"THE PARALLEL TREATMENT PROGRAM": AN APPROACH TO TREATMENT OF INTRAFAMILIAL SEXUAL ABUSE

BY

KATHY ANDERSON

A Practicum

Submitted to the Faculty of Graduate Studies

in Partial Fulfillment of the Requirements

for the Degree of

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Department of Social Work

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To know things is to be learned

To know others is to be wise

To know the self is to be enlightened

"Knowledge is Power"

Author Unknown

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Abstract

This practicum describes a "parallel treatment program" which was utilized in the treatment of multiproblem families who had experienced intrafamilial sexual abuse. This approach incorporates both "systemic" and "feminist" perspectives. Issues such as boundaries, roles and family rules were addressed in both the group and family systems work. Treatment approaches also recognized the importance of systems and social networks and focused on the empowerment of both mothers and children. This practicum emphasizes the mother's contribution to recovery as opposed to contribution to the sexual abuse. Treatment focused primarily on the system defined as the non-offending parent/caregiver and the child victim.

The Parallel Treatment Program was implemented by a team of four Master's in Social Work students and was comprised of parallel treatment for both latency and preadolescent age females and their non-offending parents/caregivers for 14 and 15 weeks respectively. In addition to parallel group treatment, each family system was offered systemic work which included individual, dyadic and/or family treatment. The purpose of the systemic work was to supplement group and address issues unique to each system. This practicum focuses on the non-offending parent's/caregiver's groups and systemic work with two of the preadolescent systems.

Overall, the program was successful in decreasing stigmatization, developing coping skills, increasing communication and strengthening the relationship between mothers and their daughters.

It was concluded that a systems ability to benefit was largely dependent on initial

readiness and receptiveness, appropriateness for group, and the scope and type of issues that needed to be addressed overall. Treatment progress was also affected by the stability of placement, relationship between mother and child, level of communication and length of time from disclosure without treatment. These factors emphasize the importance of screening and early intervention. The degree and severity of abuse appeared to be less significant than the stability of placement and sense of support.

This program was successful overall if viewed as one component of an overall treatment process.

ACKNOWLEDGMENTS

I wish to thank all the group members and people whom I have worked with over the years for trusting enough to share their experiences. Their sharing has enhanced my learning and will only benefit others with whom I will have contact with in the future.

Completing this practicum has reinforced to me, the importance of social networks and support. I have many friends and neighbours who have been helpful in many ways. Their support has been greatly appreciated.

I wish to thank my practicum committee, Walter, Barry and Aaron, for their guidance and time. In addition, Walter, for being flexible in providing supervision time, and Aaron, who has been a "teacher" to me since I began working in child welfare. Thank you for sharing your wisdom and experience.

Thank you to the individuals in my personal life who have had patience and faith. John, thank you for your support over the years, and to my son Richard . . . Mom is finally done school! I hope, however, that I never stop learning.

Thank you to my parents who both encouraged me to continue with my education and offered support through encouragment and faith. My grandmother used to say that an education is something that you cannot ever lose or that no one can take away from you. She used to tell me that "knowledge is power". I have come to realize more and more what she meant by this. Not just for myself personally, but for those I strive to help.

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INTRODUCTION

As a Social Worker working in Winnipeg, Manitoba, I have worked in the area of Intrafamilial Sexual Abuse for over twelve years. My initial experience was in level IV and V residential treatment where it was unclear to me initially, that I was working with many victims of sexual abuse. The focus with these children was always on containing severe emotional and behavioral problems, which were not always linked to their cause. In most cases, these children had been physically, sexually and emotionally abused. While these children showed their pain, there was little attempt to discover the cause.

Through realization of the symptomological origin and desire to deal more directly with the cause of these hurts from a protection point of view, I went to work in the area of child protection five years ago and focused my learning and experience in working with sexual abuse victims. While I was able to do more in the way of protecting children, my efforts were often limited to providing basic safety and not healing. There was often denial and resistance on the part of the parents and many of these children were abandoned to the care of the "system". It also became apparent that these children fared relative to the amount of support they received. While I believe some children, in extreme cases, need to be completely removed from their families and reestablished in a permanent, safe and nurturing environment, the most important source of support came from the non-offending parent or parent figure. From my own clinical observations, children who received such support, are better able to heal and

recover from the trauma of the sexual abuse.

Due to these observations it become important to me professionally, to whenever possible, act to strengthen and utilize the parent/child relationship in terms of recovery. This practicum grew out of my need to develop skills and enhance my own knowledge upon which to base these skills.

This practicum focused on the specific area of treatment of intrafamilial sexual abuse. In order to develop further knowledge and skill and general understanding, I was part of a treatment team which was responsible for developing and implementing a Parallel Treatment Program. The major portion of my practicum was committed to the development and implementation of a therapeutic non-offending parent's/caregiver's groups. My time was committed to a few components of the program which included:

1. Co-facilitation of a latency age non-offending parent's/ caregivers group.
2. Facilitation of a preadolescent age non-offending parent's/ caregiver's group.
3. Systemic work with two of the family systems involved in the preadolescent parallel groups.

Each component involved multiple planning meetings and ongoing clinical and peer supervision.

My educational objectives were to:

1. Increase my knowledge in the general area of impact and treatment of intrafamilial child sexual abuse.
2. Practice a systemic approach to treatment through the use of parallel mother/child groups as supplemented by individual and family system work.
3. Enhance my skills in working with and empowering the mothers of children who have been sexually abused so that they may be better able to protect and support their children.
4. To evaluate the effectiveness of this approach to treatment through the use of clinical observation, self-report and clincial measures.

The ultimate goal of the program described in this practicum report is to further the knowledge and practice base of clinical social work practice with regard to effective approaches in working with intrafamilial sexual abuse.

LITERATURE REVIEW

CHAPTER ONE Sexual Abuse

Introduction

Interest in child sexual abuse has long existed, however, only in the past 15 years has the interest become more wide spread. Child sexual abuse is simultaneously a crime, a mental health issue and medical and social problem, which involves professionals from all disciplines. Social workers, because of involvement with both adults and children, come into contact with cases of sexual abuse in almost every aspect of practice. The increasing emphasis on sexual abuse in the social work literature reflects the interest social workers have in this problem (Conte, 1984).

Societal attitudes toward sexual abuse of children are often barriers to the prevention and treatment aimed at preserving families (Gentry, 1978). Society tends to "talk out of both sides of its mouth". Denial along with repugnance, feelings of guilt by association, anger and uneasy fascination are often society's responses to child sexual abuse. When cases of incest come to light, society's reaction is often to punish those considered involved. On the other hand, it is society which promotes patriarchy and reinforces violence against women and children through such avenues as the media, pornography, an ineffective justice system and general gender inequality.

Historical View

Incest is considered to be one of the oldest crimes. Numerous references to it in mythology and literature emphasize that cultural and legal prohibitions against incestuous behavior have existed for a considerable period of time.

There is evidence, however, in Greek, Roman, Egyption and Persian mythologies, that in some cultures, sexual relations between members of the same family, not only occurred, but were sometimes required (Maisch, 1973). The Ptolemies, 330-320 B.C., allowed the marriage of close blood relatives in order to preserve the purity of the royal blood line (Bluglass, 1979).

Throughout history, there has been a dominant view that children are the property of adults, especially men. The possession of children by their parents has been given sanction in the teachings of the Bible (Rush, 1990). As far back as 600 A.D., women, children and slaves, were considered the possessions of their master, the male head of the house. The practice of slavery has since been abolished. The "obedience model of punishment" was typical of families in ancient Rome and predominated throughout history as the view to childrearing (de Young, 1982).

Although there are rare exceptions to incest prohibition in some societies, it is otherwise universally prohibited. In England and Wales, incest was in earlier times, considered an offence against God and for more than 250 years, was dealt with by the ecclesiastical courts, carrying the death penalty (Bluglass, 1979). Until 100 years ago, Scotland also punished incest by the death penalty but then changed the sentence to life in prison. Incest continued to be considered a religious offence until 1908 when

the Punishment of Incest Act was passed. This was repealed and the Sexual Offences Act was incorporated (Bluglass, 1979).

The Middle Ages brought changes where children had some protection under the law regarding rape of a child as being punishable by imprisonment for 2 years . In "Victorian America", the family became more child-centered due to advancement in behavioral sciences which focused on physical, social and moral development of children. The family was still viewed, however, as patriarchal (Rush 1980). In the late 1800's, Freud saw a number of female patients whom had disclosed sexual abuse by their fathers. Freud then came to the revelation that the cause of their "female hysteria" was due to childhood sexual abuse. Due to the implications this had about the behavior of "respectable" family men, he retracted this theory (Herman, 1981) and later wrote that women had erotic fantasies which led to their feelings of guilt (Rush, 1980). This only served to silence the problem and introduce clinical "victim blaming".

Much of the literature on child sexual abuse emerged beginning in the late 1960's and 1970's. This was not due to a sudden increase in the incidence of or sudden emergence of sexual abuse, but was a result of the women's movement. It was their gain in strength and consciousness raising which brought the issues of oppression of women and children to light. One of these issues, was the sexual abuse of children (Brownmiller, 1975).

DEFINITION

Definitions of child sexual abuse come in many forms, usually based on issues such as "who", "what" and "how". It should be noted, that for the purpose of this practicum report, the terms "incest" and "intrafamilial sexual abuse" will be used interchangeably.

Child sexual abuse is a manifestation of adult power. Incest is usually "coersive" and therefore appropriately considered a form of family violence. Comparisons of incestuous families with those who experience other forms of family violence show that the former are by no means more stressed, nor the individuals in those families more pathological. Incest victims are no more willing participants than are child victims of nonsexual abuse (Gordon, 1984). Sexual abuse pertains to the way in which certain adults exploit children. It has to do with psychological damage to children and is a significant determinant of emotional disturbance.

Some definitions of child sexual abuse pertain strictly to biological relationships and marital status. Russell (1984) distinguishes between extrafamilial sexual abuse and incest based on this aspect. She defines extrafamilial sexual abuse as "one or more unwanted sexual experiences with persons unrelated by blood or marriage, ranging from attempted petting (touching of breasts or genitals or attempts at such touching) to rape, before the victim turned 14 years, and completed or attempted forcible rape experiences from the ages of 14 - 17". Incestous child abuse is defined as "any kind of exploitive sexual contact or attempted sexual contact, that occurs between relatives, no matter how distant the relationship, before the victim turns 18" (p. 180).

Berliner and MacQuivey (1982) similarily define incest as "sexual activity between family members where the perpetrator is an adult or is significantly older than the child victim or where force is used" (p. 3). Sexual experimentation not involving the use of force between two children of similar age would not be considered assaultive or abusive unless one party was disturbed by it. Neither of these definitions take into account, issues with regard to the postion of trust members outside the biological family may have on the child victim. Gelinas (1986) defines incest as being sex without mutual consent seeing it as the "exploitation of a relatively powerless person, almost always a child, by a trusted and more powerful family member" (p. 328). While this contains the notion of trust, it remains defined as bound within the family.

Later definitions began to look deeper into the issues of trust and had a more psychosocial focus. Some defined sexual abuse as a form of exploitation of children and adolescents in sexual activities that they do not fully understand and by those upon whom they may be psychologically and socially dependant. These activities were deemed as appropriate to a psychosexual stage beyond their developmental level, to which they are unable to give informed consent, and that violate social taboos regarding roles and relationships within the family (Kempe & Kempe, 1978; Johnson, 1979; Williams, 1983). Some child welfare professionals define sexual abuse generally as "any sexual touch, by force, trickery or bribery, between two people where there is an imbalance in age, size, power or knowledge" (McCall, 1984; p. 35).

Sgroi (1982) defined child sexual abuse itself as "a sexual act imposed on a child who lacks emotional, maturational, and cognitive development. The ability to lure a

child into a sexual relationship is considered to be based on the all-powerful and dominant position of the adults or older adolescent perpetrator, which is in sharp contrast to the child's age, dependency and subordinate position. Authority and power enable the perpetrator, implicitly or directly, to coerce the child into sexual compliance" (p. 9). Sgroi was one of several authors who expanded on this definition to account for postion of trust and power. Incest became more relevantly and psychosocially defined as any and all forms of exploitative sexual activity between a child under 18 and a parent, step-parent, surrogate parent figure or extended family member (Sgroi, 1982; Burgess, 1984; Giaretto, 1976; Coker, 1990). The crucial psychosocial dynamic is the "familial" relationship between the incest victim and perpetrator (Sgroi, 1982). This definition also recognizes that severe psychological effects may occur even though actual intercourse does not.

Sexual abuse includes a range of activities which include exhibitionism to intercourse and also includes pornography. Conte (1982) stated that some physical contact may have a sensual aspect, but may or may not be abusive depending on two factors. One is the developmental appropriateness which directs attention to issues such as similarity-dissimilarity in age and the degree to which the activity is a developmentally appropriate expression of sensuality/sexuality. Secondly is intent, which directs attention toward whose needs and what types of needs are being satisfied by the contact. Sgroi (1982) provides a comprehensive spectrum of sexually abusive behaviors which include:

1. Nudity - e.g., parades around the house nude

2. Disrobing - i.e., in front of the child
3. Genital Exposure
4. Observation of the Child - e.g., undressing, bathing, going to the bathroom.
5. Kissing - i.e., in a lingering and intimate way
6. Fondling - e.g., breasts, abdomen, genital area, inner thighs, or buttocks.
7. Masturbation - mutual or observing of each other
8. Fellatio
9. Cunnillingus
10. Digital penetration of the anus or rectal opening
11. Penile penetration of the anus or rectal opening
12. Digital pentration of the vagina
13. Dry intercourse
14. Intercourse

Berliner and Stevens (1982) developed a "typology" of sexual abuse which divides types of sexual abuse into rape, child sexual abuse and sexual exploitation. This division is based on factors such as the nature of contact, age of the victim and relationship. This typological division is not particularily helpful in making practice decisions as so little is known about what variables are, or are not associated with particular descriptive categories or what problems are encountered in providing service to the various subtypes (Conte, 1982).

In the province of Manitoba, Canada, sexual abuse is further defined in the Child Abuse General Protocol Manual (1988) as meaning "any exploitation of a child, whether consensual or not, for the sexual gratification of a parent or person in whose care a child is and includes, but is not necessarily restricted to: sexual molestation, sexual assault, and the exploitation of the child for the purpose of pornography or prostitution" (p. 2). Sexual abuse also includes incest, which is a crime under the Criminal Code of Canada. Sexual activity between children is also considered sexual abuse if the difference in ages of the children are so significant that the older is clearly taking sexual advantage of the younger.

In 1984, the federal government of Canada released the Report of the Committee on Sexual Offences Against Children and Youths (The Badgley Report), which carefully documented the extent of child sexual abuse in Canada and made 52 recommendations directed at all levels of government and at the private sector. Among the recommendations were those designed to make the law more just and efficacious as it pertains to the prosecution of child sexual abuse cases.

On January 1, 1988, the Criminal Code of Canada was amended and Bill C-15, which incorporates some of the Badgley Report recommendations, was proclaimed in force by the federal government. Bill C-15 created new offences related to child abuse by expanding the legal definitions and revising some of the existing offences. It also created new provisions governing the giving of evidence by children which facilitate prosecutions involving child sexual abuse. Some of the relevent changes to the criminal code which are considered subject of legal definitions of child sexual abuse, include: Consent No Defence; Sexual Interference; Invitation to Sexual

Touching; Sexual Exploitation; Anal Intercourse; Bestiality; Parent or Guardian Procuring Sexual Activity; Householder Permitting Sexual Activity; Exposure; Loitering; and Offence in Relation to Juvenile Prostitution. These are in additon to existing offences relevant to child sexual abuse which include: Incest; Corrupting Morals; Sexual Assault; Sexual Assault with a Weapon, Threats to a Third Party or Causing Bodily Harm; and Aggravated Assault. While the legal definitions were greatly expanded to include a whole spectrum of sexually abusive behavior, Section 150 (Incest), despite recommendations by the Badgley Report, was not changed to include others forms of sexual contact other than intercourse. It also failed to reflect the fact that the psychological relationships, as opposed to blood tie or extent of physical intimacy, is one of the main determinants of the psychological damage to the victim, and therefore, of the seriousness of the crime (Stewart and Bala, 1988).

The Child and Family Services Act of Manitoba (1985) defines abuse as an "act or omission of a parent or guardian of a child or of a person having care, custody, control or charge of a child where the act or omission results in:

(a) Physical injury to the child

(b) Emotional disability of a permanent nature in the child or is likely to result in such a disability, or

(c) Sexual exploitation of the child with or without the child's consent (<<mauvais traitements>>)" (p. 2)

The Child and Family Services Act of Manitoba was amended in June 1989, which was considered necessary to clarify and strengthen child protection legislation. One of

the most significant changes in legislation is the inclusion of those with "care, custody, control or charge". The legislative intent includes not just parents or substitue parents, but guardians, teachers, babysitters, day care workers, coaches, group leaders, school bus drivers, school caretakers etc., or anyone in a position of trust with the child. These inclusions were not previously considered as child protection matters and were considered third party assaults. They were dealt with solely by police, and were not reported to child protection agencies. The recognition of the importance of issues of power and trust and its inclusion in the legislation, has in Winnipeg alone, resulted in a massive increase in the reporting of "child abuse" cases and children needing protection as defined by The Act.

Incidence

Reliable estimates of the number of children sexually abused each year are difficult to obtain because of methodological weaknesses, lack of uniform data collection instruments and the fact that many cases are undetected and therefore unreported (Server and Janzen, 1982; Kelley, 1990; Berliner and MacQuivey, 1982). Most sexually abused children will never tell anyone. It is estimated that 75% of boys and 66% of girls will keep the secret (Finkelhor, 1979; Grescoe, 1981). Until 40 or more years ago, the official recorded rate of incest was 1 or 2 in a million. After reporting of sexual abuse became mandatory and was encouraged by treatment programs, an astonishing new picture emerged and there was a tremendous increase in the number of reported cases (Server and Janzen, 1982; Grescoe, 1981).

Sexual abuse is the most concealed, most distressful and most controversial form of child abuse and occurs more often than is generally believed. Kent (1979) estimated that 250,000 children or 30-46% of all children were molested before the age of 18 in the United States every year. The average molester has abused 73 victims and the offender within the family has committed 80 acts of incest with female children (McCall, 1984). Pedophiles are often considered different from incestuous offenders. Pedophiles are sexual offenders whose primary victims are children. They come from every walk of life, social class, ethnic and religious background. Known offenders range in age from 12 to 94 and there are approximately 4 million child molesters in the United States, 5% of them being women. One of the main ways pedophiles gain access to children is through marriage (McCall, 1984).

