mother. Millie stated that, as a teenager, her mother had over-involved herself in Millie's life. Millie resented this because she had learned to care for herself and she felt that she did not require her mother's attentions. Millie added that it was "like her mother was trying to make up for the past". The discussion continued to focus on her needs for nurturing and safety as a child, then she immediately added that she felt like she

was competing for this attention with the males involved in her mother's life. Millie stated that she became angry at her mother because Mrs. Tony appeared to give attention to the men in her life before her daughter. At this point, Millie's desire for her mother's care was recognized as an ongoing need. In addition, Millie felt confused because she experienced feelings of anger and disappointment toward her mother combined with the desire to be the most important person in her mother's life. This experience may explain the "push and pull" sensation she felt about their relationship. It was also considered that Millie may have been experiencing a normal adolescent process of attempting to establish independence yet desiring to be nurtured by a parent. In order to strengthen the bond between mother and daughter, it appeared necessary for Millie to begin to share her conflict with her mother. When this was accomplished, both individuals felt they had developed a better understanding of the tension between them.

Another problem area that required attention was the relationship between Mrs. Tony and her mother. In order for Mrs. Tony to be able to confront her mother and take responsibility for Millie, it was important for Mrs. Tony to rebuild some sense of self esteem and to reframe the perception of herself from a failure as a parent to something more positive. Mrs. Tony admitted that her past mistakes have influenced the difficult situation between herself and her daughter. In therapy, the focus became what could Mrs. Tony do in the future to regain some of her lost self esteem and make her stronger as a parent. Also, it appeared that Mrs. Tony was deprived of a parenting role model as a child and that, therefore, she required

assistance in developing a realistic definition of what she could do as a parent for Millie.

One of the presenting problems for Millie was Mrs. Tony's need to control her daughter's behaviour. Mrs. Tony admitted to abandoning Millie both emotionally and physically in the past but said that she was attempting to regain her relationship by becoming more involved with her. Millie stated that during her childhood she was responsible for herself and her mother. It may be hypothesized that Millie was a parentified child who learned to be independent and in control of herself at a very young age. Her description provided details that portrayed Millie as assuming some adult roles and responsibilities, like personal care and decision making, that may have been inappropriate for a child. Millie stated that she found Mrs. Tony's sudden attention smothering.

One theme that was explored may be referred to as that of the "pursuer and distancer". This transaction involves two people who take the role of either a pursuer or a distancer. In this dyad, Mrs. Tony may be identified as the pursuer. She would constantly attempt to engage Millie in conversation by questioning her, initiating discussion or encouraging Millie to discuss problems with her. Sometimes, Millie would not be interested in talking with her mother and she would distance herself from her. The more Mrs. Tony would attempt to pull her close, the more Millie would be silent, resistant and would initiate arguments with her mother. At one point, Millie stated that she ran away from home to escape from her mother's intrusion.

The issue of over involvement and pushing away was attended to in therapy. The work began to focus on the motivation behind Mrs. Tony's constant need to control Millie. It was discovered that Mrs. Tony feared being abandoned--an issue from her childhood that was never resolved. So, the more Mrs. Tony pulled to have Millie closer, the more Millie pushed away. Perhaps this activity occurred as a result of the need for Millie to explore areas of independence and to resist the pressure from her mother.

During the course of therapy, it was anticipated that a point of change in the relationship would occur if Millie could express some concern for her mother. Mrs. Tony agreed that this could be a key turning point in their relationship. This did occur during a dyadic session. The discussion focused on Mrs. Tony's fear of abandonment and the conflict it created in their relationship. About half way through the session Millie was able to tell Mrs. Tony how much she cared about her and that she did not want to lose their developing relationship, but that she needed some room to grow. Millie shifted the focus from blaming her mother for all the problems to a statement about her feelings and her needs. After this, the relationship took on a more positive stance because they were able to be more open about their feelings for each other.

The boundaries between Mrs. Tony and her daughter may be considered diffused. Mrs. Tony, possibly as a result of her insecurities and desire to be needed, may have established a somewhat symbiotic relationship with Millie. Mrs. Tony was having difficulty, initially, in identifying Millie as a individual. Mrs. Tony would

continuously expect Millie to behave in the same manner as Mrs. Tony did when she was a teenager. Millie's struggle to differentiate herself from her mother was very threatening for Mrs. Tony. She had relied on Millie to provide her with unconditional love and nurturance for her self esteem. The unreal expectation to do this may have created further frustration for Millie. One of the goals of therapy was to develop with Mrs. Tony better ways to negotiate the satisfaction of needs outside of the relationship with Millie. During this process, new boundaries began to be created concerning the need for privacy, decision making and independence. Both individuals presented information regarding their realistic expectations of each other and how these could be accomplished.

Millie had some difficulty with Mrs. Tony's sincerity during the presentation of what Mrs. Tony could do to improve the situation. Mrs. Tony holds a counselling position and she would often act as a counsellor toward Millie rather than as a mother. When this occurred, Millie would question her mother's credibility. Millie stated that she felt her mother was treating her like a client and not a daughter. It was often difficult for Mrs. Tony to discontinue this role because it appeared to be comfortable, safe and familiar. She could respond with the correct terms and behaviour without risking any vulnerability. Millie was empowered to challenge Mrs. Tony whenever this occurred.

Another problem that began to surface suggested that a power struggle existed between Mrs. Tony and her daughter. The area of conflict that was considered involved who was in control in the relationship. Again this may be partially a result

of the triangle with the grandmother. An example of a power struggle arose when Millie was angry with her mother. She was often angry with Mrs. Tony. An assessment was made to determine if there was too much unresolved anger between them that would inhibit the work being done to reestablish the relationship. The response by both parties indicated the desire to continue to resolve the problems. Millie stated that anger gave her control over her mother. Millie's anger with Mrs. Tony kept Mrs. Tony off her guard and Millie felt satisfied with this response. She would continue this game for a couple of days and then would just drop the emotion until the next time. Mrs. Tony would fall victim to this because of her vulnerable perceptions regarding herself as a parent and her need to keep connected with Millie. In order to lessen Millie's impact, it was necessary to have Mrs. Tony become less reliant on Millie and find other avenues of support.

Another turning point in the relationship occurred when Mrs. Tony contacted Millie's natural father. Millie saw this as a positive and caring gesture. During the period just after this event and until the end of the practicum, the relationship appeared to have improved too quickly. This concern was discussed with Millie and Mrs. Tony and they were questioned about what they do if the situation became difficult again. Their response was positive in that both made a commitment to resolve the problems. They were informed that the difficulties would continue because of the reality of the situation. It seemed necessary to remind them that further conflict would occur so they would not set unrealistic expectations for change. When the problems reoccurred, it was anticipated that they would not experience a

sense of failure but would be ready to resolve the issues. Their relationship did become stressed after the visit with Millie's father. Mrs. Tony told Millie that this person may not be her real father. Even though they agreed that this information created more difficulties, they added that the problems could never be as bad as they were before. The message given to them regarding the possibility of further tension encouraged them to realize that they have not failed and that incidents such as the one previously explained were to be expected.

A final area that required attention concerned Mrs. Tony's involvement with two other men. In therapy, Millie stated that she felt unimportant because her perception was that Mrs. Tony cared about her boyfriends more than her child. Millie added that her mother neglected to perceive how this was impacting on her. It was important to facilitate communication between them regarding how Millie wished to be involved and what Mrs. Tony could do to dissipate Millie's feeling of neglect. Mrs. Tony required some assistance in understanding how her behaviour created a concern for Millie. Millie had the opportunity to disclose her fear that a new parent would be allowed to enter their relationship and destroy the beginning closeness they were experiencing. It was surprising to observe the flexibility on behalf of both parties regarding the negotiations of new rules and behaviours in this area, where once there was rigidity.