It is assumed that when an incestuous abuser, such as a father/father figure, abuses one of his own children, he is giving sexual expression to nonsexual needs. It is also aften assumed that incest is not a "sexual" problem and that incestuous fathers and stepfathers do not abuse children outside of their home. Men's group members often justify their abuses by blaming "demon nymphet victims and frigid unloving wives" (Maran, 1986). The fact is that offenders are men much like other men who use their power and take what they want. There is clinical and empirical evidence that incest perpetrators are sexual deviants and most of them have committed multiple sex crimes by the time they get caught for the incest. Studies show that 44% of heterosexual incest perpetrators had molested children outside their families and 18% have committed rape (Maran, 1986).

The number of reported cases of intrafamilial child sexual abuse has increased

dramatically over the past 10 years. This is due, in part, to the enactment of stricter child abuse reporting laws, an increase in public awareness, and educational and prevention programs for children in schools (Trepper and Barrett, 1986). It is estimated that between one fifth and one third of all women have a childhood sexual encounter with a male (Finkelhor, 1979; Parker, 1986; Herman, 1981). Finkelhor (1986) reports a range of prevalence from 6 - 62% of all females and 3 - 31% of all males.

One fairly recent and methodologically rigorous estimate was based on a random survey of 900 homes in San Francisco. Of all the adult women interviewed, 38% reported that they had been sexually abused (body to body contact) before the age of 18 (Russell, 1986). This is likely an underestimate as under the Criminal Code, child sexual abuse also includes acts of no body to body contact.

Of all the children that are abused, 70 to 90% of the offenders are known to the child or are in the childs' family. Usually 50% of the offenders are a relative and 25% living in the same household. Eighty percent of the victims are female, although it is expected that abuse of male children is vastly underreported. Ninety to ninety-nine percent of incest is commited by men. Although some mothers abuse, they seldom have intercourse with children (Russell, 1986; Finkelhor, 1979; Rosenzweig,1985; Conte, 1984; Parker 1986). More child sexual abuse involved genital fondling or oral/genital contact than intercourse. Under 10% of child sexual abuse is in the overt form of violent attack and is most often perpetrated through use of bribes and threats (Sanford, 1982). While incest can onset at any age, the most common ages of inception are 4 to 9 (Gelinas, 1986).

Incest occurs in all social classes, geographic areas, and ethnic and racial groups (Herman, 1981; Conte, 1984). Father-daughter incest is especially common in families with an extreme imbalance of power between the parents (Herman, 1981)

Badgley (1984) conducted the Canadian National Population Survey of 2008 subjects and found that one in two females and one in three males had been victims of sexual offenses. Children and youths consitute the majority of victims and four in five were under the age of 21 at the time of the first offense. This survey also found that for victims under the age of 16, three of four were girls and one of four were boys. Over half of the assaults occurred in the homes of the victims or perpetrators. Three in five were threatened or physically coerced.

The Child Protection Centre (1984) in Winnipeg, Manitoba has found an increasing trend in reporting. In the first six months of 1984, the amount of reports were more than the whole previous year (112 as compared to 101). It is important to note that these numbers do not reflect medical reports made outside of Winnipeg or to private practitioners. The figures also do not reflect cases that were not reported for medical follow-up. This increase in reporting was believed to be a result of increased community awareness, school prevention programs and media attention. This awareness has made it easier for children to disclose abuse and be believed.

Unofficially, Winnipeg City Police currently receive between 1000 and 1500 reports of child abuse per year. One third are physical abuse and two thirds are sexual abuse. These numbers are only a reflection of the problem in Winnipeg alone and do not account for unreported cases or cases reported to the RCMP. Charges are laid in only approximately one third of all child abuse cases.

The Child and Family Services Report on Alleged Physical and Sexual Abuse of Children in Manitoba (1989, 1991), provides the most accurate figures currently available of the incidence child sexual abuse in Manitoba, as defined under the Child and Family Services Act. These figures would not include those considered third party assault. The report shows a dramatic increase in the number of report of sexual abuse from 1986 to 1991. In 1986 there were 482 reports of sexual abuse, and 819 in 1987. For the fiscal year of 1988/89 there were 1,102 reports, 1,277 in 1989/90 and 1,179 for 1990/91. It should be noted that the figures for 1990/91 do not include statistics from one of the Native child welfare agencies.

Mara (1990) states that it is the increase in reports of sexual abuse for both male and female children, that has led to an increase in treatment programs and research. The increase in treatment services, however, still remains disproportionate to the increase in reporting and need for treatment (Steward, 1986).

CHAPTER TWO Dynamics and Effects of Sexual Abuse

The only really consistent stereotype of incest in inconsistency. Incest is so widespread and is symptomatic of so many kinds of problems that no single cause or modus operandi can be described. Prior to reviewing the dynamics and general effects of incest, the families in which abuse often occurs will be briefly described.

Characteristics of Families

While there is not such a thing as a typically abusive family, there are a number of characteristics commonly found in families in which incest occurs. Many of the parents have been victims in their own childhood. Their marriages are often fraught with serious conflicts, sexual problems in particular. One parent or both often have an alcohol or drug abuse problem and the parent of the same sex is often absent from home for long periods of time. Blended or reconstituted families, especially those with periodically changing step-parents, and single parent families, tend to constitute particularly vulnerable environments. The parents tend to be relatively immature and dependent and encourage role reversal, having their children assume more parental responsiblity than is developmentally appropriate. A sexually abused child often appears to be inordinately attached to the family and is often unable to separate adequately in order to develop social relationships and an independent identity (Rosenzweig, 1985).

Studies of father-daughter incest find families are characterized as rigid and

conforming to traditonal sexual roles, had fathers who dominated families through use of force, and expressed no contrition for their behavior. The male power principle typically dominates these families. Mothers are frequently disabled, either physically or psychologically. (Herman, 1981; Gordon, 1984). Others outside of the family, who could be utilized for support, are regarded as hostile intruders. This emotional isolation promotes blurring of boundaries between the adult and child generations which can lead to role confusion. Family members are often pressed into service to meet each others needs regardless of age. As a means of minimizing pain, victims rely heavily on defense mechanisms, the most powerful being that of denial which acts to minimize the threat of exposure to the outside world. Family members also tend to lack accurate knowledge of sex and show little respect for privacy (Rosenzweig, 1985; Herman, 1981).

Intrafamilial abuse in itself can create a classic double bind at the existential level. The experience of the family, as the primary guarantor of physical and emotional safety and survival, is juxtaposed with the experience of the family as a source of pain and/or confusion that threatens their survival. Thus the stage is then set for the evolution of psychopathology (Maddock, 1988).

Dynamics

Individual responses to incest and the severity of resulting trauma seem to be highly variable. Before discussing the effects of sexual abuse per se, it is important to understand the dynamics which lead to variation in the impact of abuse and resulting

symptoms/effects.

Much has been written in the literature about factors which are critical in determining how a child might react to and assimilate the experience of sexual abuse. There is general agreement on a number of dynamics which include: duration of experience; the child's age; developmental status of the child, relationship of the abuser, degree of force or violence used by the offender; degree of shame or guilt evoked in the child for participation; extent of coercion; and reaction of the child's parents and professionals (Mayhall and Norgard, 1983; Pelletier and Handy, 1986; Russell, 1986; Lusk and Waterman, 1983; Finkelhor, 1979; Coker, 1990).

Russell (1986) studied the "degree of trauma" associated with many of the dynamics of child sexual abuse. She found that there was a statistically significant relationship between the severity of incestuous abuse and the degree of trauma reported, especially in regards to the difference between acts of genital fondling and intercourse. There was also a significant relationship between the degree of trauma and the use of force or violence and the age gap between the victim and the perpetrator, with a greater difference leading to a greater degree of trauma. Abuse by step-fathers was reported as just as traumatic as abuse by biological fathers with step-father victims reporting being more upset. The biggest gap in degree of trauma reported was between biological/step-fathers and that with respect to other relatives. The most significant of all variables affecting the degree of trauma was the severity of sex acts involved followed by whether the perpetrator was a father.

The most consequential dynamic consistently reported in the literature is that of the parental reactions to the abuse (Lusk and Waterman, 1986; Pelletier and Handy,

1986; Kelley, 1990; Mayhall and Norgard, 1983; Sgroi, 1982). Parental reactions have significant impact on the child's future ability to integrate and recover from abuse. Negative blaming or inappropriate responses can sometimes do as much damage as the abuse itself. The extent of support the victim receives from their family has a direct impact on the victim's behavior and mental health. Divided loyalties often result in suppression in order to avoid intervention from external sources and preserve the family's privacy. The emotional climate in which the sexual trauma occurred is also considered to be one of the most potent instigators of long-lasting effects. Less severe sexual abuse occurring in a disturbed family is considered by some as much more traumatic than that of sexual abuse perpetrated with greater aggression by a stranger (Steele and Alexander, 1981).

Elwell (1979) developed "typologies" of sexually abused children based on some of the aforementioned dynamics. These typologies include: Relationship to the offender; Characteristics of the family; Nature of the attack; and Coercion versus participation. Elwell also agreed that family reaction to the disclosure of abuse was the most significant variable and will influence the process of resolution for the child. The implication of this is that the strongest support system available to the child is his or her family. Treatment efforts were then focused on opening communication between the parent and child so that the parent could support the child's need to talk about the abuse.

Effects

In discussing the effects of sexual abuse on its victims, it is important to stress that the term "effects", which has been applied almost exclusively in the literature, can be misleading in that it implies causality. Due to the retrospective nature of virtually all the studies of the sexual abuse of children, it is impossible to separate the effects of the abuse itself from the effects of the intervention by the courts and social services agencies (Lusk and Waterman, 1986; Van Scoyk, 1988). Disclosure of sexual abuse often disrupts the family equilibrium and precipitates a crisis. Multiple interviews and legal intervention often affect the child adversly. There are often other pre-existing conditons such as family pathology which may have produced the observed effects (Steele and Alexander, 1981; Lusk and Waterman, 1986; Pelletier and Handy, 1986). As a result, it is more accurate to view these "effects" as sequelae or even correlates of child sexual abuse.

The individual response to the experience of sexual abuse varies and is largely dependent on the dynamics involved. The literature is extensive in describing effects observed in victims of sexual abuse. Childhood sexual abuse sequelae include those at the affective, behavioral and physical level (Lusk and Waterman, 1986; Van Scoyk, 1988). What may not be observed affectively, will often manifest in other behavioral symptoms.

Sexual abuse is nearly always disorienting and a profoundly disruptive experience for a child with a degree of stimulation that is far beyond their capacity to encompass and assimilate. As a consequence, there is interference with the accomplishment of

normal developmental tasks. The progression of mastery of one's self, the environment and relationship with others is significantly disrupted by the child's permanently altered awareness and new role vis-a-vis the perpetrator (Sgroi, 1982).

Sexual abuse is disorienting because profound blurring of boundaries inevitably follows when someone in a position of power exploits the child by making them a sexual partner. The child cannot avoid questioning limits set for them and for others and are often confused about the appropriate uses of power and authority. Their very identities are at issue.

Destructive effects of sexual abuse are often readily identifiable. Most victims have very poor self-image and display psuedomaturity. They possess poor social skills and seductiveness which is often displayed as a substitute for the age appropriate social skills they are lacking. They are isolated and therefore have poor peer relationships as well as unsatisfying social relationships. Many children are outwardly hostile or depressed and some even suicidal. Most often, they express a reluctance or inability to trust any other human being (Sgroi, 1982; Van Scoyk et al, 1988). There is a pervasive sense of inadequate loving care which produces low self-esteem and a poor sense of identity, both general identity and specific sexual identity (Steele and Alexander, 1981).

Children also feel exploited, abandoned and never listened to. They have a conscious anger toward the perpetrator but sooner or later, also become aware of an equal or greater anger toward the caretaker who failed to protect them. There are feelings of being trapped because, to talk about problems or to seek help is forbidden or even

dangerous. Victims have a long-lasting sense of helplessness and inability to control their own life or destiny (Steele and Alexander, 1981).

It is possible to view the child's behavioral response to sexual abuse as reflective of coping styles (e.g., internalization or externalization). The child who internalizes is likely to be depressed, anxious, and withdrawn, whereas, the externalizing child can be aggressive, cruel and delinquent. Sexually abused girls are more likely to exhibit the former pattern and boys, the latter (Friedrich, 1990).

The effects of childhood sexual abuse also vary depending on the developmental stage of the child. Normal childhood contains several developmental stages in the lifelong process of individual growth and development. These developmental stages have clearly recognizable goals, tasks, and milestones that must be experienced before moving on to the next stage. Individual differences and dynamics due to genetic and environmental factors, such as sexual abuse, are evident in the child's movement in, through, and out of each stage.

Preschool age

Preschool age victims tend to have poor relationships with peers, learning difficulties, abnormal interests in sex play, irrational fears, noticeable personality changes, somatic complaints, social withdrawal and depression (Pelletier and Handy, 1986; Child Abuse: General Protocol, 1988; Van Scoyk, 1988).

Preschool victims will also often regress to earlier forms of behavior that remind them of safer and /or more comfortable times. This behavior includes thumbsucking,

bedwetting, baby talk, overeating, resuming sleep with a special toy, fear of the dark, whining, fretfulness, clinging and fear of sleeping in their own rooms (Myers, 1979).

Latency age children

Tufts (1984), in a study of child victims aged from infancy to eighteen years, found that children age 7 to 13 who have been sexually abused, exhibit greater psychopathology than in any other age group with forty percent of these children considered to be in the seriously disturbed range .

Sexual stimulation commonly produces a chronic pattern of inappropriate sexualized behavior which can lead to prostitution or perpetration by victims in later life. Nonoffending parents often have difficulty in setting limits especially after disclosure. This can result in confusion for a child whose sense of boundaries have been disrupted, eliciting severe testing of limits (Mandall and Damon, 1989).

Children who maintain silence are often preoccupied with intrusive thoughts and fears impairing their ability to concentrate in school. They often experience sleep disturbances and fatigue which interferes with learning. This can lead to them feeling helpless and inadequate. Young victims also experience depression and psychomatic symptoms and can become self destructive (e.g., suicidal gestures) . In later stages, substance abuse is often used to dull emotional pain (Mandall and Damon, 1989).

Victims generally have impaired ability to develop trusting relationships. Isolation discourages the formation of relationships outside the family and therefore allows

little opportunity to practice social skills. Children also experience severe guilt and shame which only serves to reinforce their sense of isolation. Pseudomaturity acts to further widen this gap with peers. Victims also generally do not experience adequate boundaries and therefore lack respect for the rights of others. This can tranfer into aggressiveness or sexual exploitation of others as a defense of helplessness in effort for the victim to achieve a sense of control. Diminished self-esteem may lead to further distancing or provocative behavior to alienate others (Mandall and Damon, 1989).

Normal physiological changes that occur during late latency and early adolescence often produce increased doubt and confusion in children who worry that they may have been damaged. They often believe that menstruation is a result of this damage. They also worry if they are still "virgins". This provokes severe anxiety and guilt which may interfere with later sexual development (Mandall and Damon, 1989; Sgroi, 1982).

Latency age children may also have continuous nightmares, sleep disturbances, phobias, and often act out sexually with toys, animals, and peers beyond normal exploration (Myers, 1979).

Adolescents

Incest interferes with the normal psychosexual development of a child at any age, but is more disruptive during the adolescent stage when there is a heightened awareness and involvement in identity formation and peer standards (Coker, 1990).

This would be argued by others who view sexual abuse as more damaging to pre-schoolers (Lusk and Waterman, 1986). At this age, sexual abuse robs its victims of appropriate developmental sexuality, sometimes leaving them disinterested in sex, promiscuous, or phobic.

Adolescent victims tend to lack emotions when talking about their sexual abuse experiences or become overly emotional. They are sexually developed beyond the norm and tend to act out sexually to please, or go the opposite and be touch sensitive (Myers, 1979).

Adolescent victims display a range of responses to their sexual abuse due to their different personalities and situations. They often develop some form of coping machanism in order to survive within the family context. This adaptive response is called an "accomodation response" (Berliner and MacQuivey, 1982) which is likened to learned helplessness. These responses may become a symptom of dysfunction or disturbance such as mental dissociation, running, prostitution, truancy and somatic complaints. (Berliner and MacQuivey, 1982: Pelletier and Handy, 1986; Conte and Berliner, 1981). Other sequelae include: suicide attempts, drug and alcohol abuse, stealing, lying, delinquency, self-mutilation, eating disorders, school problems, and poor relationships. They are vulnerable to other assaults and look outside the family for love (Myers, 1979; Berliner and MacQuivey, 1982; Pelletier and Handy, 1986; Conte and Berliner, 1981; Sgroi, 1982; Child Abuse: General Protocol, 1988). A large number, about 65-75% of drug abusers, prostitutes and runaways, are victims of childhood sexual abuse. (Coker, 1990, Geiser, 1979).

Adult Women

The long term effects of childhood sexual abuse observed in adult women are often similar to those that adolescents develop. They tend to have frustrated dependency needs and feelings of helplessness. They often have an underlying immaturity and lack of ego development. They also have difficulty in attaining a satisfactory level of emotional self-sufficiency or independence as adults. Poor self-image and lack of confidence often result in serious dysfunction or disability. Adult women tend to pick abusive relationships because this is "normal" to them. They may abuse their own children, tend to distrust their own reality and disconnect from childhood memories (Myers, 1979; Sgroi, 1982).

Depression is one of the most commom symptoms observed in adult victims. Suicide attempts and other behaviors such as sadness, withdrawal, fatigue, and symptoms of illness are common. Young women often use self-mutilation to express their emotional pain. Young women who mutilate themselves are subsequently hospitalized and often diagnosed as having a "borderline personality disorder". When tension of sexual abuse becomes intolerable, a transitional state of depersonalization may occur. Some victims may cut themselves or resort to other forms of self destructive behavior. The self mutilation is often used to terminate the defense mechanism of depersonalization (Shapiro, 1987).

Interviews with survivors of sexual abuse reveal long-term effects to be anti-male feelings, low self-worth, self-blame and hatred, shame, guilt, fear, anxiety, chronic depression, mistrust, bodily rejection, suicidal behavior, chronic worry for others

safety, sexual maladjustments, difficult marital and interpersonal relationships, hatred toward their mothers and avoidance of affection and intimacy (Russell, 1986; Coker 1990).

Physical indicators or effects of sexual abuse tend to be consistent throughout most of the developmental age groups. Some of the more common symptoms are: difficulty walking or sitting; pain, swelling or itching in the genital area; bruises, bleeding or lacerations of the external genitalia, vaginal or anal areas; vaginal/penile discharge; sexually transmitted diseases; constant sore throat of an unknown origin; lower abdominal pain, and colitis. Recurrent vaginal infections in children under 12 years of age; pain with intercourse; menstrual difficulties and pregnancy, especially in the early teen years are also indicators common to the relevant age groups (Child Abuse; General Protocol, 1988).

Due to the number of dynamics involved and variation in effects, it is necessary to have an integrated understanding of the impact of child sexual abuse with a view to assessment and treatment. The most comprehensive model in terms of both trauma causing dynamics and effects was developed by Finkelhor and Browne (1985). These dynamics, alter the child's cognitive and emotional orientation to the world and create trauma by distorting the child's self concept, world view, and affective capacities. The model, which is summarized in the following section of this chapter, describes four trauma causing factors, aspects of these factors which lead to variability in trauma, as well as effects specific to each dynamic.

1. Traumatic Sexualization

Traumatic sexualization occurs when a child's sexuality, including both sexual feeling and attitudes, is shaped in a developmentally inappropriate and interpersonally dysfunctional fashion as the result of sexual abuse. This can occur when a child is repeatedly rewarded by an offender for sexual behavior that is inappropriate to their level of development (e.g., through the exchange of affections, attention, privileges or gifts). The child learns to use sexual behavior as a strategy for manipulating others to satisfy a variety of developmentally appropriate needs. It occurs when certain parts of a child's anatomy are given distorted importance and meaning. It occurs through misconception and confusion about sexual behavior and morality which are transmitted from the offender to the child. It also occurs when frightening memories and events become associated in the child's mind with the sexual activity.

Variability in degree

The offender may evoke the child's sexual response which is more sexualizing than having a passive child masturbate them. Enticement to participate is more sexualizing than the use of force, however, force may result in the fear that becomes associated with sex in the wake of such an experience. Also important is the degree of understanding, age and developmental level. If the child understands fewer of the sexual implications of the activities, they may be less sexualized.

Children who have been sexualized emerge from their experiences with inappropriate repertoires of sexual behavior, confusion and misconceptions about their sexual self-concepts and unusual emotional associations to sexual activity.

Effects

Observable

Effects in young children include sexual preoccupation and repetetive sexual behavior (e.g., masturbation or compulsive sex play). They also include knowledge and interests inappropriate for their age. They are often sexually aggressive and may victimize their peers or younger children. Adolescents tend to be promiscuous and are at risk to enter into prostitution. Adults can have an aversion to sex, flashbacks to the molestation experience, difficulty with arousal and orgasm, vaginisimus, a negative attitude towards their sexuality and their bodies, revictimization, and offending their own children (physically and sexually).

Psychological

The abuse results in a heightened awareness of sexual issues, especially with children who might not otherwise be concerned with sexual matters at their stage of development. Part of the preoccupation associates simply with sexual

stimulation and conditioning of behavior that may go along with it but also is a function of the questions and conflicts provoked by the abuse about self and interpersonal relations. There is often confusion about sexual identity. Females often wonder whether they are sexually desirable and whether later partners will be able to tell. There is confusion about sexual norms and standards. Children typically have misconceptions about sex and sexual relations as a result of things offenders may have said and done. There is often confusion of the role of sex in affectionate relationships (e.g., if the child traded sex for affection, this may become their view of the normal way to give and obtain affection). Sexual contact may have negative connotation and is often associated with revulsion, fear, anger, a sense of powerlessness . These feelings can become generalized as an aversion to all sex and intimacy, and will probably account for sexual dysfunction.

2. Betrayal

Betrayal is a dynamic by which children discover that someone on whom they are initially dependent has caused them harm. This may come during the course of abuse or its aftermath. The child may realize that a trusted person has manipulated them through lies or misrepresentations about moral standards. Bretrayal is felt when someone whom they loved or whose affection was important to them, treats then with "callous disregard". This also results when a family member whom they trusted is the abuser but also when one was unwilling or unable to protect or believe them, or who has changed their attitude toward them

after the disclosure of abuse.

Variability in degree

Sexual abuse perpetrated by family members or other trusted persons obviously involves more potential for betrayal than that involving strangers. The degree of betrayal may also be affected by how taken in the child feels by the offender. For example, if they had always been suspicious, they may feel less betrayed than if initially experienced the contact as nurturing and loving. The degree of betrayal is also related to the family's response to the disclosure. If they are disbelieved, blamed or ostracised, they will experience a greater sense of betrayal than those who are supported.

Effects

Betrayal often results in grief reactions and depression over the loss of a trusted figure or additional loss of family following the disclosure. Victims often suffer from grave disenchantment and disillusionment. They often have an intense need to regain trust and security manifested in extreme dependency which results in clinging seen especially in young victims. This same need in adults may manifest itself as impaired judgement about the trustworthiness of other people or in a desperate search for a redeeming relationship. Victims show vulnerability in relationships in regards to revictimization or the failure to recognize when their

partners sexually abuse their children due to overdependency and impaired judgement. They also show hostility, anger and distrust which may manifest itself in isolation and an aversion to intimate relationships. The anger may lie behind the aggressive and hostile posture of some victims, especially adolescents. Anger is also a primitive way of protecting the self against future betrayal. Antisocial behavior and delinquency, which are an expression of anger, may represent a desire for retaliation.

3. Powerlessness

The dynamic of rendering the victim powerless is the process whereby the child's will, desires and sense of efficiency are continually contravened.

Variability in degree

A child's territory and body space are repeatedly invaded against their will, which is exacerbated by coercion and manipulation. Powerlessness is further reinforced when children see their attempts to halt the abuse frustrated. Their sense of powerlessness is increased when they feel fear, or are unable to make adults understand or believe what is happening or realize that the conditions of dependency have trapped them in the situation. An authoritarian abuser who commands abuse and threatens serious harm, instills more of a sense of powerlessness. When children are able to effectively halt the abuse or at least

exert some control over its occurrence, they may feel less disempowered.

Effects

This dynamic often results in fear and anxiety which reflects the inablility of the child to control noxious events. Children may initially respond with nightmares, phobias, hypervigilance, clinging behavior and somatic complaints. It impairs one's sense of efficiency and coping skills. The experience of multiple victimization makes it difficult to act without the expectation of being revictimized. The sense of helplessness may be associated with dispair, depression and suicidal behavior often noted among adolescent and adult victims. This may also reflect in running away, learning problems and employment difficulties noted in victims who feel unable to cope with their environments. This results in a high risk for revictimization as victims may feel powerless to thwart others who are trying to manipulate them or do them harm. In an attempt to compensate for the experience of powerlessness, they may have unusual and dysfunctional needs to control or dominate. This is more common with male victims due to the social issues reinforcing male dominance. Aggressive and delinquent behaviors may stem from the desire to be tough, powerful and fearsome, if even in desperate ways to compensate for the pain of powerlessness.

4. Stimatization

Stigmatization refers to the negative connotations, such as badness, shame and guilt which communicated to the child around the experiences and that then become incorporated into the child's self image. These connotations are communicated in many ways e.g,. from abusers who blame the victim for the activity, demean the victim, or futher convey a sense of shame about the behavior. Pressure for secrecy conveys shame and guilt. Stigmatization is also reinforced from attitudes that the victim infers or hears from other persons in the community or family. Stigmatization grows out of the child's prior knowledge or sense that the activity is considered deviant and taboo and is reinforced after disclosure if people react with shock or hysteria or if the child is blamed for what has transpired. Children are additionally stigmatized by people in the environment who now impute other negative characteristics to the victim (e.g., "spoiled goods") as a result of the abuse.

Variation in degree

There is variation in the degree of stigmatization if children are treated as bad and blameworthy by offenders and are heavily shamed as compared to those who are clearly told that its not their fault. Some children are too young to have much of an awareness of social attitudes and therefore experience little stigmatization. Others, however, have to deal with powerful religious and cultural taboos in

addition to the usual stigma. Keeping secrets of victimization may increase the sense of stigma since it reinforces the sense of being different. Those who find out that other children have also been victimized, may have some of their stigma assuaged.

Effects

Observable

Child victims of sexual abuse often feel isolated and may gravitate to various stigmatized levels of society. They may get involved in drug or alcohol abuse, criminal activity or prostitution. They may also reach extremes in forms of self destructive behavior and suicide attempts.

Psychological

Victims generally experience considerable guilt and shame which are often a response to being blamed and encountering negative reaction from others. Their sense of low self-worth is often concluded from negative attitudes that they are "spoiled mechandise". Victims also experience a sense of being different and feel that no one else has had such an experience, feeling that others would reject a person who has.

Victims of incest experience a lot of physical, sexual and emotional violence at the hands of their abusers. The subsequent effect of that abuse and what they have done to themselves as a result of the abuse, will have as profound an influence on the course of their growing up as the abuse itself. Some see the behavior that is associated with the pain, but fail to hear the pain. Others may actually see the pain, but are afraid to deal with it. If they cannot succeed in curing the symptoms of childhood pain, they spend their time diagnosing and labelling those symptoms (Myers, 1979).

CHAPTER THREE Theories of Etiology

Different treatment approaches that currently exist are derived from what is known about the etiology of child sexual abuse. Different theoretical perspectives may be represented by the numerous fields involved in child sexual abuse such as social work, medicine, psychology, psychiatry and sociology. Indeed one's frame of reference may be influenced by one's theoretical background, but also by their observations and role in their involvement with these families. These various perspectives often promote a lack of coordination in the identification of sexual abuse and its effects as well as development of treatment programs which are differentially effective with the incest family population (Teirney and Corwin, 1983; Larson and Maddock, 1986).

The literature that examines the causes of sexual abuse in families identifies multiple contributing factors which are varied and interactive (Williams, 1983). Categorizations of these factors are helpful and are frequently utilized.

Teirney and Corwin (1983) in a review of factors present in intrafamilial sexual abuse, present a model that explores the problem from four levels. These are sociological factors such as household density, geographic or social isolation; family structure including composition, role disturbance and power distribution; individual predispositions and personality characteristics of family members; and precipitating factors such as life stress or parental absence.

Belsky (1980), proposes an ecological integration to account for the etiology of "child maltreatment". He conceptualizes child abuse as a "social-psychological

phenomenon" which is multiply determined by the forces at work in the individual (ontogenic development) and family (microsystem) as well as community (exosystem) and culture (microsystem) in which both the individual and family are embedded. This framework emphasizes that causative roles that each of these factors play as well as recognition of their interaction in the etiology of child abuse. For example, while abusing parents enter the microsystem of the family with developmental histories which may predispose them to treat children in an abusive manner (ontogenic development), stress-promoting forces both within the immediate family (the microsystem) and beyond it (the exosystem) increase the likelihood that conflict will occur. Parental responses of abuse are seen as a consequence of both of a parent's own experience as a child (ontogenic) and of the values and child-rearing practices that characterize the society or subculture in which that individual, family, and community are embedded (the macrosystem).

Dixen and Jenkins (1981) review eitiological theories and place them in three categories. These include psychoanalytic theory, behavioral theory, and dysfunctional family system theory, which is most cited in the literature (Mayhall and Norgard, 1983; Mrazek and Bentovim, 1981; Finkelhor and Browne, 1986).

Waterman (1986) provides three formulations about dynamics leading to sexual abuse. These are sociological formulations, including poverty, overcrowding, and geographical isolation; psychodynamic formulations, including various personality traits and histories; and family systems formulations, including dysfunctional marriage, power imbalance, role-reversal and boundary difficulties amongst others.

Kempe and Kempe (1984) identify just two broad categories, the multi-problem

or "chaotic" family, and the "superficially stable" family with a rigid authoritarian father. This is merely descriptive of family characteristics and does not appropriately recognize other contributing factors. Haugaard and Reppucci (1988) discuss causes of sexual abuse and examine four views: 1) Individual pathology 2) Chaotic family 3) Functional explanation and the 4) Feminist explanation. The categorization presented by Haugaard and Repucci will be utilized to further elaborate on the etiological theories of incest.

Individual Pathology

Much of the early theorizing about child sexual abuse explained the problem as based on the individual pathology of the offender. Although few offenders actually demonstrate severe mental disturbances in the form of psychosis or other clear evidence of psychopathology, it has been suggested that the offenders' pattern of sexual arousal may be pathological in terms of sexual arousal to children. Although there was a move away from this perspective during the era of family systems theory, fairly recent clinical and empirical evidence points to the fact that many incest perpetrators are sexual deviants (Maran,1986). Unlike the view of "Parents United" for example, incestuous fathers are viewed as no different from other child molesters and are considered to be incurably addicted to their sexual behavior (Maran, 1986). This perspective has important implications for the treatment of sexual abuse and offenders as the goal of treatment becomes one of control, not cure.

Finkelhor (1984) developed a model that is based on the perspective that the

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

Finkelhor also discusses early contact between father and daughter in caretaking as inhibiting sexual abuse and can, therefore, be considered as a contributing factor where this early contact is lacking. This would be exemplified in a stepfather/stepchild relationship.

Parker and Parker (1986) also found significant differences in the involvement of fathers in the early socialization of their daughters. Sexually abusive fathers were more likely to have been absent from home for periods of time in the early life of the child, and were less likely to have been involved in childcare and nurturant activities during the first three years of their daughter's life. This study also found these

fathers to have experienced greater instability during their early childhood in their family of origin than non-abusive fathers. They were also more likely to have felt emotionally deprived during their own early socialization.

Gutheil and Avery (1977), present a psychodynamic view of incest as expressing the collective psychopathology of all the family members as well as their common adaptational capacities. Their explanation for incest is that among other familial functions, incest can serve as a defense against the pain of separation; moreover, the loss of an important object relationship is a common precipitant of such behavior. Incest is viewed as a collusive act, with the child active and even seductive and the parents driven by specific instinctual motivations to repeat certain childhood experiences or conflicts with a new generation. Mothers are considered as typically unloved by their own mothers and as a consequence, shun the maternal role and unconsciously demand to be mothered or parented by their daughters.

Chaotic Family

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

as "character-disordered" and suggest that they are multi-problem families characterized by chemical dependency and physical violence. Individual members are said to lack impulse control, possess criminal records, lack verbal means for expression of feelings and present narcissistic traits. The authors generalize, however, without discriminating between traits of the offending parent and other family members.

Kempe and Kempe (1984) suggest an association between chaotic families and socio economic status. They cite problems of emotional deprivation, neglect, lack of ability to form lasting relationships, substance abuse, poor impulse control, and violence among such families. Sgroi (1982) identifies these families as lacking goal-directed negotiation among members and being absorbed in fantasy with little awareness of reality. She also suggests a poor prognosis for these families, but sees them as being less prevalent than the higher functioning "mid-range" familes characterized as rigid, with limited coping mechanisms and a high degree of vulnerability.

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

Functional Explanation

The functional explanation involves principles of family systems theory and structural models of family functioning. This view suggests that the act of incest serves some function in maintaining behavioral patterns as they exist within the family unit. Although this function is actually damaging to the family, the incest behavior is viewed as a symptom of an already dysfunctional family system. Family abuse is considered a symptomatic result of the dysfunctional system's enmeshment, disengagement, faulty alliances, blurred boundaries, and ambiguous role relationships. Outwardly, the incestuous family appears to be conservative and protective, however, the system within is governed by pathologically excessive patriarchal norms. The system begins to deteriorate when the individual needs of the two mutually dependent parents are unmet. The formation of a triangular coalition with the eldest daughter is often an attempt by the parents to relieve that tension (Coker, 1990). From this perspective, corrective intervention with an incestuous family involves restructuring of the rules and patterns of interaction within the family, as well as in the community and outside systems.

Several other authors emphasize the need for intervention to be directed at increasing the exchange between the family system and the external system. Alexander (1985) highlights the significance of the interaction of the family system with its environment. She describes the incestuous family as dysfunctional and characterized by "entrophy" (i.e., lack of differentiation, rigid patterning, inflexibility and

avoidance of growth and change). " Too much homeostasis" is said to exist, and the family is isolated from its environment, avoidant of role and individual differentiation. Mrazek and Bentovim (1981) also suggest that patterns develop between the systemic characteristics and are impacted by stressful family of origin events. The systemic characteristics of the family are alliances, communication, parental functions, boundaries, roles, affective processes and exchanges with outside systems. These influence and are influenced by family of origin events and the degree to which these events have been accepted, integrated or resolved by the present parental dyad. The authors suggest that in an incestuous family, what should be nurturant physical contact becomes sexualized. Intimacy and closeness between adults is problematic, and separateness is threatening. The coalition in the parental subsystem is weak, and boundaries are crossed in other areas in addition to sexuality. In this model, the occurrence of incest is explained by a combination of family of origin events and present family systems characteristics. Others have identified family dysfunction and intergenerational issues as key to the understanding of sexual abuse in families (Sgroi, 1982; Gelinas, 1983, 1986; Koch and Jarvis, 1987).

Family therapists move from viewing incest in a linear fashion to a more interactional expression of family dysfunction. While, in some ways this moves away from blaming the mother towards a concept of shared responsibility, mothers are still regarded as "pivotal" in the establishment of the father-daughter incestuous bond (Hildebrand and Forbes, 1987). It is unwise to assume that all mothers contribute to or condone the abuse. Less weight should be given to psychological explanations of mother's roles in abuse and more to factors which lead women to perceive themselves

Feminist Explanation

Feminist theory has contributed much to our understanding of sexual abuse and exploitation of children and adults in relationships. This has occurred in the analysis of basic sexual inequality and the patriarchal social system.

Feminism is defined as having the belief in and commitment to social change which will allow women equality with men, economically, politically and socially. Many feminists hold that "the oppression of women in the present patriarchal system has consequences for everyone in society, including children" (Carter, 1985; p. 4).

Feminist literature that examines the problem of sexual assault against adult women and the abuse of women by men, has been adapted to explain the sexual abuse of children, both within and outside of the family (e.g., Brownmiller, 1975). From the feminist view, sexual abuse of children is a consequence of male socialization and historical social processes that identify females as the property of men. Power, inequality and male social control of women and children are also key contributing factors. Feminists criticize functional or systems theory as inappropriate since it is viewed as implying shared responsibility for the abuse among all family members.

Two of the most influential models, psychodynamic and systemic approaches are each marked by gender bias and result in two kinds of prejudice. The first kind of prejudice in psychodynamic theories, exaggerates gender differences and the second kind of prejudice in systemic approaches, ignores them (Hare-Mustin, 1986). The literature on family violence exemplifies the prejudice in the systemic approach

which focuses on circular causality, in an attempt to move away from linear thinking. An act of violence which could potentially cause severe injury may be activated by the provocative behavior of the other and so reinforce a violent circular pattern. "Once severe damage or death is caused, reinforcement is not possible, a linear act is completed and the circle is broken" (Bentovim, 1987; p. 383). One third of all murdered women are killed by their husbands or boyfriends yet some family therapists, within the framework of their theories, claim there are no "victims" per se (Hare-Mustin, 1986).

In a survey of family therapists, differentiation and negotiation was considered to be the most important goals of therapy. These represent stereotyped male values of individuality and rationality. For women, the differentiation and clarification of self, are viewed as "Utopian fantasies" until such time the structure of the family and society change. It is also noted that the lowest ranked, therapeutic goal was caretaking, typically considered the mother's major responsibility (Hare-Mustin, 1986).

Family therapy has also been criticized for supporting existing power imbalances and male dominance by seeking family restoration. Giaretto (1981) is one such model which utilizes family reconstituion as an indicator of success. Goals of treatment include mothers accepting a share of responsiblity for the conditions leading to the abuse. This places a large part of the blame for the incest on a failing marriage for which both spouses are considered to be responsible parties.