During the individual sessions with Millie and Mrs. Tony many areas were covered. It was difficult at times to sort out the pertinent issues and to stay focused on those that were connected to their relationship. It was necessary to clarify some

of the personal issues such as self esteem, guilt, betrayal, victimization, and to lower some of the personal expectations to a level that was surmountable. There was a need at times for some nurturing and support as well as gentle confrontation. Mrs. Tony and Millie were a challenge to work with, yet their cooperation and motivation helped to create a good learning experience.

At the termination of this practicum, Mrs. Tony and her daughter requested to continue with therapy. They both recognized the need to resolve the difficulties in order to have a strong future together.

Measures

This family was the only dyad that did pre and post Family Assessment Measures III (see Appendix G and H). In comparing the two, the post measure showed some improvement after intervention. Initially, the pre measure indicated that there was some anxiety expressed by both Mrs. Tony and Millie. This was shown on the graph by the low social desirability and low defensiveness scores. This may be interpreted to suggest that this mother and daughter dyad was attempting to increase the severity of the problems by inflating the scores. There was a consensus between Mrs. Tony and Millie that Values and Norms, Task Accomplishment and Control were problem areas. This coincides with the assessment that values were somewhat confused. There appeared to be a double standard of expected behaviour between mother and child. Millie's behaviour with men was not consistent with how Mrs. Tony behaved within her own active relationships. It appeared that what was said by one party was not followed through by that same

individual. Mrs. Tony lectured Millie to be respectful of herself when she was involved with men, however, Mrs. Tony was involved with two men at the same time in a deceptive situation. Millie assumed the role of moral monitor with her mother. The high score in the area of Control validates the assumption that a problem existed in this area and that an intervention was required.

Millie felt more strongly that Affective Expression was a problem. This may have been due to Mrs. Tony's difficulty in shedding the role of counsellor and exposing the more real self. The problem that appeared to create a conflict was Millie's perception of the degree of honesty in Mrs. Tony's concerns. Mrs. Tony expressed interest in understanding Millie's concerns, however, the feelings associated with the interest appeared to be lacking. Millie wondered if Mrs. Tony was worried about Millie or feared losing someone who fulfilled Mrs. Tony's need for companionship.

The post test that was completed indicated that perceptions about family functioning were in the normal range. There was some indication that Millie experienced anxiety because the social desirability and defensiveness scales were elevated. The post measure portrayed Involvement and Control as problematic.

Mrs. Tony and Millie completed the pre and post test of the Beck Depression Inventory. Mrs. Tony's pre-treatment score indicated a level of moderate depression. The post test total score improved to show an absence or minimal level of depression. There were eight areas showing a decreased level of depression. They were sadness, pessimism, dissatisfaction, guilt, self harm, indecisiveness, work

difficulty and fatigability. The only subject area that was never mentioned by Mrs. Tony was self harm. During the sessions she never indicated any desire, nor did she behave in any way which would suggest a desire, to hurt herself or to terminate her life. The other areas of concern were explored by Mrs. Tony during the therapeutic process. Many were dealt with directly or indirectly through changing the patterns of relating with Millie.

Millie's pretest total score indicated a moderate level of depression. When Millie began therapy, it appeared by her behaviour and her attitude that she was very unhappy with the relationship with her mother. She indicated that living away from home would resolve most of the tension and that a strong connection with her mother was not possible. The post test total score showed a decrease in the level of depression to none or minimal. There was improvement in ten of the thirteen items. The three items that did not change were guilt, self image change and fatigability. These areas may speak to Millie's adolescent struggle to differentiate herself from her mother and to define her own self-identity. Millie experienced guilt associated with her attempts to break away and the conflictive manner in which she made these attempts. Some of the improvements may have been a result of the positive change that had occurred in the relationship. It seemed that Mrs. Tony was becoming more hopeful that the two of them could become closer and that their relationship would become more stable.

CHAPTER FIVE

GROUP

The other approach to clinical intervention that the student became involved with was group therapy. The group was composed of nine mothers who were identified by child welfare as being high risk. They were given the designation of high risk because their children had been either physically and/or sexually abused. Most of the children had been in the care of Child and Family services. Approximately six of the mothers did not have their children living at home during the student's involvement in group. The age range of the mothers varied from approximately twenty to thirty years. Many of them resided in the core area of Winnipeg.

The purpose of the group was to provide a safe and nurturing environment for these women to express the difficulties of their daily lives. They were also gently encouraged to talk about the reason why they were having difficulty protecting their children and what could be done to create change and resolve some of these issues. Support and encouragement were offered to help build up their self esteem and parenting skills; this was done in the hopes that there would be a chance for them to provide some form of protection for their children. The group began on June 20, 1990 and would continued until December 1990. Due to the time limitation of the practicum, the student attended the group until mid-September, 1990. The role assumed was one of co-facilitator and observer. Enid Britton and Marcella Lastra

were the group leaders and continued with the mothers until December 1990. The meetings occurred at the Community Resource Clinic every Wednesday afternoon. The number of mothers that attended varied from week to week: sometimes there were three mothers and other times, six or seven. The importance of attending regularly was emphasized to the mothers but attendance continued to be a problem. While there were one or two women who attended more consistently than the others, it often felt like there were two separate groups because each week there would be a different set of mothers. It was difficult to carry a theme through from week to week because of the irregular attendance. There was some discussion among the group leaders to speculate on the reason for this situation. It seemed that, due to the chaotic nature of these mothers' lifestyles, it was difficult for them to follow a schedule. Further, group attendance may not be regarded by them as a priority. Some of the mothers felt they did not need the help, therefore they perceived themselves as having nothing to gain by participating. A few of the members stated that they attended only to appease their case workers. As a result, they expressed some resistance because of the perceived intimidation created by the authority of child welfare and their power to apprehend.

This population presented a therapeutic challenge which required creativity and flexibility to work within these limitations. The group facilitator can become comfortable working with this population if they are able to adjust their expectations and adopt a positive view that change may occur in very small steps.

The group process involved discussions on a variety of issues. The subjects

that produced the most intense expression of feelings were those concerning the child welfare system, the mother's relationships with men, the abuse and loss of their children and the tragedy of their own childhoods. One of the concerns expressed by the facilitators, regarding the subjects raised in group, was the absence of follow-up therapy. The women did not have access to individual therapists where they could gain support and completion on some of their outstanding concerns after the group process. Some of the women complained that when they left the group, they were depressed. This was described as a very uncomfortable experience for them. Occasionally they did not want to come back because they feared being left to cope on their own at the end of group. An individual therapist could have addressed these outstanding issues and, in addition, provided some assistance to ensure the regular attendance of these women. The combination of individual and group therapy would be more effective in helping the women with their personal growth.

During the group discussions, the emotional neediness of some of these women was very apparent. Sometimes one of the women would dominate the group discussion and not allow others to present their concerns. There were incidents where one woman would be sharing painful personal information and another would interrupt by presenting a new subject or turning to her neighbour to begin a new discussion. Since there appeared to be a lack of empathy and compassion for other group members, a concern was raised regarding the mothers' ability to understand their childrens' emotional needs. Their capacity to empathize with others may have been limited because of their own personal problems and neediness. The extent to

which each of these mothers had been deprived of nurturance and security in their own childhood became evident during some of the sessions. Their lack of exposure to a normal and nonviolent childhood appeared to contribute to deficits in their basic parenting skills. They appeared to have serious personal needs and therefore it may be difficult for them to extend themselves emotionally to their children. The immaturity shown by these women made it seem that the group consisted of very young teenagers rather than women with the emotional capacity to be mothers.

Some of the women could not remember any good childhood memories and others refused to share memories, stating they had blocked out their childhood experiences because they were too painful to share. It was observed by this student that the women had acquired through their own abuse a knowledge far beyond their chronological years and yet in other areas they lacked the experience and knowledge necessary to help them in their efforts to live normal lives.

A great deal of time was spent discussing their anger at the social services system. It was important to let them vent their anger within the group. There were efforts made to reframe the situation with social services and to help the women to try and understand some of the positive aspects of social service involvement. At the same time, attempts were made to have the mothers begin to recognize their responsibility for the loss of their children. This was difficult to do because the mothers had learned to use blame as a form of self defence. Often, it was too painful for the women to admit that they could not care for, or protect, their children from the same abuse that they were exposed to as children. Some of the mothers were

able to accept the responsibility for placing their children at risk, therefore, these women were encouraged to help the others who were still struggling with this issue.

One of the benefits of the group was the sharing of information and the cohesion that developed because of the similarities in histories, feelings and experiences. The mothers were able to tell each other about their hopeless relationships with men and about how to get out and try to create a better life. The women shared their stories about unsupportive families and methods of obtaining help elsewhere, and they shared their plans to make the future a better place for themselves and their children. There was also some reaching out to each other. During one of the sessions, one mother was extremely upset about the possibility that her children may not be returned home. Another member, at the end of group session, offered her support by giving her some information and extending an invitation to get together outside of the group over coffee to discuss their problems further. This gesture was even more hopeful when it is considered that earlier in the summer these two women had a very serious conflict with one another. They resolved their differences and were taking the next step by putting aside their own personal difficulties and reaching out to understand and help someone else.

CHAPTER SIX

CONCLUSION

The opportunity to participate in this practicum increased the awareness of the effects that sexual abuse has upon the mother and daughter relationship. Also, this experience permitted the student to make specific clinical observations during the therapy experience which enhanced the student's knowledge of and skills in sexual abuse counselling and the therapy process. The following chapter will describe these observations and how they relate to the theoretical knowledge regarding the impact of sexual abuse on the mother and daughter relationship.

Social Practise Issues

When sexual abuse is disclosed, many times the child welfare authorities become involved with the family to ensure the protection of the child. In two of the practicum cases, child welfare involvement appeared to be disruptive rather than helpful. The protection of the child usually occurred in one of two ways: the first and most preferred option is to request that the offender leave the home; the second method involves removing the child and placing her in foster care. This latter choice may be traumatic for both the parent and the child.

Prior to any decision regarding the child's placement, an assessment is required to determine if the non-offending parent is able to provide protection for her child. It was observed that two of the mothers who were involved with child welfare had difficulty believing their daughter's disclosures about the sexual

assault. The issue that they were challenged by was loyalty. It appeared that these women had to explore the strength of their allegiance to both the child and the perpetrator before they could except the truth about the abuse. It appeared that the mothers initially wished to remain connected to both individuals, despite the stress to their emotional health. When the time came to support their child, it was difficult for these women to turn away from the men because these women realized that they could potentially lose the emotional or financial support that the perpetrator provided to them.

If the non-offending parent was perceived by the child welfare authorities to be supporting the perpetrator and, at the same time, putting the child at risk she could be judged as unable to provide protection for her child. The child could then be apprehended and placed in foster care. Mrs. Kelso and Bonnie Bear experienced the aftermath of apprehension. Their experiences provided some understanding about the consequences of removing a child from her home.

The separation of the mother and child may put additional strain on an already tenuous relationship. The child will be protected, however, the support and comfort that she may have obtained from the mother will not be as readily available. Also, the placement in a new home may create further feelings for the child of alienation, rejection, and self-blame. The child may also perceive her placement as punishment for the sexual abuse and the disclosure. Therapeutic intervention should be required as soon as possible after the placement. Therapy could provide an opportunity to bring mother and child together with the goal of supporting the child

and helping to alleviate the potential for her to suppress or internalize the negative experiences of the sexual assault, disclosure and placement into care. Without immediate access to the mother, it is possible that the child might suppress her concerns and fears, such as the fear of rejection and anger, until she is no longer able to communicate these issues to her mother.

In addition, the mother may experience further feelings of failure and incompetence in parenting. She often requires some assistance from therapy in order to empower her to confront the social service systems and prove herself capable of protecting and nurturing her child.

Another concern that arose from the child welfare intervention was the non-offending parent's use and commitment to therapy. The mother's primary concern in therapy is usually the return of her child. All of her actions may be directed toward satisfying their expectations rather than sincerely acknowledging that a problem existed in her relationship with her daughter. Initially, it may be important to help the mother regain access to her child. Sometimes this assistance will encourage the mother to trust the therapist and to begin to deal with more pertinent issues related to the child. However, if the parent attends therapy but appears resistant and unsure, then there may be a concern that she will not become committed to the process. In addition, if the mother has successfully completed the tasks outlined by the social worker and if the safety of the child appears secure, then the chances of the mother discontinuing therapy are increased. Since the mother and daughter have been reunited and the risk to the child has been alleviated, social

services may also disengage with the family. This can have a negative impact because once the child is returned home the parent may no longer feel that therapy is required. The parent may then wish to terminate her involvement even though there are some outstanding concerns.

Sometimes the child welfare social worker may inadvertently use their authority as leverage to direct the mother and daughter to attend therapy despite their lack of desire to engage in this process. If this service is imposed upon the mother and daughter they may react with anger and frustration. The initial focus of intervention should be upon the perceived resistance expressed by parent and child. In one of the cases, the student and social services representative were required to meet and reevaluate their involvement with the family. The student and the social worker engaged in a questioning process that focused on the following: identifying who requested the service and for what purpose, establishing whether the clients understand why they are involved in therapy, and ensuring that all the protection issues have been addressed and resolved. As a result of this discussion, everyone involved should have received clarification about the need for therapy and about the role each person providing service to the family is required to perform. Taking the time to question the validity and necessity of services may also help to establish a boundary between the mother and daughter dyad and the service providers. This boundary may be composed of the client's expectations and limits for the service provider's involvement. This boundary can also protect the integrity of the mother and daughter relationship from interference that could create conflict and disruption.

While the involvement of service providers is regulated, an opportunity may arise for the family to employ their own coping resources rather than to rely on outside sources. The over involvement of an agency in the client's family life could potentially disempower the members by not respecting their own ability to resolve difficulties. Mothers and daughters require the opportunity to explore their own sources of strength and their problem solving ability. If these efforts are assessed by the professionals involved to be unsatisfactory, then the mother and daughter may be offered some assistance. In this way their coping abilities are enhanced rather than disrupted because someone has taken over the responsibility for problem solving.