Incest is a silent topic. This silence stems from deliberate or inadvertent attempts by theorists, professionals, and offenders to abstract the reality of incestuous assault from the societal and cultural context in which it occurs. With little exception,

current knowledge about sexual abuse ignores the existence and impact of patriarchy and the influence of male dominance on virtually every sphere of thought and action (McIntyre, 1981). Gelles and Maynard (1987) consider "radical feminist" literature as "impeding" the development of both conjoint and systemic approaches to treating spouse abuse as the radicals "assume" that the women are always the victims of battering and the men are always fully responsible for the violence. They consider feminism as constraining due to the practice of identifying "who is to blame".

Much of the literature refects societal "offender like" attitudes toward women and children. Pittman, (1976) claims that incest between children and nonparental adult relatives in the form of child molestation or precocious sexuality "usually does not have a severe impact on the child". Some even go as far as to blame the child victim for the incest. Bluglass, (1979) suggested that daughters play an active and initiating role in establishing incest which may continue for long period of time without protest. He states that daughters are rewarded with gifts and only after an argument or "fit of pique" is the relationship impulsively reported to a schoolteacher or authority.

Mothers have been charged with an even larger portion of the blame. Many mental health professionals view the mother as, at the worst, culpable and in collusion with the offender, or at least, passive and inadequate. They believe that the incest has occured as the mother has failed to set or enforce appropriate limits on the interaction between her husband and daughter and have not acted as "restraining agents" (Browning and Boatman, 1977; Sgroi, 1982; Strand, 1990; Friedrich, 1990). This implied maternal role is contrary to a true belief of shared responsibility and further implies that mothers should be trained to set up "armed

camps". Placing the responsibility on mothers also reinforces the notion that women should "parent" men.

There is particular controversy about the power role of mothers in incestuous families. The feminist perspective views mothers and daughters as victims of a process of indiscriminate male dominance. Non-intervention by mothers who are aware of continuing abuse is viewed as inhibition due to physical fear. Systems theorists view "withdrawal" as a powerful position for women to take (Dale et al, 1986). "Power of the weak", however, goes too far in assuming total circular causality because this entails the disappearance of both power and individual responsibility. It is the ability to get others to do what you want them to, either by persuasion or force, that is power. The notion of reciprocity impiles that in each interaction, everyone in the system has an equal amount of power, a vast oversimplification which renders the concept meaningless (Wilbach, 1979). The systemic perspective is viewed as incapable of addressing violence, power and control, the essential ingredients of incest. It fails to adequately account for individual behavior, thought and emotion. As the victim is constrained by material limitations in reacting to the activity of the offender, coercive power is based to a large extent on the effective control of material realities, not simply on ideas (Wilbach, 1979). Abuse is qualitatively different from other actions in that the harm it causes is not capable of being controlled by the person harmed.

Mothers are scapegoated for the actual assault in many ways. McIntyre (1981) describes four categories of mother criticisms: "the way the mothers are involved in the incest; the personality characteristics they possess; the nonfulfillment of their

roles as wife and mother; and their reactions on discovering incest" (p. 462). Women are chastised for not performing their traditional roles in a variety of ways. First, mothers are expected to be the source of emotional nuturance in the family. If they do not or cannot maintain a nuturant and affectionate relationship with their husband and children, they are often accused of abandoning the family emotionally which is blamed for setting the stage for incest.

The second criticism focuses on mothers who supposedly try to escape responsibilities in the home by taking care of their own needs, often through activities outside of the home. The third criticism of mothers revolves around her inability to satisfy her partner sexually. Mothers are often viewed as frigid, hostile or unwilling to meet the sexual demand of their partners. The last category of criticism involves the reaction of mothers upon discovering the incest. Mothers are chastised when they do not take steps to stop or prevent incest. Mothers are expected to protect their children from any kind of abuse, even if that means going against the stereotyped passive, submissive female role in a patriarchal family. The message to mothers is clear: " virtually everything they do will be seen as contributing to incest, whether directly or indirectly" (McIntyre, 1981; p. 462).

Placing blame on mothers has a tremendous impact on the mental health of all women generally and specifically on women who are mothers of a sexually abused child. Most theorists tie denial to the mother's having set up the incestuous situation in the first place. The denial then becomes a way for the mother to maintain her sanity in a pathological situation that, one is led to believe, she initiated (McIntyre, 1981). Mother blaming, unfortunately, is a common characteristic of our society and affects

mental health professions as well. It is necessary for clinicians to analyze their own attitudes and emotional reactions to the mother in the incest family (Strand, 1990).

The nonsexist or feminist appraoch focuses on the mother as a victim in the family rather than as an offender herself. Although the family system may by no means be functioning harmoniously, the responsibility for the assault is placed on the perpetrator and no one else. Therapeutic intervention can help mothers to recognize the purpose the incestuous assault serves in this society - to enforce male dominance (McIntyre, 1981).

Herman (1981) suggests that the restoration of the family must begin with strengthening the mother-daughter relationship toward assuring the victim protection and support. The health of this relationship is seen as the most meaningful index of family rehabilitation. Affective support serves as an important protective mechanism. Attachment behavior grows stronger during times of trouble or crisis, which supports the finding that parents, especially mothers as primary attachment figures, are important to their child's ability to cope (Everson et al., 1989).

The disclosure of incest differs from other family crises in that mothers are asked to believe something that they may not want to believe, to interpret something that is at best difficult for them to comprehend, and to resolve the conflict between their roles as a central support figure to both their child and male partner at a time when their own social, emotional, and economic supports may be at risk. Mothers who are unable to support their children may be struggling with their own personal problems and consequently, may be out of touch with the distress and emotional needs of their children (Everson et al., 1989).

When mothers themselves have been abused and lacked a maternal figure to turn to, they often feel so damaged by these early experiences that they consequently expect little for themselves in an emotional relationship. This could partially explain why some women tolerate continuing violence and abuse (Maran, 1986).

Clearly, there is a need to deemphasize the mother's "contribution" to incest and place more emphasis on her contribution to her child's recovery. "Immediate intervention aimed at supporting mothers and helping them to believe and empathize with, and offer consistent emotional support and protection to their children may be the most effective way of reducing the child's emotional stress and disruption following disclosure of incest" (Everson et al., 1986; p. 206). Treatment approaches then, should focus predominantly, and appropriately, on groupwork projects for victims and their mothers (Dale et al., 1986). Herman (1981) also suggests that intervention be aimed at the social level, altering the social structures that support vicitimization by males, and at the individual perpetrators of abuse.

There are few areas in the conceptualization and treatment of sexual abuse that generate more controversy than that of the role of the family in incestuous abuse. There is polarization in the treatment field into two nonoverlapping camps. These are the" victim-advocacy" group and the "family-systems" group. An over simplification of victim advocacy involves emphasis on the rights of the child victim and the non-offending parent victim (usually the mother). If the father is to have a future role in the familiy, it is to be severely curtailed. Victim advocacy reflects a well-developed and justifiable outrage at our culture which allows parents and

fathers in particular, to exploit children and, in a broader sense, allows men to sexually and physically exploit women.

Friedrich (1990) states that there has been some softening of the purely systemic viewpoint as many family therapists who work with families with serious psychological problems have developed an appreciation for the place of individual psychopathology. Dell (1989), a previously unrelenting systemic theorist, recently criticized the purely systemic conceptualization of wife abuse, suggesting that power issues may also need to be considered and allowed that systemic theory had been remiss with regard to issues of power. It is interesting that despite family theorist's emphasis on the system, it can be accused of ignoring the larger cultural system that victim advocates see all around them.

The above explanations for child sexual abuse in the family encompass the prevalent theories concerning its etiology. Much of the literature is now strongly emphasizing that no one theory or explanation alone is adequate to explain its development in all situations where the problem occurs. It is becoming increasingly apparent that all explanations have relevance. A "truly" systemic perspective needs to incorporate family systems and functioning as a context for the incest, feminist perspectives of power and sexual socialization, and individual psychodynamics of sexual offenders.

Finkelhor's model is one which combines explanations. Sgroi (1984) also identifies multiple factors of family dynamics, individual pathology and abuse of power in the family. This allows for conceptualization of the sexually abusive family which includes both underlying movitvation of the offending parent, and the familial and

social structures that contribute to and maintain its occurence within the family. Gelinas (1983) discusses the importance of the role of the female, first as an incest victim, and later as a parent in contributing to the intergenerational patterns in sexually abusive families. Again, she views patterns as based on both individual and family processes. In her work with women who were molested as children, Gelinas explores how these victims often enter into relationships with men whose characteristics and dynamics put families at risk for repetitive sexual abuse. Relational imbalances exist in the victims family of origin, since the victim is typically parentified by both parents. They may then enter into relationships with men who experienced early emotional deprivation or abuse. These men may be characterized as insecure, dependent, immature and sometimes sociopathic in personality, however, this is subject to variation. Some patterns involve mothers with multiple boyfriends who abuse their children, or offenders described as domestic tyrants with whom mothers have no influence. The "typical profile" describes a gradual initiation of incest occuring out of the father's need's for nurturance and affection, and the mother's emotional depletion and daughter's parentified role. Mothers's are not presented as invariably collusive or as abandoning their partner sexually. The intergenerational pattern occurs when the victim is exploited in subsequent relationships as she gets older, repeating a pattern of marriage to a male possessing similar characteristics as her father. Her early parentification leads to ambivalent feelings toward her own children. She may be able to meet the earlier biological needs of her children and parent adequately , but as the child matures, relational problems begin to emerge.

While this pattern may fit many of the situations encountered in practice, one should be cautious about generalizing or suggesting that one typical profile exists. An example of this would include the numerous cases of violent and coercive sexual contact and threatening behavior toward children in the family. It is also not known if violence will develop as a child becomes more overtly resistive. The existence of violence does not alter the psychological impact and damaging effects on the victim although may influence the severity of effects.

Larson and Maddock (1986) take an integrative view and conceptualize incest as a "distortion of the sexual dimension of family experience, arising out of a complex combination of mutually influencing variables in each of four "existential" categories: Intrapsychic, systemic, developmental and situational" (p. 27). The authors provide a structural analysis of incestuous behavior and view incest as a reflection of "boundary disturbances" in four areas: 1) Family/Society boundary 2) Intergenerational boundary 3) Interpersonal boundaries and 4) Intrapsychic boundaries. Taken together, these four boundary disturbances in the incest family reveal a skewed, or distorted family structure in which sex is a reflection of "dis-ease" and a vehicle for abusive, exploitive interaction.

Like other theoreticians, Larson and Maddock (1986) agree incest serves a function in the family system, however, propose that incest does not serve the same function in every family in which it occurs. Incest is viewed as meaningful within the context in which it occurs. This does not imply linear causality, rather, it demonstrates how behavior can be developed and maintained by circular and reciprocal

processes. Larson and Maddock further provide a functional typology of incest families which may be useful for assessment and treatment planning. Incest is viewed as serving one of four basic functions in interpersonal exchange processes: 1) affectional process 2) erotic process 3) aggression process or, 4) the process of expressing rage. Treatment considerations are then based on these functional differences. The authors believe that a systemic understanding of incest families allows for an integration of treatment modalities that includes both individually-focused and family focused approaches without any inherent conflict.

Haugaard and Repucci (1987) suggest that the best approach is to conclude that there are several equally valid explanations depending on the family in question. A search for a singular theory of incest may then be fruitless and a combination of factors and explanations are suitable to the understanding of why sexual abuse occurs in families. Conte (1982; 1984) points out that there is a tendency to view the problem of why sexual abuse occurs in families as originating in interpersonal or intra-personal functioning. A more "systemic/ecological" perspective would be helpful toward recognizing the contribution of sociological factors such as pornography and socioeconomic conditions which is also supported by Finkelhor (1980).

The review of the literature on the effects of sexual abuse on children and families also supports the rationale for family-focused treatment. The problem of sexual abuse has an impact on all family members and their interaction with each other. For the child victim in the family, the relationships upon which they depend for security and

safety are threatened. There is little debate among professionals that physical and psychological harm occurs as a result of abuse (Finkelhor and Browne, 1986: Russel, 1986). In attempting to identify the specific effects of sexual abuse in the family, much of the literature has pointed out that it is difficult to separate the effects of the abuse itself from the effects of numerous other factors in the child's environment (Kempe and Kempe, 1984; Mrazek and Mrazek, 1981; Finkelhor and Browne, 1986; Lusk and Waterman, 1986; Mandall and Damon, 1989; Myers, 1979). This is in reference to the family system where the sexual abuse occurs. The sexual abuse is frequently accompanied by physical abuse, neglect and impaired family relationships and the children are often exposed to chaotic and isolated environments. These factors that pre-date the onset of the sexual abuse and all of the child's earlier experience both positive and negative, will influence observable effects on the child victim.

The risk of the development of intergenerational patterns of incest have been frequently explored in the literature, and this needs to be considered one of the long term effects of sexual abuse on the family as a whole, and even on future generations (Gelinas, 1983; Koch and Jarvis, 1987; Larson and Maddock, 1987; Sgroi, 1982; Mrazek and Bentovim, 1981). The risk is present for victimized children and for siblings not directly abused but exposed to the problematic family dynamics and inappropriate sexual behavior. Gelinas (1983) examined patterns of abuse transmitted through the female victims experience, and Parker and Parker (1986) found patterns of early deprivation in the adult male sexual offender. Clinicians working with incestuous families often routinely explore the adults early childhood

experiences and frequently discover sexual or physical abuse in the history of the family of origin. The evidence strongly supports the need to recognize intergenerational risks and to view the family system as a target of intervention.

In addition to the consideration of long-term risk, a family focused intervention acknowledges the immediate and short-term impact of disclosure and disruption of the family system. The family is often faced with overwhelming information, multiple social service involvement and separation of family members. Solin (1986) has observed families' responses to the social services system and interprets it as anger displaced from the offending parent onto the service system. This is viewed as an extension of family loyalty and the need for the child victim to reframe the abusive parent as "good". Disclosure of sexual abuse brings both relief and fear. Many abusers express relief at their behavior being stopped by the disclosure and external intervention, as previous attempts at self-control may have failed. This relief is also mixed with a fear of loss of significant relationships and the threat of criminal charges. Victims are relieved of the burden of the secret and of continued abuse, yet frequently regret disclosure due to the responses of family members and numerous disruptive consequences of disclosure. Non-offending parents both want to protect their children and yet are faced with mixed feelings toward the victim and their partners, as well as doubts themselves as parents and as partners.

Sgroi (1982) also discusses the intensity of divided loyality in situations where parents choose to support one another and ignore the needs of the child victim. Fear, denial, and ambivalence are manifest by fluctuations in loyalty and conflicting feelings related to complex family and individual dynamics. The recognition and management of

these feelings by the professionals involved, has strong implications for the outcome of the situation for the family. This suggests the need for clinical involvement to begin with the entire family immediately after disclosure.

In summary, the literature tends to highlight different contributing factors and targets of intervention while dealing with commonly identified treatment issues. Structural dynamics, intergenerational issues and environmental needs are consistently cited targets for change and exploration in treatment, with the common goal of stopping sexual abuse. A structural model as a basis for evaluating families explores characteristics of boundaries, subsystems distance, involvement, and connectedness. These concepts can be useful for describing family functioning and defining targets for change. A structural model, which does not necessarily claim a causal link between the family system and the problem of sexual abuse, may be utilized as a way of conceptualizing how a system maintains the problem behavior. The process of change would, therefore, involve changes in the relative positions of family members, while exploring new rules for transacting (Colapinto, 1982). The systems theory position in the purest sense, however, doesn't account for power differential and tends to absolve the individual from personal responsibility and therefore the consequences of private behavior. As an individual is a subset of the larger family system, they must take final and ultimate responsibility for personal actions.

CHAPTER FOUR Treatment Models

The literature on treatment of intrafamilial sexual abuse is replete with methodological problems such as insufficient control of extraneous variables, inadequate measures including anecdotal treatment outcome evidence, small samples and lack of follow-up data (Dixen and Jenkins, 1981; Conte, 1984).

There are two major approaches to clinical intervention with child sexual abuse cases. The first is "traditional therapy" which consists of the direct application of traditional forms of psychotherapy to child sexual abuse. Some traditional therapists locate the problem in a individual, usually the mother or in victims, but occasionally the offender, while other traditional therapists locate the "real' problem in the family system. This approach may not deal with abuse but rather with the presumed "real" cause such as a mother's unresolved hostility toward their own mother, which they act out by subjecting their daughters to sexual abuse by their husbands (Conte, 1984).

The second approach is through use of specialized multimodal programs which are targetted at treating the whole family. Most of these offer a combinations of therapeutic strategies incorporating individual, dyad, group, and family therapy within an overall treatment plan (Conte, 1984; Rosenzweig; B.C. Ministry of Human Resources, 1979; Fredrickson, 1982; Berliner and MacQuivey, 1986; Giaretto, 1981). These models are based on the premise that members of sexually abusive families have both individual treatment needs and relationship problems that require intervention to facilitate healthier family functioning. When a family approach to treatment is utilized, it is intially preferable to work with the various subsystems in

establishing individual therapeutic relationships (Sgroi, 1982; Alexander, 1985; Giaretto, 1981; Dixen and Jenkins, 1981). Dale et al (1986) discourage individual work on the basis that it is "symbolic replication" of the secret and private relationship in which the original abuse occurred.

Family Treatment

The most frequently cited program was developed by Henry Giaretto (1981) which has led to the subsequent development of other programs based on the principles and structure of the Giaretto model (e.g., Anderson and Mayes, 1982; Anderson and Shafer, 1979). The Giaretto program treats families where the offender is a parent or occupies a parental role within the family. It is described as a humanistic approach, based on family systems theory and emphasizes the marital/parental system as the foundation of the family system and reflection of health of the family. The program objectives are focused on halting the sexual abuse; assisting the family in gaining insight into the family dysfunction leading to and perpetuating the molestation; providing treatment as an alternative to incarceration for the offender; relieving the victims feeling of guilt and responsibility; reconstituting the family and restructuring role relationships.

The first phase of treatment consists of individual counselling for the victim, mother and father, followed by dyad work in combinations. The final phase of treatment is family therapy if reunification is chosen by the family and focuses primarily on adjustment to living together again, with open discussion of the abuse,

the changes in earlier therapy and implications of the fathers' return. Group therapy and guided self-help (Parents United, Sons and Daughters United) are a very important component of treatment. As the family therapy sessions are not initiated until the final stage of treatment, siblings are not included as a focus of intervention until the final stage.