After the disclosure of incest and with minimal intervention by an outside agency, some mothers and daughters are able to confront and overcome the crisis of sexual abuse. However, some families are unable to do this and thus require the involvement of the legal system. These clients may be considered involuntary because they believe that therapy is unnecessary even though the problems within the relationship continue to exist. Without any choice, the mother may reluctantly agree to attend therapy while motivated by reasons other than the desire to change her behaviour. Voluntary clients do not appear to be motivated by external threats like the involuntary client, but rather by a desire to change and function in healthier ways. It is important to understand the reasons why the involuntary client attends therapy because these reasons may be the primary focus for any therapeutic intervention. A referral for therapy usually consists of a request for the client to

have access to a resource that will alter problematic personal and behavioral issues. It is possible that the involuntary client will attend therapy to comply with the direction and plan put forward by social services or the legal system. The client's unspoken motive may be the desire to maintain or secure the return of a valued resource such as a child. Also, the client may wish to avoid any punitive action such as incarceration (Kadushin, 1990). The legal and social services system may be satisfied that the client had complied with their direction, however, the therapist must then deal with the client's resistance which is often complicated by feelings of fear and mistrust. Sometimes, it may appear that the client is uncertain of the therapist's connection with the child welfare system. The therapist may be perceived as an extension of the authority who may punish them if they do not follow through on therapy. It is important for the therapist to reassure the client that the position is one of neutrality, and that the therapist has the clients' best interest in mind. The therapist may choose to side with the client against other agencies in order to empower and assist the client to take action on her own behalf. This position may encourage the mother to trust the therapy process with the hope that she will then be able to recognize the therapist's value as a resource for improving the relationships with her daughter and ultimately the family. It is important to recognize and understand the motive for the involuntary client's resistance. This understanding can enable the therapist to work toward helping the mother alter her negative perception and then begin to work on overcoming her difficulties. With this goal in mind, the mother may feel some success because she is addressing social

services' expectations and is securing the return of her child.

General Practise Issues

During the practicum experience, several issues became apparent because of their consistent reoccurrence during the therapeutic process.

One of the themes that emerged from the practicum was the influence of the intergenerational process upon the mother's ability to protect her children. According to the practicum experience and the information found in the literature, it seems that mothers of sexually abused children have been exposed to similar experiences within their own families. The experience of working with mothers of sexually abused children in the practicum appeared to validate this theory. All of the mothers described a history of neglect, emotional abandonment and some form of physical or sexual abuse. These mothers indicated that at a young age they were expected to be responsible for themselves and sometimes for many siblings while their parents were emotionally and physically unavailable. They also described the feeling of never having had the opportunity to experience freedom and security in their childhoods. The mothers involved in this practicum blamed their parents for the abuse and the neglect they suffered as children. Also, it appeared that because they lacked supportive and consistent parenting these mothers were deficient in both skills and knowledge regarding areas like the use of appropriate discipline, the selection of non-abusive spouses, the availability of healthy coping skills and the development supportive friendship networks. It also appeared that these women experienced and displayed a learned helplessness that may have resulted from the

distorted use of parental power and from a personal sense of powerlessness in their past lives. The learned patterns of helplessness and chaos seemed to be enacted within the new families as the mothers sought spouses who appeared to be similar, or who incorporated values similar to those which the mothers experienced in their own homes.

Another consequence of the neglect these mothers experienced as children appeared to be the tendency to become part of a role reversal process with their children. Three of the mothers from the practicum indicated that they did not feel that their parents provided any positive role modelling. These mothers blamed their lack of appropriate parenting behaviours, again, on their past family experiences. It appeared that the mothers became involved in a process of role reversal with their own children. The mothers described situations where their children would be required to perform duties and roles more suitable to adults such as putting an inebriated parent to bed or assuming responsibility for the care of many children. When the mothers explored their childhoods, they discovered some similarities in the way they treated their children and the way they were treated as children. Since they received little or no attention from their parents, these mothers expected their children to attend to their own physical and emotional needs just as they had done. Once the mothers began to recognize the similarities between themselves and their children, they were able to express a desire to stop this process and to work toward a more positive relationship with their children.

In conjunction with the intergenerational transmission process, the

intergenerational coalition had the potential to create further difficulties between the mother and the daughter. This type of relationship can occur when a child aligns with an adult member of the family against another member of the family. An intergenerational coalition occurred with Mrs. Tony, Millie and her grandmother. This type of coalition can disrupt the normal hierarchy within the family. Rather than the mother assuming responsibility for parenting her daughter, another adult takes over. When this occurred in the practicum, the mother perceived that she lost her position of power and responsibility. In some cases the mother's role may be reduced to the position of sibling with the other children. The daughter may perceive this transition as another example of her mother's helplessness and vulnerability. This triangulation can also displace the focus of attention away from the problems within the mother and daughter relationship to a power struggle between the mother and the new authority figure. If this occurs, the daughter may become caught in the middle of the power struggle. She may then be expected to choose between these adults, and this choice often creates a problem of divided loyalties. The child experiences some anxiety because she perceives that whatever choice she made could create anger against her from the other adult.

Sometimes the process of triangulation may extend beyond the immediate family and involve an external party such as social services. This situation occurred during the practicum. Social Services became over involved with a family by assuming the role of parent with a sexually abused daughter. Involvement of this sort by an agency could create consequences like the disempowerment of the mother and

interference in the family's ability to regain stability. An agency's role is time limited and artificial when compared to the involvement of the natural family. Agencies like Social Services are not part of the emotional life of the family, as is, for example, a grandparent who has a life long role with specific emotional and biological attachments. Social services' involvement could cause the family or the child to become dependent upon them for security and safety. This dependency may interfere with the family's need to reorganize and gain stability after the crisis of sexual abuse. Also, the family may not learn to recognize and rely on their own strengths to manage difficulty and resolve tension because another resource is accomplishing this for them.

A feature of the incestuous family is the breakdown of communication between its members. This appeared to be apparent between the mothers and daughters in three of the practicum cases. It seemed that any important information that was communicated between mother and daughter would often be stated in a manner that would leave the other person frustrated and confused about the content of the message. The discussion between the mothers and daughters seemed to be at a superficial level with a focus on non-threatening subject matter. In the initial phase of therapy, the mothers and the daughters were not ready to share their true feelings because they appeared to fear the reactions from the other person. In order to begin to facilitate a discussion between them, it seemed important to help them understand and confront their fears.

Also, to encourage communication between mother and daughter, the

therapist may be required to create an environment of trust and security. Within this context, the mother may be encouraged to assume the lead role in developing an open and honest discussion with her daughter. It appeared that, in the practicum experience, when the mother initiated the therapy and admitted to her neglect of past responsibility to the child, she was also indicating to her daughter that she was willing to resume responsibility for her child's protection and welfare. By acquiring this responsibility, she may be allowing the child to be the recipient rather than the provider of nurturance and protection. When the mother and daughter began to discuss the circumstances regarding the incest, they also formulated new rules of behaviour which may help the child avoid becoming involved in other dangerous relationships. The child may also feel more confident about turning to her mother for assistance in the future.

In order to continue restoring the emotional bond between the mother and child, it seemed important for the non-offending parent to advise the child that the responsibility for the abuse belonged with the perpetrator. The gains in therapy appeared to be delayed until the child was able to hear from her mother that the sexual abuse and the crisis of disclosure was not their fault. It appeared that the daughters responded favourably when the mothers continued to state that the disclosure by the child was appropriate and necessary and that they were not at fault for the breakup of the family.

Facilitating the communication between the mother and child appeared to help empower them and give them a sense of control over the instability felt in their

lives. Helping the non-offending parent to recognize the child's needs, teach her new skills and provide some guidance and resources may strengthen her ability to care for and protect her child. Also, it appeared that assisting the mother to examine her strengths and to reframe her self perception to one that is more positive may provide her with the encouragement and strength to continue resolving the problems between herself and her daughter.

Personal Practise Issues

One of the most challenging personal practise issues involved the ability to identify what was happening in the relationship rather than to focus on what was being said. This adjustment required a shift in thinking from a focus on individual problems to an identification of a series of actions between two people that required some changes. This process seemed to occur in two parts. The first necessitated the ability to focus upon and hypothesize about the interactional sequence that occurred and which may have created problems within the relationship. An example of this occurred when Mrs. Tony became over interested in Millie's life. The more the mother attempted to get closer to her daughter, the more the daughter distanced herself from her mother. The second phase involved the formulation of appropriate questions that would illicit more material to confirm or refute the hypothesis. The questions needed to be phrased in a manner such that the information provided would give the student an idea of how each member behaved or responded to the other person. An intervention was then administered to change the pattern of problematic behaviours displayed by the mother and daughter. The process through

which problem areas were identified and appropriate questions were developed was at times confusing. Sometimes the client would willingly provide information that was not needed, but was often this information concerned an area that was non-threatening to the client. Disclosures of this nature had the potential to divert the student's attention away from an exploration of the primary issue. It was necessary at times to allow the client to divert her attention away from the primary concern because otherwise the clients would become uneasy and anxious. This brief diversion from the core subject would provide an opportunity for the client to regain a certain level of comfort and control. Eventually, a decision had to be made by the student regarding the appropriate time to redirect the discussion toward the primary concern. Sometimes the client would not be ready to resume her focus upon the issue, therefore, another opportunity had to be selected. All of this required the student to be alert and to concentrate on the discussion while simultaneously developing questions and hypothesis regarding the problem areas within the relationship.

Two style issues were identified that required some modifications in order to enhance the student's effectiveness as a clinician. The two areas of difficulty were the student's pace and the tendency to overfocus on one particular issue with a client.

There was a tendency for the student to proceed quickly through the sessions in an effort to resolve the issue at that time. Many questions would be asked at a quick pace without observing the clients reaction to this process. This inattention can be detrimental to the therapeutic relationship especially if the client's style is slow

and quiet. It is important to be aware of the pace of the therapy process in order to avoid overloading or overwhelming the client. As a consequence of poor pacing by the student, the client may withdraw and lose interest in the therapeutic process. In order to alleviate this tendency to proceed too quickly, it was necessary to develop greater patience and self awareness. A slower and more thoughtful approach would provide the opportunity to explore the client's style and the purpose of her behaviour in therapy. A slower pace will also permit the student to monitor her reactions to the client and to the information they present. It is the student's or therapist's responsibility to slow down the process and avoid disrupting the relationship by overwhelming the client.

In addition to the speed of the therapeutic process, there was a need to become more aware of the tendency to over-focus on an issue. The problem that was created by this was the loss of flexibility to determine other options or plans of action. Over-focusing does not allow for flexibility because it blocks out any other interpretations of the client's behaviour. Over-focusing may be a result of the student's need to provide an immediate solution in order to feel that something has been accomplished in therapy. The need to have solved a problem must be recognized as the student's issue and one not related to the client's presenting problem.

The student has had an opportunity to recognize the personal style biases that could interfere with the therapeutic process. An important element of this learning experience has been the creation of an awareness that one must remain flexible in

order to reassess the situation and determine if the student and the client are proceeding at the same level.

Measurement

The use of the clinical measures assisted the student in both the assessment and intervention with the clients. The genogram was employed to help identify the members of the immediate and extended families. This visual aid could be referred to as often as needed and was utilized at times as a tool to interest the clients in exploring their histories and problems. The use of clinical measures sometimes substantiated the student's hypothesis about the problems in the relationship between the mother and daughter. The measure that appeared to be helpful was the Family Assessment Measure III. It assisted in identifying the particular facets of family dysfunction and supported some of the student's ideas regarding potential problem areas. Also, some of the questions in the booklet provided a subject guide for the student to follow when asking the families to share information about the relationships. The pre and post measures provided a concrete tool with which to measure the effectiveness of intervention and the areas that changed as a result of therapy.

There was one concern about the use of the Family Assessment Measure III. It appears that the norms are culturally biased, and therefore do not account for those individuals who are of a different ethnic background or who speak a different language. There is some speculation that the Family Assessment Measure III may not be sensitive to the values, attitudes and roles of another culture.

It was difficult to obtain consistent measurement because of the nature of the practicum. There are very few, if any, scales that measure the interaction of the mother and daughter relationship. This lack may be due to the fact that the subject area is relatively new. There may be a need to address and develop measures that evaluate the problem areas and suggest appropriate and effective intervention strategies. The client group explored was composed of mother and daughter dyads who were coping with sexual abuse issues. The mother and daughter dyad requires a specialized focus and, to date, it appears that few clinical measures have been developed to reflect the particular needs of this dyad.

Consideration For Future Practicum

A future practicum might explore the various intervention techniques that could be employed to strengthen the mother and daughter relationship. Play therapy with the mother and daughter could be utilized with children from ages four to thirteen and possibly older. Play therapy could be used to facilitate communication and the expression of feelings as well as to provide an environment of safety where parent and child have the opportunity to learn to be more spontaneous with each other. Group therapy could provide an environment where both parent and child are given the opportunity to recognize that others are experiencing difficulties similar to their own. This recognition may result in their finding support in their efforts to restore their own relationships. Perhaps a combination of both types of intervention, with the addition of an evaluation component, would help to determine which of these is the most effective therapy, or when children of various ages are most likely

to benefit from either style of therapy.

The goals outlined at the beginning of the practicum experience, appear to have been met. The practicum experience provided the opportunity to:

1. Develop a basic set of assessment skills with which to identify the difficulties presented by a mother and daughter relationship that has been strained by sexual abuse.
2. Utilize basic structural family therapy concepts and skills to assist in the development of an assessment and subsequent working hypothesis.
3. To participate in a mothers' therapy group and to incorporate specific issues which were raised by the participants in the mothers' group into a knowledge base which may assist others.