Sagatun (1982) studied the effects of Parents United on the members of families in which the incest had occured. A sample of 56 offenders and 35 spouses were studied to assess the impact of the program on the participants' attribution of responsibility for incest, changes in family relationships and subsequent referral and recidivism. Sagatun found that the program appeared to be successful in increasing the participants' feelings of responsibility and in decreasing recidivism, but was less successful in keeping the family together. While all respondents reported an improvement of perceived family relationship, the actual family bonds had often been disrupted. Some of the findings of increased sense of responsibility were attributed to the possibility of fathers simply trying to "mouth the desired responsibility pattern" in order to ingratiate themselves with the courts. This demonstrates some of the shortcomings in relying on self-report attitudinal data without corresponding behavioral measures, random samples and proper control groups. Evaluating recidivism is also difficult as one must judge duration of follow-up of offenders and means of detecting recidivism. It is also not clear in this evaluation if the issue of family reunification is related to the stage of intervention. It also presupposes that effective intervention and success means reunification.

Giaretto's program is in contrast to the family treatment program as outlined in the

work of James and Nasjleti (1983). Like other family treatment programs, this model incorporates individual, couple, group and conjoint family therapy, although, includes family sessions from the point of disclosure and assessment to termination of treatment. There is a progressive increase in the frequency of family sessions and the focus of change and intervention is more on the system dynamics and patterns of abuse in the family. Siblings of the victim are included in treatment with the overall focus on behavior and interaction in the family, boundary disturbances and parenting skills. Their therapeutic stance tends to be direct and confrontive, particularly in terms of defining the circumstances and patterns of abuse in the family. Change involves restructuring of rules and patterns toward minimizing the potential for recurrence of abuse, with specific attention to rules of relationships and behaviors.

Larson and Maddock (1987) also utilize a family systems approach to treatment of incest families. Their understanding of incest is based on the interactional dynamics in the family, boundary issues and sexuality. Structural and strategic family therapy techniques are employed toward realigning intergenerational boundaries, establishing clear interpersonal boundaries, creating intrapsychic boundaries and developing flexibility in the boundary around the family system. Therapeutic goals are achieved in individual, group, couple and family therapy. The extended family and parents of adults in treatment are also included in family sessions in order to address intergenerational issues surrounding abuse. Larson and Maddock also strongly emphasized the sexual dynamics in the couple relationship as well as the way in which sexuality is expressed in the family as a whole. In comparison to other treatment models reviewed, Larson and Maddock place a much greater emphasis on the sexual

aspect of the couples relationship in treatment with the exception of Mayer (1983) who provides a guideline for sexual history of partners and identifies sex therapy as the focus of couple work.

Like the approaches described previously, most family system based interventions involve attention to the structural characteristics of the family system and target structural changes with particular emphasis on boundaries, family rules and family roles. Sgroi (1982) identified similiar issues in family intervention, however emphasizes abuse of power as a key treatment issue. As in other programs, family therapy is suggested as part of a comprehensive treatment plan, but Sgroi also points out that intervention needs to take the form of "aggressive outreach" involving the therapist's entry into the physical environment of the family. She suggests further that "total life support" is needed for the family whose patterns of functioning have been disrupted after the disclosure and that the therapist needs to attend to environmental services as well as provide support and guidance (i.e., an ecological framework in intervention). It is important to perceive the family system as a part of it's ecological environment with social and physical components surrounding it. Therapists need to examine the nature of the transactions occurring within this network of systems. Many abusive families are characterized as socially isolated and lacking meaningful and healthy interaction with outside systems. An important part of any intervention may involve, for example, mobilizing resources for a family, such as financial needs, or access to training or child care. This view is supported by other authors as well (James and Nasjleti, 1983; Gelinas, 1986).

The case study approach in sexual abuse research has been criticized with respect to the tendency to focus only on father-daughter incest, and the overall lack of control to determine the effectiveness of a family system approach to treatment (Conte,1982). It is clear that insufficient data has been generated regarding the effectiveness of sexual abuse treatment programs in stopping abuse.

Some have argued against a family focused treatment approach. In reference to child abuse of any form, Williams (1983) suggests that current child abuse programs that have a goal of keeping the family intact discourages a focus on strategies directed toward creating new alternatives to keeping children at home and protecting their well being. She states that most treatment services are focused on parents and neglect psychosocial problems of abused children. She argues for a child advocacy orientation directed at removal of children, termination of parental rights and freeing children for adoption. While few would disagree that there are situations where this approach would be recommended, decisions need to be based upon careful and ongoing assessment of each family in question, with the the degree of risk to a child being the first consideration. Assessing degree of risk is not always a simple matter and professionals are often faced with a dilemma in making their recommendations. Server and Janzen (1982) in discussing contraindication to reconsititution of sexually abusive families, reviewed characteristics of families that did not reunite in the Giaretto program. Given the priority of continued protection of the child from further maltreatment, it was the experience of the program that a child tends to be placed at risk when any of the following conditions persist: the report of sexual abuse is not believed by the mother or non-offending parent; the father or offender denies

the sexual abuse; the nonabusing parent is unable to protect the child from repeated assault; or one or both parents lack motivation to work toward change in the family system. The child is also vulnerable when the psychopathology of the offender precludes their ability to empathize with the victim, or to comprehend the detrimental effects of the abuse, and when the mother's own needs tie her to the abuser and interfere with her capacity to relate positively with her daughter. They conclude by saying that since incest is committed by so many different kinds of parents, it is not possible to adhere religiously to any one prescription for handling cases. The needs of the child, parents and community are sometimes in conflict and therefore the issue of family reconstitution requires time and professional intervention in order to reach a safe and healthy resolution.

Herman (1981) emphasizes the strength of the mother-daughter relationship as providing the best assurance for protection of the victim. She also sees the need for confrontive and supportive offender treatment with attention to intimacy and affection needs and control of sexual impulses. The problematic family dynamic is viewed as the father's excess power and control. Essentially Herman's ideas can fit into a more family focused model if the mother-daughter relationship is viewed as one dyad in the system. James and Nasjleti (1983) agree that the strength of this relationship is significant to the mother's ability to protect and support the child. It must be recognized, however, that this cannot be accomplished without intervention also focused on the mother's individual needs and relationship issues with her partner.

Mother-Daughter Treatment

Group Treatment of Victims

Malone (1979) argues that family treatment is actually contraindicated for abused children because of the self-centered, destructive relationship of abusive parents with their children. Group therapy is only one possible treatment modality. There are often needs and concerns best addressed in individual therapy and in many cases some kind of parent/child therapy is desirable (Berliner and MacQuivey, 1982). Therapy groups, however, offer one place where the victim and their personal concerns are central and is uniquely their resource.

A review of the literature reveals little documentation of the use of groups for preadolescents/adolescents. From a developmental point of view, group is particularly appropriate as a treatment modality. Normal adolescence involves a shift from reliance on family to reliance on the self and increased peer orientation. Abuse often results in an unnatural break in the natural progression of trust and healthy closeness between child and parent. Many of the tasks of adolescence are worked on, in and about a peer group. Given that peer relationships are frequently impaired in sexually abused children and social support is considered essential to coping with stressful events, group therapy approaches can be quite useful in the overall treatment plan. The group therapy experience can provide opportunities for therapeutic movement not available within the context of either individual or family therapy. This approach can deal with issues of social isolation; can avoid intense costly and time consuming

individual therapy; can allow for discussion of others problems rather than to avoid the threat of immediate self-disclosure; and also provides an empathic setting for the disclosure of the secret which can be of enormous relief to the victim (Berliner and MacQuivey, 1982; Cornman, 1989; Fredrich, 1990; Steward et al, 1986; Mara and Winton, 1990; Kitchur and Bell, 1989).

Therapy must not only help the child victim recover from traumatic effect but also focus on the enhancement of age-appropriate skills. Mandall and Damon (1989), in discussing treatment needs of younger/latency age children, recommend that groups be geared to improve socialization by encouraging healthy interaction with peers and teaching children to respect themselves and the rights of others through maintaining appropriate boundaries. Groups should also focus on organizing drives into socially acceptable behavior through the strengthening of impulse control and use of reality testing.

Victims generally feel stigmatized and isolated from peers by belief that they are "damaged goods". The use of a group context for treatment reduces this sense of stigmatization and isolation and provides a social opportunity to meet friends who understand the pain and share in similiar feelings and eventually learn healthy ways to cope with the aftermath of abuse. Group therapy is also useful for addressing common issues of: low self-esteem; impaired ability to trust; distorted learning; and impaired abilities of self-mastery and control. (Cornman, 1989; Sgroi, 1982; Friedrich, 1990; Kitchur and Bell, 1989).

Treatment of Mothers/Non-offending Parents

The literature to date continues to suggest that the time is ripe to help educate parents about sexual abuse. Parents who have children or adolescents who have been sexually abused are a good place to start (Mara and Winton, 1990). This is reinforced by the fact that the most consequential dynamic consistently reported in the literature, with regard to effects on the child, is that of the parental reactions to the abuse (Lusk and Waterman, 1986; Pelletier and Handy, 1986; Kelley, 1990; Mayhall and Norgard, 1983; Sgroi, 1982). As parental reactions have significant impact on the child's future ability to integrate and recover from abuse, working with the non -offending parent becomes an integral part of treatment (MacFarlane et al., 1986).

Hildebrand and Forbes (1987) argue that groupwork with mothers of children who have been sexually abused can be a major tool in circumventing the cyclical nature of sexual abuse and preventing further recurrence in these families. In the long term, preventing sexual abuse ultimately depends on the strengthening of the position of mothers within their families so that they can protect their children more effectively (Mara and Winton, 1990). There is evidence that incest and abuse are likely to recur from one generation to the next, and therefore, mothers need to protect and support their children more effectively now if they are not to recreate their past . As the vast majority of abusers are men, it is generally the mothers who must become more alert, sensitive and assertive in the defence of their children (Hildebrand and Forbes, 1987) while not taking the responsibility for behavior of men. Work with mothers, therefore, should focus on education (Mara and Winton, 1990) and empowerment

(Friedrich, 1990). This would also implicate the need to improve the general status of women, through civil equality for example (Mara and Winton, 1990).

In working with the mother, the therapist tries to help the mother see that the two must work together and that the therapist alone cannot "fix" the child. After disclosure, the mother herself is in crisis and needs a great deal of support and nurturance and generally needs therapy for herself to express pain and anger at family disruption (MacFarlane et al., 1986). Following the shock of disclosure and outrage, many mothers feel guilty and responsible for choosing an offender as a partner, for not seeing signs of abuse or disbelieving/misunderstanding children. The feelings of responsibiliy and guilt are as a result of them knowning and trusting the perpetrator. They often feel that they have failed as parents because their child had not told them sooner, yet are angry with the child for not telling them. They also feel betrayed and enraged, not knowing what to do with their anger and wish for revenge (Van Scoyk et al., 1988).

As mothers are routinely blamed for the abuse, parental support is critical (Friedrich, 1990). Mothers often feel shunned and blamed by society for not having protected their children from the abuse. They also feel isolated, powerless and frustrated by the criminal justice system over issues such as no charges being laid as their children were considered "too young to be certified as witnesses". Self-help groups for mothers can offer emotional support in coping with legal, financial and psychological affects of child abuse (McCall, 1984; Van Scoyk et al., 1988). Therapy groups for mothers also permit both peer support and confrontation which are essential elements of treatment that are difficult to reproduce in individual therapy

(Sgroi, 1982).

Mothers need support and practice in developing new patterns of communicating their needs. Fear of rejection often causes mothers to limit their requests, and often need to understand that they are not "bad" if their needs are not met (Vancouver Incest and Sexual Abuse Centre, 1989). Role reversal between parent and child is considered the key focus of treatment. Indicators of this include nonprotective parenting, non-empathic parenting, lack of recognition of needs and lack of differentiation in roles. For mothers whose ability to trust is severely impaired by her own history of childhood deprivation, abuse or neglect, the treatment needs to be seen as long term. Unless mothers can explore their own feelings about abuse in their early lives, the development of insight and empathy towards their own children's feelings and needs will be also impaired (Vancouver Incest and Sexual Abuse Centre, 1989).

Treatment of parents is necessary as parents often have ineffective means of dealing with their childrens' inappropriate behaviors. Parents will often sexualize normal behaviors and have unrealistic expectations of their children. Some parents also attempt to sabotage the child's treatment and are often uninvolved in treatment in general. There generally is a lack of support systems available for the parents and individual meetings are generally seen as ineffective (Mara and Winton, 1990).

There is no empirical research examining parental coping with the sexual abuse of a child. The closest approximation comes from research of parental coping with the chronic illness of a child (Friedrich, 1990). Specific coping resources include: social support; specific belief systems that are positive and realistic; financial

resources; problem solving abilities; physical health and energy; good morale; and absence of depression. Also included as a predictor for positive change is the presence of social supports (Friedrich, 1990).

Strand (1990) states that clinicians should work toward adopting an empathic stance toward the mother through an analysis of counter-transference reactions. She reviews strategies for overcoming the salience of betrayal experiences in engaging the mother in treatment, and empowering the mother in early phases of treatment. She also reviews issues relating to the dynamics of betrayal and powerlessness, the impact of sexual traumatization and stigmatization that need to be addressed by the therapist. Strands major theoretical construct in working with the mother in an incest family is Finkelhor and Browne's traumagenic dynamics model (1985). This model was utilized due to common findings that many mothers of victims have never worked through their own past abuse experiences (e.g., Cohen, 1984). Mothers too, feel stigmatized, isolated, betrayed and powerless. Strand suggests a group model utilizing co-therapists with the use of concrete services (e.g., financial resources) to address the issue of powerlessness.

Coker (1990) describes a three-phase model of treatment for adult survivors of sexual abuse. A group setting is used during the first phase which has been reported as a successful modality with survivors (Burgess, 1984; Herman, 1981; Sgroi, 1983). Because each client's situation is unique, the second phase progresses in individual and conjoint family therapy. In the second phase, confrontation of the perpetrator and protective caretaker are hightly important tasks that take place. The final goal in the third and last phase is to change the direction of the survivor's life which involves

education and retraining as directed by self-goals established in the first phase.

A parent support group can be viewed as a system in itself. The goal is to help the parents deal with the sexual abuse through education, therapeutic and supportive intervention. The system is made up of group members and the therapists, which may facilitate changes in the family system by teaching the parents how to help themselves and their children cope with the sexual abuse.

Concurrent Group Treatment of Non-offending Parents and Victims

Any program that provides treatment to abused children needs to provide concurrent treatment to mothers/non-offending parent, through such avenues as individual, group, parenting groups and family counselling (e.g., Vancouver Incest and Sexual Abuse Centre, 1989; Mann and McDermott, 1983; Sgroi, 1982; Friedrich, 1990; Damon and Waterman, 1986).

The major premise of a parent support group is that "if the parents can change in positive ways, then the parent-child relationships within the family system will change as well in a positive manner. This is accomplished partly through the skills taught to parents" (Mara and Winton, 1990; p. 64).

For example, Coufal and Brock, (1984), compared a traditional parent education model to a parent program which included their children. Both programs were evaluated by pretest-posttest, control paradigm indicating that the parent's group which included the children was more effective than the parent's group alone.

The literature with regard to treatment of sexual abuse describes a number of group treatment approaches for children with varying degrees of parental involvement in

treatment. Kitchur and Bell (1989) describe a 16 week group therapy model developed to meet the treatment needs of 11 and 12 year old female victims in a mandated inner-city child and family agency in Winnipeg, Manitoba. Parental contact was limited to pre and post-group interviews. The purpose of the pre-group interview was to provide information about the group format and themes and establish a means of communication with the parents. The pre-post group interviews were also utilized to collect data and as a means to limit parental resistance. The authors report apparent gains in spite of frustrating realities which plague therapeutic work with inner-city children (e.g., house burning down, addiction problems in the family and struggles with loss and separation due to the children being moved). Some of the difficulties such as parental resistance and children being moved, may have been circumvented by including parents in the treatment process. The authors make recommendations with regard to the need for intensive parental communication which may be best met through the use of parallel groups. They also emphasized the need to address concrete issues such as baby-sitting and transportation.

Steward et al. (1986) utilized what they decribe as a "parallel model" using group treatment for victims and home visits with caregivers. The length of treatment varied according to individual needs, from eight months to two years. The role with caregivers was limited to consultation on a bi-monthly basis and referral. Due to concerns regarding children moving a number of times during the course of treatment,

the therapists kept in touch with the full range of caretakers. Once again, parallel treatment as opposed to contact with individual caretakers, may have prevented the need to continually move children. The authors also emphasize the importance of establishing cordial relationships with the many professionals and agencies involved in decisions about the child care.

Van Scoyk et al. (1988) describe concurrent treatment of 37 families whose children had been abused by a non-family member who was in a position of trust. This program focused on the family system and included parents' groups, childrens' groups and family work. While the focus of parental treatment was on both parents in this program, it has significant findings with regard to the need to supplement group work. Van Scoyk et al. found it necessary to include brief focused family work in conjuction with individual sessions with the child due to the different familial beliefs and preexistent history. The authors concluded that it is critical to address the child's and families' unique issues and needs as opposed to just processing them through a preconceived treatment plan (i.e., group treatment alone).

Pescosolido and Petrella (1986) describe parallel family treatment utilizing a psychotherapy group for pre-school girls age 4 to 6. The group focused specifically on the emotional and behavioral sequelae of the sexual abuse. Its primary purpose was to diffuse the psychological isolation experienced by each girl utilizing a format of eduction, psychotherapy and prevention. Parental involvement included some of the mother's attendance in the first group session with all families involved in either individual or conjoint sessions. While there was concurrent treatment of mothers, the children's group was later modified to involve mothers in the group process.

Mara and Winton (1990) developed parent support groups based on the previously stated premise of such a group. Their program was designed to aid parents and caretakers of sexually abused children. Over a two-year period, approximately 50 parents and caregivers participated in four different group formats. The first format consisted of five of fourteen sessions of parents and children together which were composed of parent-child activities. The second format consisted of two of thirteen sessions with parent and child. They then deleted the joint sessions due to parental reports of anxiety about having their child present. The third and fourth formats consisted of thirteen actual sessions of two hours each to which the children did not attend. The overall goal of the program was to help the parents to help themselves in order that they may support and help their children. Specific objective of the parent support program included:

1. "To assist parents in recognizing his or her responsibility to protect their child from abuse.
2. To assist parents in dealing with feelings of guilt, anger and shame about the abuse of their child.
3. To assist parents in supporting his or her child during the acute period, following the disclosure of the abuse.
4. To assist parents in supporting the children in resuming normal development following resolution of the trauma of the abuse.
5. To teach parents to discriminate between normal developmental issues versus issues arising from the sexual abuse.

6. To assist parents in establishing boundaries in the parent-child relationship.

7. To ensure continuity between the child's treatment and that of the parents." (Mara and Winton, 1990; p. 67).

Winton (1990) conducted a preliminary evaluation of the group to determine whether it had been effective in providing aid and assistance to the parents. He used a sample of 27 parents-caregivers who had participated in the group and completed both the pre-group and post-group evaluation packages. The Louisville Behavior Checklist, the Parenting Stress Index and a subjective evaluation using a rating scale and content anaylsis were utilized. The results were that the group began to approach effectiveness, as evidenced by the parental report of decreases in the children's dysfunctional behaviors and group participants' ratings and comments. As many of the children of the participants were also in a treatment program, this precludes clear determination of the effects of the children's treatment, parent's treatment, or a combination of the two. Winton concluded that it did seem likely that the parent support group helped to reinforce the child's progress in treatment. The participants in the study were taught parenting and coping skills, and indicated that these skills helped them to feel more confident as a parent. Results of the Parenting Stress Index did not support their hypothesis that there would be a decrease in the overall level of parental stress. Subjective evaluation showed that parents rated the group as positive in the areas of content and group leader skills. Parents also indicated that they wanted more group therapy sessions.

Hildebrand and Forbes (1987) describe a model of group work with mothers of

children who had been sexually abused, however, utilize concurrent group treatment with both mothers and children. Their family based approach included:

1. A caretaker's group for adults which included parents and foster parents for the purpose of informing and helping caretakers deal appropriately with the children.
2. A children's group which was designed to help them learn how to protect themselves in the future.
3. A mothers group - 16 weeks.
4. Family meetings every 4 to 6 weeks to integrate the experience of all members in group which also included siblings.

The main tasks of the mothers' group was to acknowlege personal anger, distress and frustration, and consider the mother's own relationships with their partners and children. The goals for the mother's group were designed:

1. To provide a peer group where they could share their experience.
2. To acknowledge how their marital relationship as well as structure and organization of their family may have contributed to the sexual abuse.
3. To consider the nature of the mother's relationship with the child, especially where the child was unable to share the "secret".
4. To boost self-esteem, independence and assertiveness so that they can take on an appropriate protective parenting role in the future.
5. To help them manage anger and feelings of ambivalence toward their child,

siblings and perpetrator.

6. To facilitate more open communication between mothers and victims and reinforce generational boundaries between the two.
7. To help them deal with their own experiences of being abused.
8. To encourage the use of self-help.

Hildebrand and Forbes noted the advantages of mother's group in providing mothers with a forum in which to share their isolating experiences with peers. Aside from the therapeutic aspects, the group performed an educative function through sharing information and learning new skill. In evaluating the effectivness of this approach, the authors reported that the women's appearances and self-confidence levels improved. Many of the mothers also reported greater competence in managing their children and in handling financial matters. Mothers made it clear that they had no intention of reverting to previous dependent patterns and many were also able to make links to their own early history. While the authors focused predominantly on the victim and parental system, they utilized a "systemic" approach whereby all family members were seen as having a role in the abuse even though the ultimate responsibility lay with the perpetrator. They also integrated any change into the wider family system through family meetings, thereby also affecting the siblings of the abused child.

"Parallel" Group Treatment of Non-offending Parents and Victims

Treatment of families in which the mothers and/or their children were sexually abused reveals that mothers and children often share many common issues and conflicts. The emergence of these common themes suggest that they may be more systematically addressed through the development of a "parallel" curriculum (Damon and Waterman, 1986). Issues of parental resistance and need for communication may also be best addressed through the use of parallel group treatment (e.g., Kitchur and Bell 1989).

Mothers, who are often victims of sexual abuse themselves, tend to deal with their children's abuse in much the same way which they experienced themselves. These mothers, are likely better able to support their children once they themselves have been assisted in working through their feelings and thoughts regarding their own sexual trauma. A parallel curriculum, which allows for the discussion of the children's weekly activities with the mothers, facilitates their ability to explore feelings and thoughts with regard to their own early abuse (Damon and Waterman, 1986).

The inclusion of parallel treatment groups for caregivers also offers non-offending parents and guardians the opportunity to examine their own feelings and concerns regarding the sexual abuse of their children, thereby, increasing their capacity to understand the effect of the abuse on the development and functioning of the victims. To achieve such goals, issues and conflicts need to be addressed in a nonthreatening manner through systematic and longterm group treatment. The parallel curriculum

allows the children and caregivers to explore the sequelae of sexual abuse and to integrate complicated and conflictual feelings (Mandall and Damon, 1989). Latency age children, for example, are in the stage of development where discomfort and conflict are often manifested in behavior rather that in direct verbal communication.

The parallel format allows mothers to be apprised of the issues addressed in the children's group on a weekly basis, and therefore, allows them to respond more appropriately to any material that their child brings home. Establishing this level of communication is one of the best methods of protection and prevention (Gentry, 1978). Uninformed mothers are more likely to suppress their child's expression of feelings in an attempt to maintain denial and homeostasis in the family (Damon and Waterman, 1986).

Parallel use of materials in a group therapy format provides an environment in which both children and their mothers are able to stimulate each other, thereby enhancing the therapeutic experience for both. The prevalence of corresponding concerns and reactions of children and mothers is an important variable in treatment. When caregivers exhibit a strong objection to a particular group activity, the children will often display a similar resistance. Respect for the power of the paralled process and integration of parallel issues is considered critical to the success of treatment for children (Mandall and Damon, 1989).

MacFarlane and Cunningham (1988) describe a treatment program for children age 5 to 12 who have "touching" problems. This program untilized parallel groups for parents and children, which adopt a 12 step approach from Alcoholics Anonymous. The 12 steps allowed for a parallel curriculum in which the parents group is coordinated

with the childrens' progress. The authors state that this program is intended as a supplement to and not a substitue for comprehensive treatment of children and families.

Mandall and Damon (1989) developed a manual which provides detailed step-by-step information on setting up parallel treatment groups for nonoffending parents and their children. The curriculum described takes approximately 10 months to complete and includes an organized format for closed weekly parallel group sessions with caregivers and children. The caregiver's groups are run concurrently with the children's groups and include nonoffending parents and caretakers (e.g., relatives, foster parents and guardians). The groups are designed to emphasize and promote current caregiver-child relationships and are not considered to be adult therapy groups. The main goals of the caretaker's group were:

1. " To emphasize that the caretakers' commitment to and support for their children are essential to the therapeutic success.
2. To decrease the sense of isolation for the caretakers by providing a safe place for them to share problems, ask questions, and receive validation for their feelings.
3. To assist caretakers in working through and integrating the various responses to the sexual trauma and its aftermath, and to help them to separate their own feelings from those of their children.
4. To educate caretakers about the dynamics of child sexual abuse and increase awareness of the underlying motivation of their children's behaviors.

5. To help caretakers to become more empathic, responsive, and nuturing toward their children.

6. To reinforce the parental role and to help caretakers provide adequate protection from the perpetrators.

7. To increase bonding and improve communication between caretaker and child outside of the treatment sessions" (Mandall and Damon, 1989; p. 20).

In order to reinforce the parallel nature of the group experience, Mandall and Damon recommend presenting the children's group's main theme to the caretakers on a weekly basis, which is then addressed in their own group with a dual focus on the caretakers' own feelings or fears and aniticipation and understanding of their children's responses. Also, at the beginning of each session with the caretakers, the therapists provide feedback about the previous children's session and then have the caretakers to share any noticeable reaction or changes in behavior. Formal feedback regarding each child's progress in group is then provided to the caretakers during scheduled collateral sessions every 4 to 8 weeks.

Nelki and Watters (1989) utilized parallel group treatment for female victims and their mothers. The children's group consisted of seven girls age 4 to 8 who had disclosed sexual abuse anywhere from 3 to 15 months prior to the onset of group. The parallel parent's group consisted of five natural mothers and one foster mother, who were informed of the main themes as well as the specific material to be covered each week in the children's group. Three cohabitees and two social workers also attended

the parents group from time to time. The groups consisted of 9 sessions run over a period of 9 weeks. The means of assessment focused on the observations of the caregivers. This was to reinforce the importance of their own views and encourage them to join the group whose success was considered essential to the whole therapeutic intervention. Following the termination of group, an assessment was made regarding the need for further intervention.

Damon and Waterman (1986) describe a series of modules for the treatment of sexually abused children and their mothers, developed in a parallel mother-child groups format for children age 8 and under. The unique aspects they describe include a structured curriculum which provides for the exploration of common issues in sexual abuse for both mothers and children in a parallel fashion. The parallel group also allows mothers to handle their child's sexual trauma more effectively as a result of receiving help in dealing with their own abuse. The program presented can be used long-term or short-term over 20 to 30 weeks. The parallel format for the parent's group includes: one of the children's group therapists receiving brief reports on the child for the past week; informing the parent of the week's activities and themes in the children's group; use of parallel themes; and informing the parent as to the child's response on a weekly basis at the end of each group session.

The general aim of their group treatment model was to: help mothers and children express and resolve their feelings regarding the sexual abuse; to assist them in being more assertive in both sexual and nonsexual situations; to help mothers become more aware of their children's needs for protection from coercion; and to help mothers and children obtain nurturance in less sexualized and more appropriate ways. The goals

specific to the treatment of the mothers were:

1. " To assist denying mothers to accept that the sexual abuse really did happen.
2. To sensitize mothers as to what constitutes sexual abuse and to help them be more alert and vigilant to possible abusive interactions that may occur with their children.
3. To help mothers protect their children from reabuse
4. To assist mothers in working through their own feelings with regard to their early sexual trauma, thereby enabling them to assist their own children more effectively.
5. To help mothers become more nuturing, less guilt inducing and more positive with their children.
6. To help mothers work through and integrate their feelings toward the perpetrators" (Damon and Waterman, 1986; p. 247).

Damon and Waterman note that individual and family therapy may be introduced as needed for families involved in the group therapy setting. They also note that although the modules may be presented in 20 to 30 sessions, more extensive therapy is often necessary for disturbed families to show significant lasting gains. They recommend a minimum treatment period of one year in cases of intrafamilial sexual abuse.

CHAPTER FIVE Structure and Format Issues of Parallel Group Treatment

Screening/Group Member Selection

Both caregivers and children need to be carefully screened prior to joining a therapy group, in order to maximize the possiblility of a successful experience for all of the group members. Not all sexually abused children and their parents/caregivers belong in group treatment (Fredrich, 1990; Mandall and Damon, 1989). In considering the appropriateness of group treatment, one should consider both individual (e.g., developmental level and degree of symptomology) and situational (e.g., family dysfunction and parental psychopathology) variables. The screening process needs to consider whether the family will be able to benefit from a structured group approach and whether the child possesses an adequate level of social and emotional skills.

When evaluating the appropriateness of children for group, the following criteria are suggested (Mandall and Damon, 1989; Friedrich, 1990; Kitchur and Bell, 1989):

1. The child is able to respond to limits and is able to control impulses. They are not a threat to others. Care should be given to not accepting children with "attention deficit disorders".
2. The child has potential to talk about abuse in group.
3. The child has sufficient ego strength and is able to wait to speak, follow rules and be able to attend to group content.

4. The child is not mentally retarded or have significant cognitive impairments or reading difficulties.

5. The child is not psychotic, schizoid or depressed.

6. The child is not denying the abuse and is not reluctant to participate in group due to anger at their caregivers.

Many authors(Cohen, 1984; Friedrich, 1990; Mandall and Damon, 1989) also emphasize the importance of screening caregivers and suggests the following criteria for consideration:

1. The caregiver has no severe psychopathology or past history of emotional problems with intensive treatment, hospitalization or no treatment. (e.g., suicidal ideation).

2. The caregiver has no untreated substance abuse or history of severe child neglect.

3. The caregiver shows no evidence of denial.

4. The caregiver is not ambivalent or involved with the offender.

5. The caregiver has no rigid belief systems.

6. The caregiver is not overly enmeshed with the children

7. The caregiver has no anger as related to court ordered status (i.e., not involuntary or resistant).

8. There is no severe marital discord

9. The foster parents or caregivers have sufficient emotional investment.

Kitchur and Bell (1989) recommend an age span of no more than 2 to 3 years. Due to developmental differences, it is also considered prudent to separate pre-school, latency, pre-adolescent and adolescent stages of development. Latency age groups usually have children who range in age from 7 to 12, however, both the upper and lower age limits are determined more by the individual child's cognitive and emotional development than by their biological age (Sturkie, 1983).

Recommended group numbers vary from a minimum of 3 to a maximum of 8 (Kitchur and Bell, 1989; Mandall and Damon, 1989). The maximum number protects the group against unexpected attrition but is still manageable enough for productive interaction.

There was nothing found in the literature in regards to age, gender and group size as relating to membership in a parallel treatment group for nonoffending parents. It would be assumed, however, that, in utilizing a parallel group format, the number of caregivers would equal the number of children in group. Also, given issues of past sexual victimization and need for cohesion, trust and empowerment, it would stand to reason that same-sex membership would also be more effective for the caregivers' group.

Duration/Length of Group

The duration of group treatment is generally dictated not only by clinical wisdom, but also by expediency and group of children/caregivers available to be served. Short-term groups are used for diagnostic purposes, the imparting of information and

development of a beginning sense that the child is not alone in the victimization. Brief educative formats are increasingly utilized because of the number of children and families requiring intervention and the difficulties that disorganized families have in managing anything more than a few sessions in a row. A structured approach focused on resolving victimization experiences, prevention of further abuse and empowering the child for future life experiences would require a minimum of 16 sessions (Friedrich, 1990; Kitchur and Bell, 1989; Hildebrand and Forbes, 1987). The literature, however, reports a range of duration from 13 (Mara and Winton, 1990) to 10 months (Mandall and Damon, 1989). The duration of the caregiver's group is restricted by that of the children's group. There is often a discrepancy between the time required for an adult to change their lifelong attitudes and the shorter time in which some children can respond to peer group learning (Hildebrand and Forbes, 1987). In part, the rationale for a time-limited group stems from the necessity to remain focused on the issue of sexual abuse. Beyond that scope, treatment needs to have more of an individualized focus (Pescosolido and Petrella, 1986). There is also potential danger in prolonged sexual abuse treatment groups. Children may continue to be identified as victims of sexual abuse and the group may perpetuate the victim role rather than promote individual development (Nelki and Watters, 1989). The length of each group session is generally recommended to be 90 minutes (Mandall and Damon, 1989).

Most of the literature recommends a closed group (Mandall and Damon, 1989; Friedrich, 1990) with the exception of Mara and Winton (1990). This allows for greater cohesiveness, experience of peer support and emergence of central issues in a

supportive context. Longer term, more open ended groups may be more optimal for adolescents (Berliner and MacQuivey, 1982; Sturkie, 1983), however, unstructured groups do not work with extremely disturbed children (Friedrich, 1990).

Group Leadership/Therapists

The literature on group therapy consistently contains recommendations regarding the use of co-therapists (Mandall and Damon, 1989; Hildebrand and Forbes, 1987; Nelki and Watters, 1989; Kitchur and Bell, 1989; Barret et al, 1986; Steward et al, 1986; Strand, 1990). Having two group therapists allows for shared responsibility for the families, the simultaneous use of both psychodynamic interpretation and behavioral interventions, the opportunity to model cooperative interaction and also support and feedback. The use of co-therapists also helps to monitor tendencies to concentrate too much attention to any one particular needy client. The ability to retain leadership and avoid being swamped by intensity of emotions is more successfully accomplished by two group leaders being able to alternate passive and active roles. The use of co-therapists also increases the resources available to the client when two therapists share a common event from two perspectives, two temperaments, two levels of energy/fatigue but with common therapautic commitment. Another important benefit of having two group leaders is that group is not disrupted by the unavoidable absence of one leader.

The issue of gender of the group therapists is one in which there are variations in opinion. The use of a male-female team is often a purposeful decision when working

with young victims of sexual abuse. On both conscious and unconscious levels, maternal figures may be experienced as unprotecting in "allowing" the abuse to occur. This can result in ambivalent feelings toward "maternal" figures. Mothers are sometimes experienced as passive, emotionally weak and unreliable with regard to protection. The victim's potential to identify with a submissive mode of relating may be addressed through the group process through observing a female therapist in confident and active engagement in negotiations with a male therapist (Pescosolido and Petrella, 1986). Utilizing a male cotherapist can also provide a sense of activity, without violation of physical and sexual boundaries. Young female victims can then observe a male who is respectful and responsive to female-initiated and directed negotiations (Hildebrande and Forbes, 1987; Pescosolido and Petrella, 1986).

Mandall and Damon (1986) point out the need to recognize the importance of gender identification for latency-age children. Also in consideration of the sensitive nature of the material, they recommend the use of female therapists in groups for female victims. The inclusion of a male therapist in a girl's group can be more disruptive when concerns about safety and security result in extreme guardedness or heightened activity to mask anxiety.

The use of female therapists with adolescents and women is often recommended in the literature (Hildebrand and Forbes, 1987; Coker, 1990). The use of a male therapist can prove to be a barrier for women who are still at a stage where they may be unable to relate to a male in any fashion other than a negative one. It may also be difficult for a male therapist not to succumb, at some level, to the transference and competitive demands of a needy group. Young females and mothers who

have been victims may also find it difficult to discuss their sexual experiences and feelings with a male therapist. Authors such as Nelki and Watters (1989) utilize a male and female therapist for both the children's group and the parallel caregiver's group.

THE PRACTICUM - THE PARALLEL TREATMENT PROGRAM

CHAPTER SIX

Definitions

For the purpose of this practicum, the term "intrafamilial sexual abuse" will refer to any form of sexual activity between a child and a parent, step-parent, nuclear or extended family member or surrogate family member.

The term "parent" will refer to the "non-offending" biological parent of the child whereas the term "caregiver" will refer to the primary caregiver of the child other than the parent and will include foster parents and "non-offending " extended family such as grandparents. The term "mothers" is sometimes used generically to denote both "non-offending "biological and surrogate mothers.

The term "systemic work" will refer to individual, dyadic and family work which can include the child, parent or caregiver, siblings and significant others.

Introduction

This practicum describes a parallel treatment program which was utilized in the treatment of families who had experienced intrafamilial sexual abuse. This approach incorporates both "systemic" and "feminist" perspectives. Issues such as boundaries,

roles and family rules were addressed in both the group and systemic work. Treatment approaches also recognized the importance of systems and social networks and focused on empowerment of both mothers and children. While I believe that mothers need to take responsibility for issues of neglect by acting, I also believe that it is the greater responsibility of society to make the changes necessary to afford the protection of "our" children. This practicum, therefore, emphasises the mother's "contribution to recovery as opposed to contribution to the sexual abuse". Treatment focused primarily on the system defined as the non-offending parent/caregiver and the child victim.

The format utilized in this program incorporates that of Mandall and Damon (1989), Damon and Waterman (1986), Nelki and Watters (1989), and Hildebrand and Forbes (1987). Mothers' and childrens' groups had parallel themes and mothers were informed of topics and materials used in the childrens' groups. The parallel group treatment was also supplemented by systemic family work for the purpose of addressing issues unique to each system (e.g., Van Scoyk et al., 1988). The systemic work was provided by case managers as assigned to each particular system. Case management was provided by group facilitators who were all a part of the treatment team. The treatment team consisted of four clinical Masters in Social Work Students including Barb Gajdek, Karen Gammey, Ron Kane and myself.