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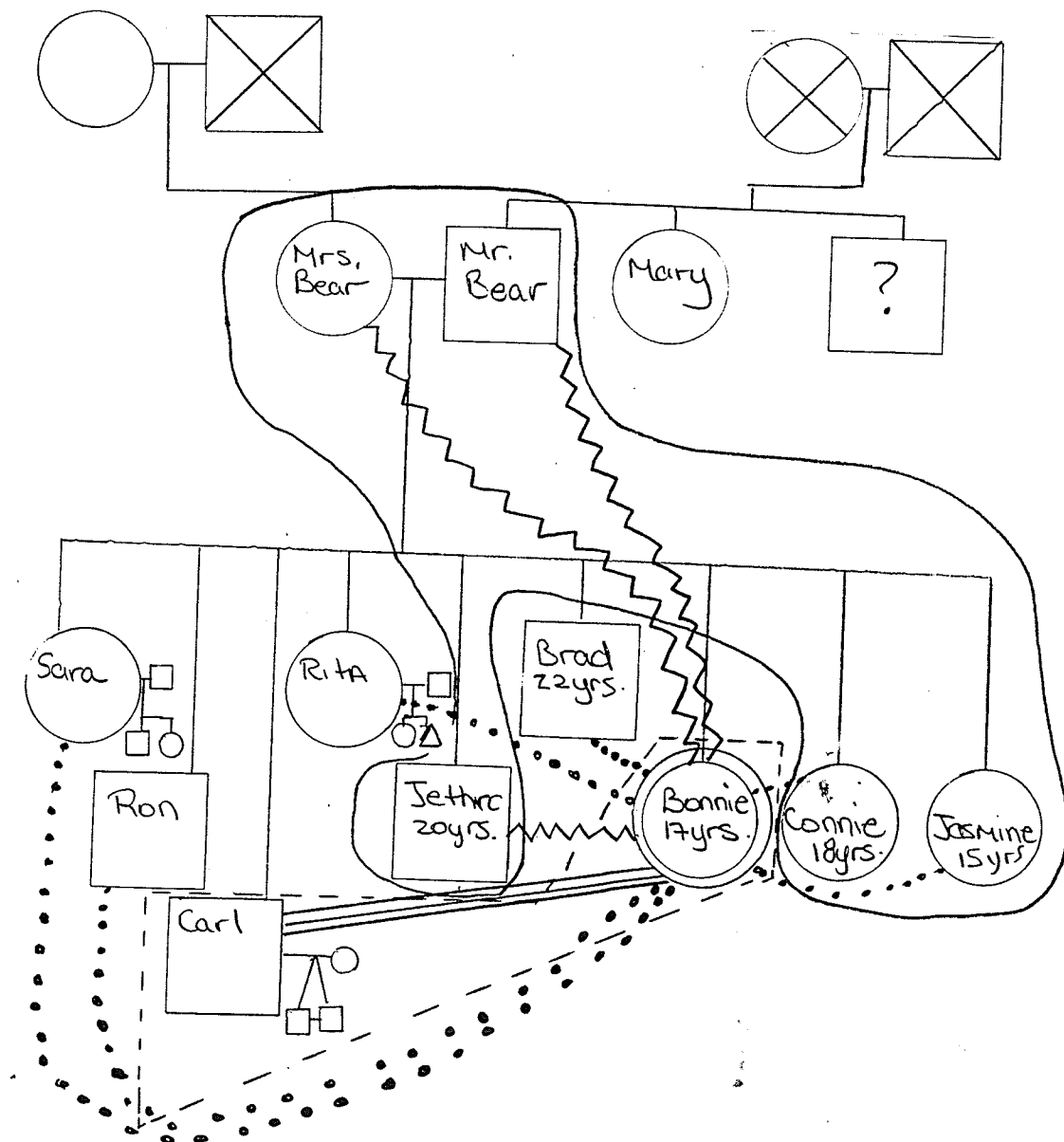
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APPENDIX

APPENDIX A

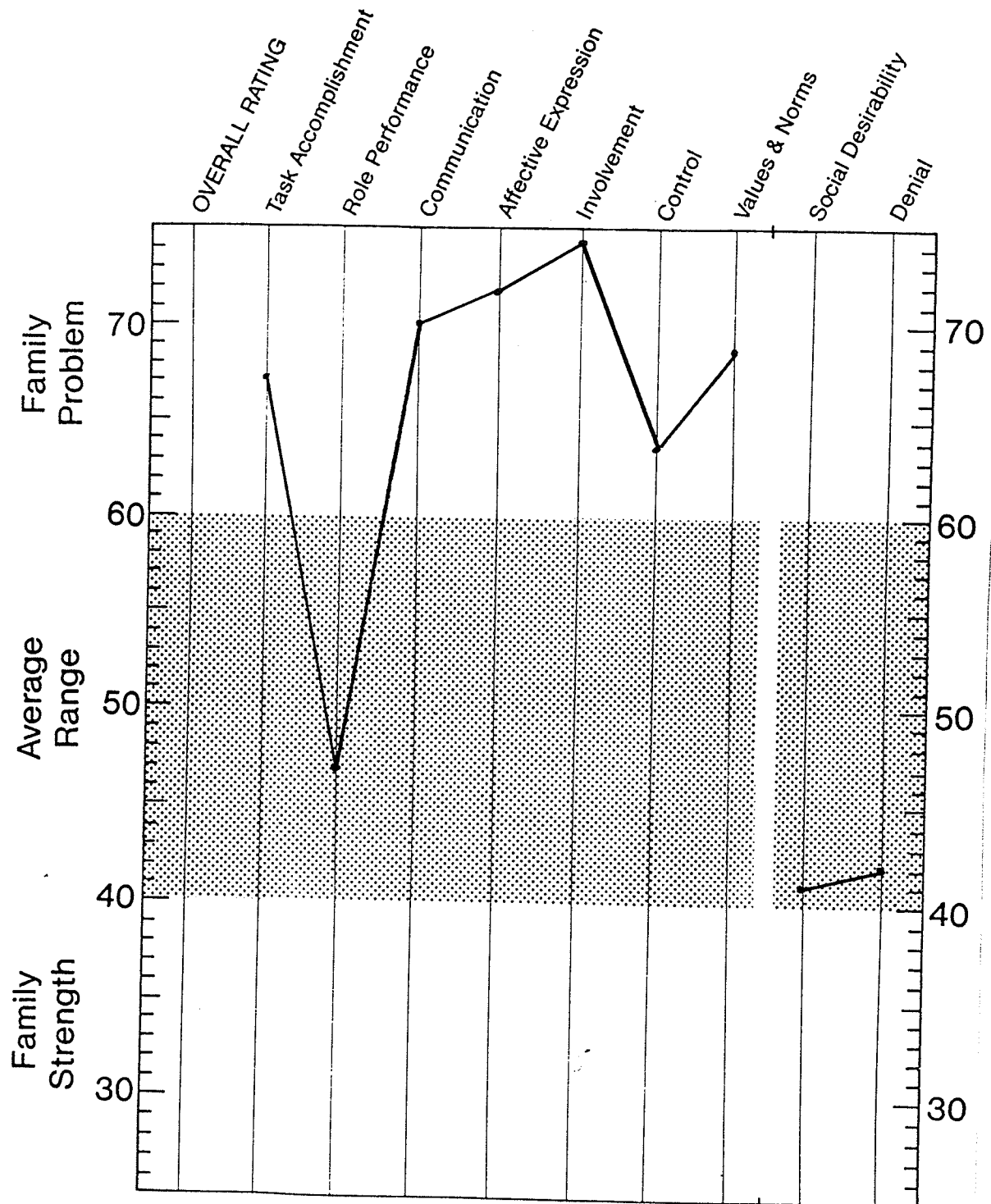
The Bear Family



APPENDIX B

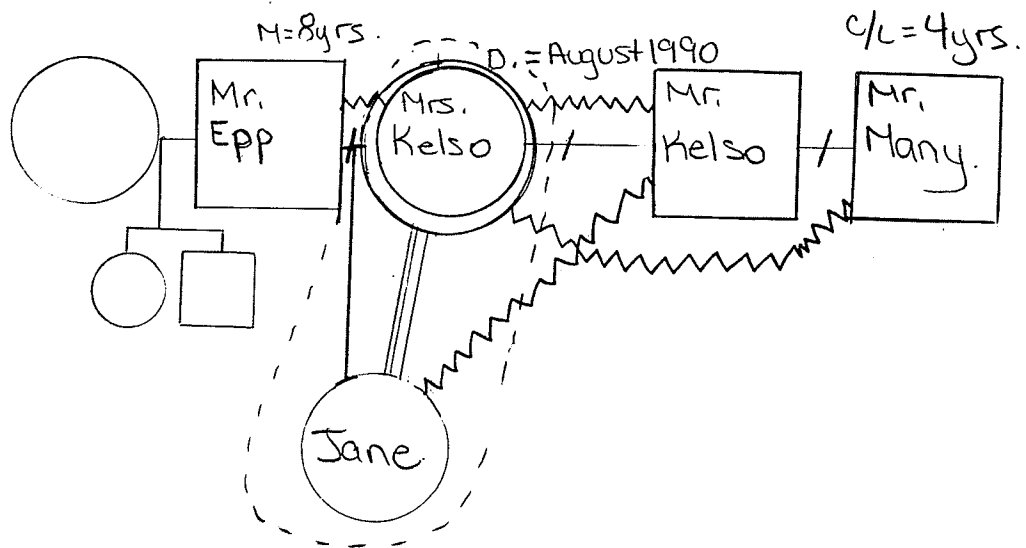
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FAM GENERAL SCALE



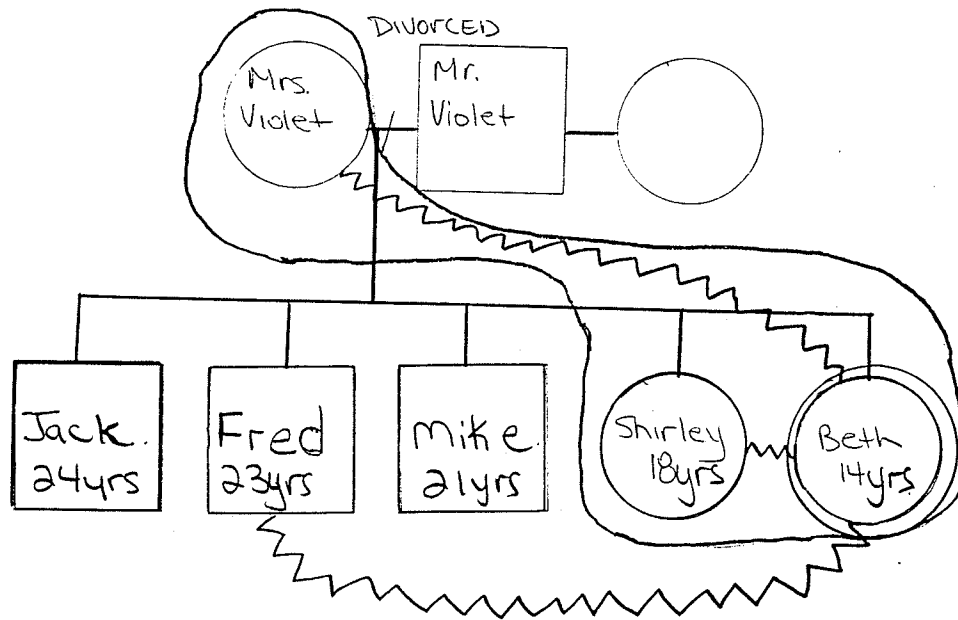
APPENDIX C

The Kelso Family



APPENDIX D

The Violet Family

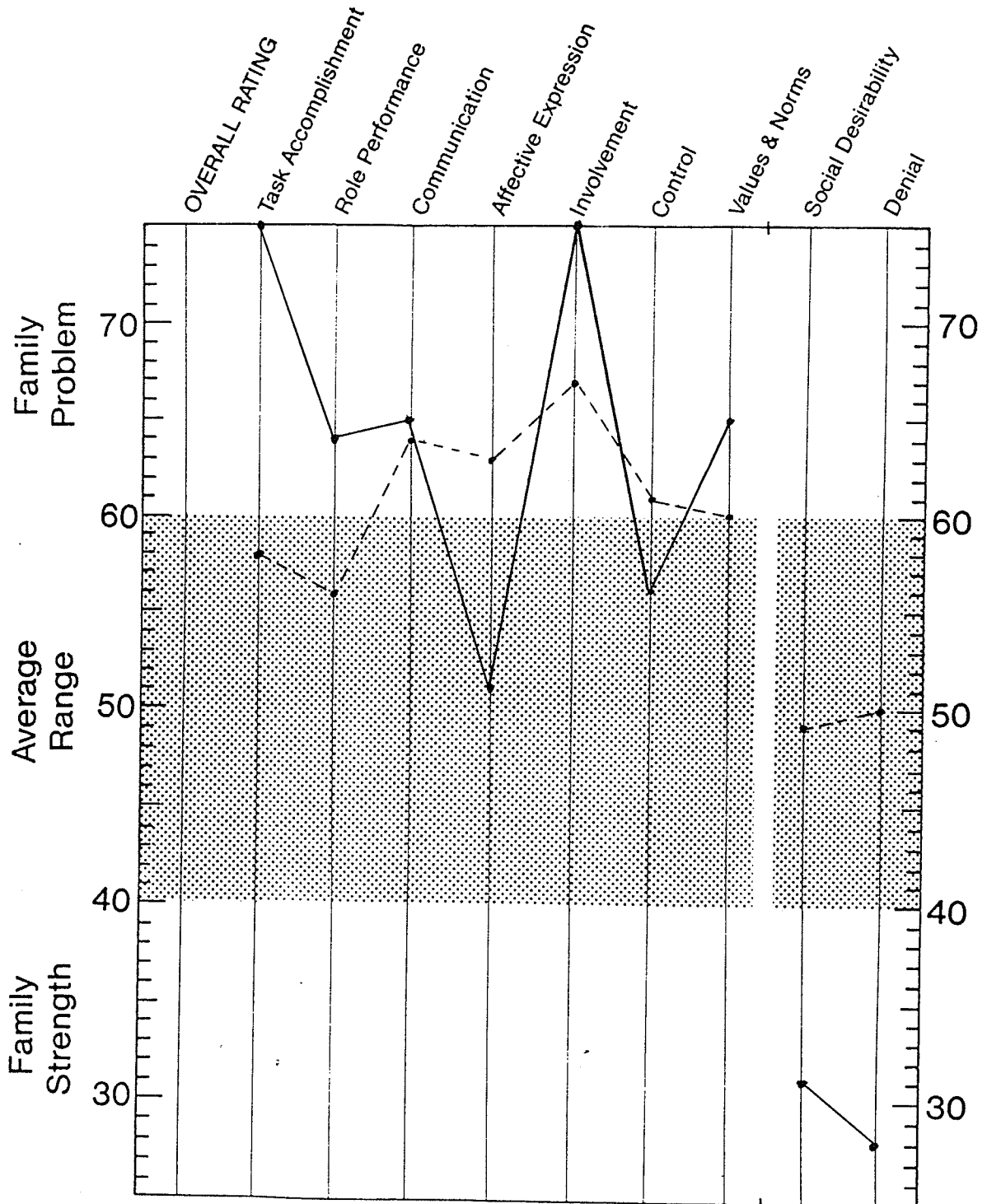


APPENDIX E

The Family Assessment Measure III: The Violet Family

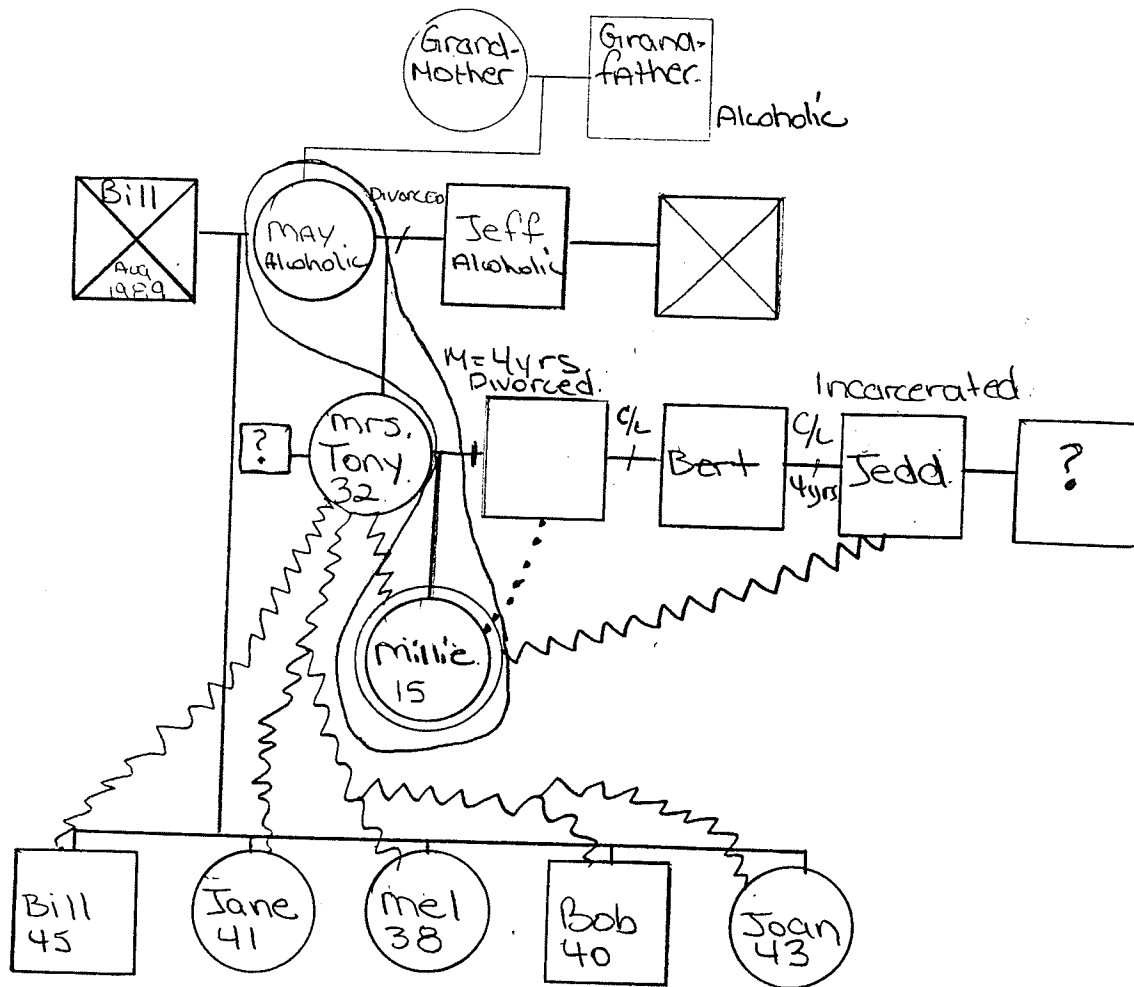
Beth ———
Mrs. Violet - - - -

FAM GENERAL SCALE



APPENDIX F