The program focused on two sets of parallel treatment groups for a total of four groups. For the purpose of this practicum report, I will describe the two groups which I facilitated/co-facilitated . The members of one group consisted of the female non-offending parents/caregivers of female children aged seven to nine who had

experienced intrafamilial sexual abuse. This group was co-facilitated by myself and Barb Gajdek. The children in the care of these mothers were in a parallel group co-facilitated by Karen Gamey and Ron Kane. The second groups' membership consisted of the female non-offending parents/caregivers of female children aged eleven to thirteen. This group I facilitated alone. The children in the care of these mothers were in a parallel group co-facilitated by Barb Gajdek and Ron Kane.

This report will also provide two case studies in which I was the assigned the role of case manager. The case studies will describe the systemic family intervention provided over and above the parallel groups. Both of the systems decribed in the case studies were from the preadolescent groups.

Group Criteria and Referral Process

The criteria for group membership was determined by the treatment team and screened for during the initial interviewing process of the children and their non-offending parents/caregivers. Following are the criteria for group membership:

1. All children must have experienced intrafamilial sexual abuse.
2. All children must have acknowledged the occurrence of the abuse at some point.
3. Children for the latency age group must range in age from seven to nine years. (Note: There was one exception of a ten year old, based on developmental appropriateness).
4. Children for the preadolescent age group must range in age from eleven to thirteen.

5. All children must be currently residing in a relatively stable and long term home environment.

6. No mental retardation, severe developmental delay or mental illness which would interfere with group process or impair their ability to benefit from group treatment.

7. The primary caregiver (i.e., non-offending parent/caregiver) of the child must agree to attend group. (Note: There was one exception made for each age group due to last minute changes and low referral rates).

8. All children must be protected from the offender/offenders (i.e., no contact).

Referrals for the program were received through the various Child and Family Services agencies, Marymound, the Child Protection Centre and the Community Resource Clinic. All referrals were made by CFS workers with the exception of two. One referral was made by the suggestion of the CFS worker and one was self-referred.

Referrals were initially restricted to the inner-city central CFS area, however, due to time constraints and low numbers of referrals, acceptance of referrals was expanded to include the bordering areas. As referral numbers remained low, cut-off dates for referral included the first week of group.

Screening and Clients

Each child/mother dyad was interviewed at least once and up to three times by generally two of the facilitators (i.e, .one from the mother's group and one from the children's group) prior to the onset of group. Clincial interview and

information from the Intake Checklist (see Appendix A), was utilized in determining the appropriateness for the program. Each guardian was also asked to sign a consent for treatment (see Appendix B). Acceptance for the program was generally determined jointly by the appropriate group facilitators and/or the entire treatment team.

There were seven children accepted for the latency age group which included five mothers in the parallel mother's group. One mother had two children in the children's group and one mother declined to attend group beyond the intake meeting. Two of the mothers in the mother's group were foster parents, two biological parents, and one an extended family member. There were five children accepted for the preadolescent group with three mothers in the parallel mother's group. One mother had two children in group and one declined to join group. Two of the mothers in the mother's group were biological mothers and one was a foster parent. Demographics and information for mother-child dyads accepted for the program are as decribed in Appendix C.

Each system was provided with a non-identifying code as was each significant member in that system for purposes of confidentiality (see Table 1). Each system was assigned a letter (e.g., "A", "B", etc.) which follows the coded name of each person in that system. The lower case letters following the first name in each system indicate the children in the children's group. The second name in each system indicate the mothers of these children. "CFS" stands for the Child and Family Services Worker and "FSW" stands for the Family Support Worker as assigned by Child and Family Services.

Insert Table 1 about here

Time and Location

Both the latency age and preadolescent mother's groups ran at parallel times to the respective children's groups. The latency age groups ran on Tuesdays from 4:30 p.m. to 6:00 p.m. for fourteen weeks beginning on November 19, 1991 and ending on March 3, 1992, with a two week break at Christmas. The preadolescent children's group ran on Wednesdays from 1:45 p.m. to 3:15 p.m. for fifteen weeks from November 20, 1991 to March 11, 1992 with a two week break at Christmas. The parallel pre-adolescent non-offending parent's/caregiver's group ran for five weeks beginning November 20, 1991 and ending on December 18, 1991. This group was terminated prematurely due to low initial numbers, drop out, and movement of children due to protection concerns. All groups were run at the Community Resource Clinic located in the inner-city of Winnipeg, Manitoba.

Additional systemic work described in this practicum, ranged from the onset of group to March 27, 1992. The systemic work took place either at the clinic or in the home/shelter of the family.

Table 1

SYSTEM CODES

Latency Systems

System A

Fiona-a
Fran-A
Frank-A
Freda-A

System B

Heidi-b
Helen-B
Hanna-B
Harry-B

System C

Cindy-c
Carol-C
Cheryl-C
Connie-C
Cam-C

System D

Laura-d
Lucy-d
Lori-D

System E

Ellen-e
Erica-E
Eric-E
Elsie-E

System F

Dee-f
Donna-F
Dena-F
Don-F
Derek-F

Pre-Adolescent Systems

System-G

Ruth-g
Rhonda-g
Rose-G
Ruby-G
Ron-G
Rob-G
Randy-G
Raylene-G

System-H

Ann-h
Alice-H
Abby-H
Alex-H
Ashley-H
Allan-H
Alvin-H
Andrea-H
Art-H
Abe-H
FSW-H

System-I

Gail-i
Gert-I
Garth-I

System-J

Pam-j
Pat-J
Pauline-J
Penny-J
Peter-J
Patrick-J
Paul-J
Parker-J
Phil-J

Overall Objectives of Mother's Groups

The overall goal of the mother's groups was to help the mothers to help themselves in order that they may support and help their children. The specific objectives of both mother's groups were:

1. Empower the mothers by developing awareness and enhancing ability with regard to the safety and protection of their children and prevention of further abuse.
2. Assist the mothers in dealing with their own feelings of guilt, anger and shame about the abuse of their child.
3. Encourage the development and use of empathy and assist the mothers to establish communication with their children in order to strengthen the mother-daughter relationship.
4. Teach mothers to discriminate between normal developmental issues versus those arising from the sexual abuse (e.g., issues of sexuality).
5. Assist the mothers to establish appropriate roles and boundaries in the mother-child relationship.
6. Assist the mothers in establishing and utilizing appropriate coping mechanisms and supports.
7. Ensure continuity between the child's treatment and that of the mother.

SUPERVISION AND PLANNING

Direct clinical supervision for my practicum work was provided by Walter Driedger, Professor of Social Work and Director of the Community Resource Clinic. Supervision for the latency age mother's group was provided for 2 1/2 hours per week through the use of video-tape review and clinical report. Supervision of the preadolescent mother's group was provided for 1 hour per week by video-tape review and clincial report. Supervision for systemic work was provided for 1 to 2 hours per week through clinical report and review of materials.

Peer supervision and debriefing, which included the mother's and children's group facilitators, occurred for 1/2 to 1 hour following each parallel group session. There were also monthly/bi-weekly treatment team meetings which included the treatment team and three of the clinical supervisiors, Walter Driedger, Dr. Barry Trute, and Aaron Klein.

Planning time with my co-facilitator for the latency age mother's group included two times per week for a total of 3 1/2 hours each week. Planning time for the preadolescent mother's group and systemic work varied according to need but was generally no less than 2 hours per week.

CHAPTER SEVEN

Group Process - Latency Age Mother's Group

One of the large interviewing rooms at the clinic was used for all of the sessions. This room had eight comfortable chairs, a coffee table, video-taping and viewing equipment. All sessions were video-taped for the purpose of supervision. A snack was also provided for group members for each session.

All fourteen session's objectives, agenda and content notes were recorded on a weekly basis (see Appendix D). Each session will be described in detail so that the reader can receive an accurate impression of the group content and process as well as the ongoing treatment process for each individual*.

SESSION ONE

The first session was attended by all five group members. The purpose of this session was for group members to get to know the facilitators and each other and begin the joining process. Introductions were made and name tags given out. The facilitators provided members with information on the group (i.e., time, number of sessions, purpose). Some of the group members brought up the issue of transportation which was a difficulty for them. Facilitators promised to try and make acceptable

*Note: Sessional process notes were jointly prepared by Kathy Anderson and Barb Gajdek. These notes are taken from the sessional notes.

arrangements for them through their CFS workers.

Individual group members were then asked what their children's reactions were to coming to the first group. All members said that the children had been looking forward to group. Helen-B brought up the issue of concern by her child that a male was co-facilitating the children's group. The facilitators addressed this concern by discussing the importance of role modelling with a male and the children observing a male in an non-offensive, helping role.

Each member was then given the opportunity to give some information about themselves and their families. In discussing who was in their family, Erica-E and Lori-D discovered that their children went to the same school and knew each other. This appeared to add to the comfort level of group members because they had something in common. Group members asked the facilitators if they had children and what their experience was. Both facilitators gave information that they either had children or experience with them as well as having experience in working with children who have been sexually abused. It was pointed out to members that, while they all had different relationships to the children (e.g., Lori-D and Donna-F, natural mothers; Carol-C, natural grandmother; and Helen-B and Erica-E, foster mothers), they were all the primary caregivers of the children in the parallel group. Group members were informed that one of the children did not have a parent/caregiver in the group.

This led to a detailed discussion of the purpose of parallel groups. The facilitators described the purpose as providing support, education, and support in parenting. Members were told that the facilitators were there to answer questions and

share information, but that they also had valuable experiences and information to share with each other. The group members were given positive feedback on the interest they were showing in their children. They were also recognized for the support they provide by coming to group with their children and in attending group for themselves in order to support their children, learn more about sexual abuse, and work towards prevention of any further abuse. The goals of the children's group were reviewed and it was pointed out that most of the issues they covered would also be covered in the parent's group (i.e., parallel themes). Parents were informed that they would be provided with feedback with regards to the children's group on a regular basis so that they would be more prepared in dealing with the children, their reactions and understand the dynamics of the sexual abuse in relation to the family. Group members were then given information on some of the topics that would be covered by the facilitators. It was pointed out that many of the topics may be of common concern for them, however, they were invited to bring forth any issues they wished to discuss in group.

Initially, Helen-B was presenting more in the way of a "group facilitator". In talking about Heidi-b, she would often make comments about natural families which appeared to be offensive to some of the group members. The facilitators dealt with this by quickly reframing the comments which resulted in Helen-B having more questions than answers and therefore placing her more on the same level as other group members.

As group members were discussing their individual situations, the facilitators noted that all of the group member's were single parents with the exception of Erica

-E. This also appeared to add to the cohesiveness of the group.

The facilitators had the group members decide on group rules as a means of empowerment and establishing ownership of group. The group rules established included: full attendance, confidentiality and smoking only at breaks. In discussing confidentiality, there was discussion about the difference between being indiscriminate and telling the appropriate people, as both Lori-D and Donna-F had told their children not to tell anybody at all about the abuse. Most members expressed that their children had not discussed their abuse with them. Each member was given the opportunity to disclose what had happened to their children, to the extent that they felt comfortable. Helen-B expressed concern that Heidi-b's grandmother should get some help as Heidi-b will be going to live with her in the near future. This discussion was difficult for Donna-F, as it was her son, Derek-F who had sexually abused her daughter, Dee-f. Donna-F stated that she was very angry with her own sister who abused Derek-F. In talking about some of the details of the children's abuse, it was apparent that Lori-D was very confused as to what happened and by whom and when. It was noticed that she had one of the offender's names tattooed on a visible part of her body. Carol-C and Erica-E were also unclear as to the details of their childs abuse.

In completing the measures with the group members at the end of group, the facilitators needed to assist Lori-D and Carol-C due to difficulties in reading and/or understanding the questions. The facilitators were under the impression that Carol-C was illiterate and made a point in further groups to limit writing exercises and assist with any reading for all group members in order to prevent Carol-C from being singled out. It was noted in this group, that the faciltators needed to be concrete in use

of examples and aware of language used in general for all group members.

SESSION TWO

During today's check-in, facilitators followed up with Lori-D's comment from last week and asked how she had resolved her concern about a boy in Lucy-d's school inappropriately touching her chest. Lori-D repeatedly stressed that she was pleased that Lucy-d had told her about the incident and explained to the group that she had involved the principal in confronting the boy and that this had resolved the problem. Facilitators and other group members validated Lori-D for her quick response in protecting her daughter. Erica-E raised concerns about her own children's safety with regard to her foster daughter Ellen-e, and wondered what she could do to educate and protect her natural children in regard toprevention of sexual abuse. The facilitators discussed the need for the sexual safety education of children being age-appropriate and advised members that this topic would be discussed in more detail in an upcoming group. As well, facilitators advised Erica-E to arrange a meeting as soon as possible with her case manager. (Note: As the case manager at that time was one of the group facilitators, a time was arranged that day to explore in more detail why she had become concerned about her own children's safety.)

Donna-F was almost indiscriminate in disclosing her situation today and her concerns. She dominated most of this week's session expressing both her anger and ambivalence in regard to her daughter's sexual abuse by her son Derek-F. Donna-F is also receiving counselling from another agency as Derek-F is in the care of Child

and Family Services. she expressed confusion between attending both counselling services. Donna-F expressed little hope of her son being rehabilitated. She repeatedly emphasized her need to hear him verbally acknowledge responsibility, and for him to apologize for the sexual abuse. Donna-F also spoke of having "bad nerves" and self-medicated with aspirin in the evenings. Lori-D and Carol-C also acknowledged this as a means of coping, which was of concern to the facilitators.

Facilitators and group members proceeded to listen attentively to Donna-F's outpouring of confusion and anger towards her son, due to her apparent neediness in group today. Facilitators utilized Donna-F's situation to exemplify some of the issues and dynamics of sexual abuse. For example, the facilitators stressed that Donna-F's reactions to the offender may be quite different from other mother's reactions as the offender was her own son.

Donna-F again related that Derek-F disclosed that as a child he had been sexually abused by his maternal aunt. Facilitators used this disclosure to educate mothers that sexual offenders have often been sexually abused themselves and that without appropriate intervention, these child victims may go on to become offenders themselves. This, therefore, results in an inter-generational transmission of the problem of sexual abuse. Donna-F appeared to have greater difficulty this week in accepting that her sister had sexually abused her son, so the group challenged her resistance to now believing Derek-F. The facilitators suggested the possibility that if she believed Derek-F, then she would need to deal with her anger towards her own sister, which might be more difficult for her than being angry at her son. She neither confirmed nor denied this hypothesis. Group members and the

facilitators, however, supported Donna-F's expectation that Derek-F accept responsibility for his sexual abuse of Dee-f. The facilitators explained that there are no guarantees in regard to offenders not re-offending and suggested that Donna-F meet with her case manager to begin to address her concerns in regards to Derek-F's progress, as well as the overall treatment plan of the family. In keeping with good team communication and by way of supporting Donna-f, facilitators raised her issue and needs with her assigned case manager.

During a smoking break, Carol-C, who had remained fairly non-verbal during the session, sat beside on of the group facilitators and began to talk. She disclosed how abusive and unsupportive her deceased husband had been. After the break, the mothers were shown the film "Finding Out: Incest and Family Sexual Abuse" (Caulfield and Haig, 1984) which they appeared to watch attentively throughout. After the film, the facilitators validated the mothers for being supportive just like the mother in the film was of her daughter's disclosure. Due to a shortage of time, there was little time to debrief the film. Although Donna-F dominated this week's group with her neediness, the other group members appeared to be genuinely interested, empathic and supportive even though this precluded the completion of the agenda. Facilitators chose to utilize this as an opportunity to concretely exemplify some of the complex dynamics of sexual abuse.

SESSION THREE

Four of five members attended this session. Donna-F did not attend or call to notify

group that she was not coming. During check-in, Lori-D told the group that her ex-husband, who had abused her two children, was just arrested for abusing a child of his present relationship. She stated that she found it hard to believe before, especially as he was their father. This news appeared to confirm for her, that her own children had indeed been abused by him even though he was never charged. She said that she hadn't told her children yet and was still confused about what had happened to them. Group discussed the feelings the children may have when they hear their father has been arrested (i.e., confused, hurt, scared) and encouraged her to be honest with her children. Helen-B questioned the difference in reactions children have when the offender is known versus unknown. The main differences were described by the facilitators as the feelings of betrayal and role confusion. Lori-D was quick to tell other group members that she had no man in her life and was just there for her children. Lori-D's comment appeared to be more in reaction to Helen-B's question about known offenders and need to "say the right thing" in group.

The facilitators then asked group members how they felt about their children being abused as the children will also be talking about feelings this week. The members were also informed that feelings often come out in the form of behaviors and that they need to encourage their children in identifying their feelings

All members generally stated that they were "angry" or "mad" that their children were abused. Erica-E discussed concerns she had about Ellen-e's behavior (e.g., tantrums, acting out, swearing etc.). She also said that Ellen-e threatened her and said that she wanted to hurt herself. Two other parents, Helen-B and Lori-D stated that their children wanted to hurt themselves as well. The group then discussed the

meaning of behavior, specifically issues of self-blame, relevant to latency age developmental stage. The facilitators reinforced the importance of telling children that they are not to blame and that the responsibility for the abuse must be placed on the abusers.

The need to deemphasize behavior and focus on feelings was again reinforced. Each member was asked to identify the feeling they thought their child had when describing a certain behavior. Group members felt the children were feeling violated, were lacking trust, were afraid, angry and hurt. Helen-B and Eric-E in particular, demonstrated insight in their children. Some also felt that they also used anger or magical thinking to prevent further hurt. Lori-D talked about her children, Laura-d and Lucy-d, who constantly sought attention from her. Facilitators reinforced the importance of showing children affection and needing constant reassurance as this reinforces the notion that they are good and safe. Helen-B raised concerns about Heidi-b as she is often oversexualized in her behavior with men. The facilitators talked briefly about the need to reinforce appropriate boundaries but also to balance this with an appropriate show of affection. Group members were asked about how they can spend special time with their children. Lori-D responded to this by saying that Lucy-d slept with her every night. This led to further discussion of children's symptoms of fear (e.g., fear of the dark, wanting to sleep with others at night, have a light on at night). Helen-B stated that Heidi-b used to look after her 3 younger brothers. There was a fire one time and she blamed herself for not knowing how to dial 911. Ellen-e had also looked after a baby herself when she was only 7 years old. This led the group to discuss issues around "pseudomaturity" and lost childhood. Carol-C was fairly quiet

for most of the discussion around behavior and feelings. She was asked by the facilitators what behaviors she noticed with Cindy-c. Carol-C said that she was not aware of any unusual behavior or changes in Cindy-c since the abuse.

There was then a group exercise which involved discussion on general myths about sexual abuse. It was apparent from the discussion that the group had little information around the facts. Group members were surprised that women abuse and that boys were abused so often. Group members also had alot of questions about offenders and why they abuse. Members were told there would be an entire session devoted to this at a later date.