The Tony Family



APPENDIX G

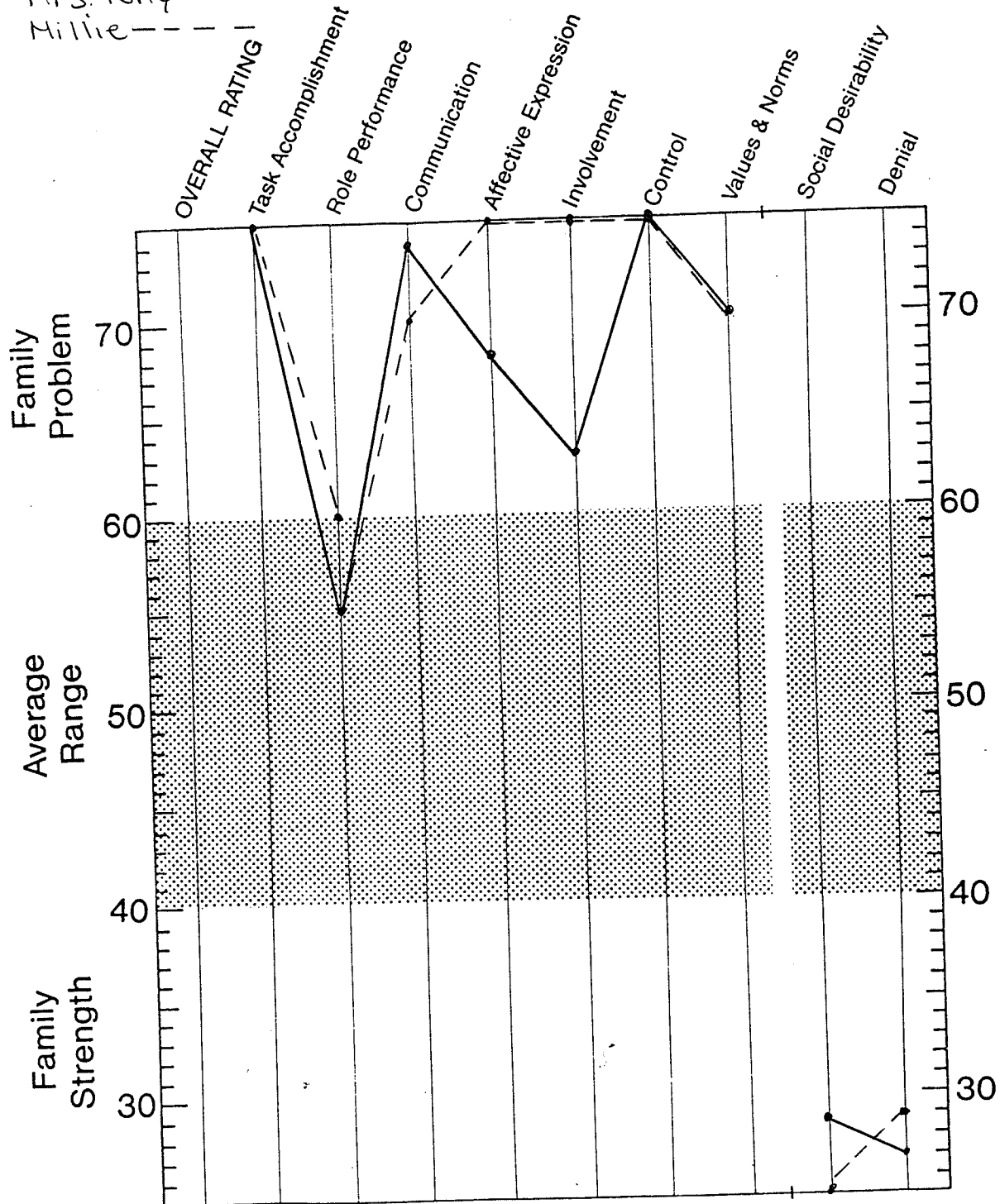
The Family Assessment Measure III: The Tony Family

June 6, 1990

Mrs. Tony —

Millie - - -

FAM GENERAL SCALE



APPENDIX H

The Family Assessment Measure III: The Tony Family

September 6, 1990

Mrs. Tony

Millie

FAM GENERAL SCALE