Group members then participated in an exercise of making a list of examples of sexual abuse. Most members had a difficult time even hearing some of the examples. It was pointed out to the group that if they have a hard time even hearing the words, they can then imagine how the children must feel having had experienced these acts. This exercise was helpful in desensitizing them in talking about sexual abuse as they became more explicit and more verbal. Erica-E expressed a question of whether Ellen e would ever get better. This led to discussion of the fact that children will talk about abuse at their own pace and that healing is a process.

The facilitators then provided the group with information about the incidence of sexual abuse (1 in 3 females and 1 in 5 males). All members were surprized at how often children are abused and that males were abused as often as they are. Group members were left with the message that sexual abuse is multigenerational and that secrets perpetuate the problem. Treatment can also help break the "chain". It was pointed out that abuse happens in all cultures and at all socio-economic levels as Helen

B asked if there was a specific group to which this happens. That information appeared to facilitate the breaking down of the barrier between foster and natural parents.

The facilitators forecasted that the children may escalate in their behavior after group today as they were going to be talking about feelings. Members were encouraged to help the children identify the feelings behind their behaviors.

SESSION FOUR

All five members attended group today. Donna-F, however, who had missed last week, arrived late for group today. Donna-F explained her absence from last week's group as being due to the fact that it was cold and that she did not have adequate transportation. Group members expressed having missed her last week which appeared indicative of the developing group identity.

Facilitators began group with the standard check-in. Helen-B began by stating that Heidi-b had given the police a report this week about her sexual assaults. Helen-B expressed concern for how hard the court process will be for Heidi-b who will have to face her perpetrators in court. Facilitators informed her that a resource person was available to work in supporting children through the court process and provided the person's name along with information on how she could be contacted. This naturally led the facilitators into asking each mother to comment on whether or not charges had ever been laid and the current status of any criminal charges or proceedings with respect to the offender. They were also asked what their feelings

were in regard to this matter (i.e., whether they see charges as a viable consequence or penalty for their children's offenders).

Lori-D continued to express confusion as to why no charges had been laid in the case of both offenders yet she clearly knew that no crinimal charges were pending. The facilitators redirected her to her CFS worker should she desire clarification of these matters. Carol-C informed the group that Cindy-c's offender fled the province to avoid criminal charges but that the police had informed her that he would be immediately charged upon his re-entry into the province. Erica-E said that Ellen-e has not given a statement to police and that will only be pursued to do so once she is more verbal about her sexual abuse. Donna-F said that she had finished with the court process and that the outcome had been residential treatment for her son Derek-F. Facilitators utilized this as an opportunity to recognize issues of family loyalties that are evoked when the offender is a family member. Lori-D spoke of having a hard time telling her girls that their father was currently in jail for sexually abusing another one of his children. The facilitators and members empathized with how hard this must be for her but challenged her to be honest with her daughters. The facilitators discussed some of the shortcomings with respect to the legal system's prosecution of sexual offenders (i.e., the believability/credibility of child witnessess). The facilitators stressed the importance of mothers believing their child's disclosure, and validated them for believing their own children.

The facilitators introduced the need for this week's topic , "human sexuality and sex education", because of the children's distorted and deviant knowledge as a result of their sexual victimization. The facilitators attempted to empower the caregivers by

asking them to screen the appropriateness of the film "Where do I Come From?" prior to the children potentially seeing the film next week. By previewing the film, the mothers would also be prepared to discuss the film with their children and answer any of their resulting questions. Lori-D spoke of how Laura-d would inappropriately poke her in the buttocks. The group validated Lori-D as she stated that she had quickly put a stop to the inappropriate touching. Lori-D also spoke of her children's sexual curiosity as exemplified by their questions to her (e.g., the purpose of the condom they found in her purse). Carol-C said that Cindy-c asked such questions, however, directed them to her natural mother, Connie-C. Donna-f said that Dee-f "knows all there is to know". Helen-B said that Heidi-b had inappropriately touched a boy's genitals at school. This lead to Helen-B appropriately modelling for the group how she had discussed "good touches and bad touches" with Heidi-b. There was a general discussion of good and bad touches with mothers providing examples of each.

After viewing the film, all members mutually agreed to the benefits and appropriateness of showing the fim to their children. The facilitators stressed the need for children to be aware of their upcoming developmental/bodily changes with the onset of puberty. There was a discussion on how sexually abused children feel shame about their bodies and normal pubertal changes. Sexual curiosity was defined as normal when age appropriate and examples were given. Facilitators explained how seuxal curiosity may be heightened in children who have been sexualized at an early age and encouraged mothers to be open in answering their children's questions regarding sex and sexuality. There was a discussion about the difficulty of this task and each member was asked how they had learned about sex. All members were

forthcoming in disclosing a lack of sex education. Lori-D who had grown up in foster homes and a girls' home, had never been talked to about sex. Carol-C said that she was raised in a residential school setting where any talk of sex was taboo. Donna-F stated that she was afraid when she started to menstruate as no one had ever talked to her about puberty or changes she could expect. Helen-B also disclosed that she was never taught anything about sex and was surprised when her first baby did not come out of her belly button. This discussion helped all the mothers to see that, despite their apparent differences, they had some commonality within their upbringing. This session appeared to serve as the turning point from the joining stage to the working/growing stage.

SESSION FIVE

All five members attended group today with Donna-F arriving late again. Coming to group late appears to be a pattern for her, alternating with her absenteeism. The facilitators raised these concerns with her case manager. Both Donna-F and Carol-C remained quiet throughout most of group today. Carol-C's participation in group has generally been more non-verbal. This may be due to the age gap with her being the oldest member. It has been noted that her verbal participation increases with fewer members in attendance or on a one-to-one basis.

Group began with check-in, at which point Lori-D disclosed that she has been dating a man who has stayed overnight. This self-proclamation was surprising, as it is contrary to her previous statements of wanting to be single in order to best meet the

needs of her children. She had also discussed fears of her girls being reabused. She explained how she had found Laura-d under the bed one night while she and her male friend were in bed together. She quickly clarified that they were not engaged in any sexual activity. Group members offered her insight as to why her daughters may have been hiding there (e.g., sexual curiosity, concern for their mother's safetey, and so forth). The facilitators raised the importance of setting appropriate sexual privacy boundaries with children. Lori-D responded saying she had already set a privacy boundary with the girls as a result of this incident. The facilitators noticed a pattern emerging with Lori-D. She would often raise problematic situations with her daughters, then seemingly use the group for guidance and support. She would then, however, quickly retract, stating that she has already done and said all that other members might suggest. It is the facilitators hypothesis that this is the result of Lori-D's need for constant approval and validation from the group which she may have been lacking in from her own family of origin or past foster parents and substitute caregivers.

When facilitators gently probed Lori-D to explain how she had come to decide that this current male friend was safe with regard to her daughters, she deferred the responsibility by saying that the girls themselves had requested his presence, so she assumed they must feel safe with him. She then moved from the issue of safety to the issue of the overt violence she had experienced with the girl's primary abuser, her ex-husband. In an effort to diffuse Lori-D's defensiveness, facilitators engaged other members in discussing their experiences in relationships with men. Carol-C denied that her husband had been abusive of her, even though she disclosed emotional abuse

last week to one of the facilitators. It was apparent that emotional abuse was not equated with abuse in her mind. Helen-B stated that she feels women are "better off without a man", yet spoke well of her ex-husband, describing his nature as supportive. Erica-E said, as the only married mother in group, that she is grateful for her husband and her children. In bringing closure to this extended check-in, facilitators stressed that all women and children are entitled to and need the assurance of basic safety in all of their relationships. The facilitators, however, stressed that this did not equate with mothers needing to be without a partner, as the only means for assuring safety. The facilitators provided characteristics indicative of an abusive relationship and stressed the importance of giving this topic more serious consideration. Members agreed this topic would be further discussed during a later session with a guest speaker.

After returning to todays's topic of sexual education and values, some members indicated that they had followed up in pursuing other resources and shared this information with the group. Helen-B modelled what she might tell her children by way of discussing last week's film, framing sex as one means adults have of expressing warmth and love for each other. Most mothers agreed that this would be a good way to preface any discussion of sex with their children. They also stressed the need to inform their children that sex should be between adults and should be limited to a committed relationship (e.g., marriage).

The facilitators initiated the exercise of going through an "askability" questionnaire inviting members to take turns answering questions their children may ask, in accordance with their child's level of development and comprehension. The facilitators

were surprized at how much discussion the questionnaire generated and felt this was the result of a growing level of comfort amongst mothers in general and greater ease in discussing the topic of sexuality. Group concluded with a discussion on the significance of the upcoming Christmas holidays for each member, reflecting, with appreciation, the cultural differences and similarities amonst the members. Helen-B spoke of her concern for Heidi-b's safety in regard to her visiting and staying with her natural family over the holidays. Carol-C spoke of her plans to take her family to the local church mission for Christmas but noted no other significance in this holiday. Lori-d agreed with Carol-C as they share the same culture, that Christmas is not a big celebration or event. The facilitators presented each member in closing with a small Christmas gift in an effort to model nurturance for the mothers. This gesture was paralled in the children's group. The members appeared surprised but delighted that they as adults were also being nurtured.

SESSION SIX

This session was attended by three of five group members. Donna-F again did not attend group or call to explain her absence. Group facilitators informed the group that Erica-E would not be returning to group as Ellen-e's placement had broken down. Ellen-e had been moved to another foster home as Erica-E was concerned about the safety of her own two young children due to threats by Ellen-e. All group members responded with concern for Ellen-e being moved to another foster home, however, they were able to empathize with Erica-e's concerns. While acknowledging the difficulty of

being a foster parent, the members also pointed out indicators of placement breakdown in previous sessions.

Group members discussed their Christmas holidays during the check-in time. Lori-D monopolized a large portion of this time stating that she had many problems with her girls over the holidays. Lori-D said that the girls had been physically aggressive towards her. She dealt with this by threatening the girls to go drinking. Members did not challenge her use of threats to discipline due to her established pattern of defensiveness. They did, however, offer empathy and support for her as a single parent and suggested that she needed a break. This led to general discussion around the difficulties of being a single parent and lacking in outside supports. Carol-C, who is normally the quieter member of the group, talked a fair amount likely due to the decreased group size. She stated that her daughter, Connie-C had come to live with her before Christmas but was now moving between her home and her sisters. Connie-C is expecting her fifth child. Carol-C said that she wanted to keep this child as her four other children live with other family members, three of them with Carol-C. This led to discussion around the difference in being a "visiting" grandmother vs the primary caregiver. Carol-C said that after her husband died four years ago, she found it difficult to be on her own. She stated that she just about "gave up" as he used to help in raising the grandchildren. She said that her grandchildren keep her busy, especially Cam-C who has medical problems.

The facilitators let the group members know that the children were being prepared to share their stories of abuse during this weeks group. The children's group were also going to be talking about keeping secrets which was a topic paralleled in the

mother's group.

In discussing the issue of why children keep secrets, group members were able to come up with a number of known reasons. The main reasons given were that: the children didn't know that what was happening was abuse; there was a lack of, or poor communication within the family; the kids or their families were threatened; nobody asked the kids; and bribes were used. Group members related these to their own situations when they were aware of why the children didn't tell.

The issue of abuse of alcohol in the home was discussed and how this inhibits a caregiver's ability to protect their children. This was raised for discussion by a facilitator as a means of indirectly addressing the concern of alcohol abuse in the home of one of the members.

The members also discussed how they felt about their children having been abused. Helen-B stated that she was angry and also felt powerless. She said that you can teach your children saftey but you can't be there 24 hours a day to protect them. Helen-B discussed the issue of power differential, emphasizing that its not the child's fault. Lori-D and Helen-B found commonality in their family's negative reactions to them taking time for themselves or going out. Lori-D felt very blamed by her own family for the abuse but found this hypocritical as her mother is a heavy drinker. She expressed both guilt and anger for being blamed for the abuse of her children as her children had also been in the care of her mother at the time of their abuse.

Both Lori-D and Helen-B's children had been abused on more than one occassion. Helen-B talked about her difficulty in fostering as she knew little about abused children before Heidi-b was placed with her. She stated that Heidi-b had presented

many symptoms of abuse but had not yet disclosed when she had first come. Helen-B stated that it was a hard decision to foster an abused child because of the commitment required and the confusion caused by moving children.

The group discussed the issues of assertiveness, particularily the difficulty in saying "no" to family. Carol-C said that she has looked after babies since she was 14 years old as her own mother was crippled and kept on having babies. She stated that she was prepared to say no this time to raising Connie-C's baby.

In discussing how members felt about the offenders that abused their children, they generally expressed that they were "angry" and felt like "shooting" them. Members were also concerned about the legal system, feeling that offenders should be punished. Lori-D stated that she was "pissed off" that the offender wasn't charged and she was confused as to why he hadn't been charged. Helen-B was also concerned as Heidi-b was currently going through the legal process. The members felt that charges being laid at least gave a message to the children as to whose fault the abuse was. The members also expressed that they would like some answers about the lack of action on the part of the legal system in way of a guest speaker. The group then took a ten minute break.

After the break, Lori-D talked lot about her family and feelings of powerlessness in not being able to change the past. She appeared to be more comfortable in self-disclosure this week and did not seem as pressured to always say "the right thing". The group talked about how one moves beyond feeling hopeless. Lori-D told group that the turning point for her was when whe went back to school and became involved with elders and the church and had the opportunity to talk. During this part of the discussion, Helen-B was very supportive and validating of Lori-B which further

"broke the ice" between natural parent and foster parent.

At the conclusion of group, members were informed that the children will be discussing feelings about their abuse next week. Facilitators also brought up the subject of parallel letter writing with regard to feeling around the abuse and as a means of facilitating communication.

SESSION SEVEN

At the start of group, Lori-D stated that she could not locate her daughters, who appeared not to have come home after school. The facilitators consulted with the children's group facilitators and agreed to use this crisis as a natural opportunity to illustrate, vis a vis modelling, the theme of safety and protection planning. Due to concerns for the children's safety, one of the facilitators left group with Lori-D in an effort to assist her in locating her girls. Group members expressed their hope that the girls would soon be found as it was -30 C outside. This again reinforced the need to have co-facilitators in order to accomodate the group in times of crisis or in the absence of a group facilitator.

The remaining facilitator proceeded with group. The group began with check-in at which time Helen-B updated Donna-F as to what she had missed in last week's group. The members stated that their children remain excited about the group, and look forward to attending group. Donna-F updated that group on how her Christmas holidays had been. This was a means of reconnecting with the group. She also noted that Dee-F is having trouble in school and that the school is therefore offering additional

counselling. She said that she is unclear as to whether to accept involving yet another agency with her family. It was suggested that she consult with her case manager. As the case manager was at the clinic, the facilitators ensured that he attended to her. The members generally commented that their children experience trouble concentrating in school as a result of the sexual abuse, with the exception of Carol-C. Helen-B interjected that sexual abuse may affect children differently. The facilitator informed mothers on factors which influence the impact of sexual abuse. Donna-F disclosed that her son had physically restrained her daughter when he sexually molested her. She spoke angrily of how premeditated her son's sexual offending appeared to have been.

Helen-B spoke of how Heidi-b had not revealed her sexual abuse earlier because she had been afraid that she would be blamed by her natural family. It was not until after she came into care that she began to feel safe enought to disclose. Helen-B explained how she had initially been shocked by Heidi-b's disclosure and how she had been unsure of how to proceed. Helen-B described how CFS-B was supportive in giving her guidance on how to talk to Heidi-b. Helen-B was validated for all her efforts and all the good work she has done with respect to Heidi-b. It appeared much more significant that a natural mother, Donna-F, further validated Helen-B.

The issue of keeping secrets was once again raised by the facilitators in order to build on the mother's empathy for their own children. This was seen as necessary due to the mothers lack of insight and anger towards their children for not having told them sooner about the abuse. The mothers were then each asked to describe how they eventually learned of the sexual abuse and how they had responded.

Donna-F stated that Dee-f had not told her as she was afraid her mother would

blame and punish her. Dee-f had said that Derek-F had threatened to beat her up if she told. Donna-F said that her youngest son, who on occasion had witnessed the abuse, eventually disclosed the abuse to her. Donna-F said that when she learned about the abuse, she confronted Derek-F and he denied it. She was enraged and thought she might hurt Derek-F so she called CFS-F and Derek-F was placed outside of the home. Donna-F said that since this time, she has beome very protective and wonders if she is now overprotective of her children. For example, when anyone comes to the door, her children are not allowed to let them enter unless she is home and subsequently she said the children follow the rules strictly, not even letting relatives in, if she is not home. The group validated her for this plan and reinforced the notion that most often children are abused by family members and/or a person in a position of trust, and that any safety plan should include precautions against even trusted people. Donna-F appeared less condemning of Derek-F this week as she framed the sexual abuse as a "family problem" and that the whole family needs to continue to deal with the problem in therapy. She commented that this is not an easy process for her or her family. The group members supported her, empathizing with the difficulty given that both the victim and offender are her children.

Carol-C divulged that Cindy-c first disclosed the abuse to her older cousin last summer. Carol-C said that she had noticed that Cindy-c's vaginal area was extremely red and sore, however, accepted Cindy-c's explanation that this occured as a result of falling on the monkey bars. In discussing this further with Carol-C it was apparent that Connie-C was expected to parent Cindy-C with regard to any sexual matters. Carol-C stated that upon Cindy-c's disclosure, she was seen at the Child Protection

Center and that CFS became involved. Carol-C displayed some insight into the effect of sexual abuse stating that Cindy-c now views all men as "bad" including her male relatives and she remains physically distant from them. Helen-B stated that she had learned the importance of not forcing children into being affectionate, touching, or going near anyone with whom they feel uncomfortable. Carol-C showed recognition of the need for safety by recounting how a man had attempted to accost a girl in the neighbourhood and how she had responded to the situation by reiterating basic safety rules to all of her children.

The facilitator then utilized the current crisis with Lori-D as a natural opportunity to discuss the topic of safety and protection planning. Carol-C, who was increasingly comfortable in group today, as demonstrated by her talkativeness, revealed that Cindy-c and her sister had "given her a scare" recently when they had not returned home. Carol-C said she involved the assistance of the police, however, shortly after this, the girls had come home on their own initiative.

During the group break, Lori-D returned with the group facilitator and her two children who had been found. The group facilitator who had assisted Lori-D in the search used the break in order to debrief the incident with the family prior to their return to group. The goal of this meeting was to assist Lori-D in creating a safety plan which would be mutually agreeable to her children.

After the break, the mothers come together to discuss how the crisis had been resolved. The facilitators raised the need for mothers to have a safety plan. Lori-D stated that she was angry with her girls who were found at two different homes. The group members, particularly Carol-C, empathized with Lori-D. They reframed her

feelings as fear. The facilitators then proceeded to ask each member to share whether they had a safety plan or not and to share what these plans were with their fellow members.

In further discussion, it appeared that there was a conflict in Lori-D's safety plan on the definition of a "safe person". The facilitators attempted to assist her in making a better safety plan and alerted her case manager to the need for further clarification of the plan.

In closing, the facilitators noted the importance of the children's safety and extended the discussion to include sexual safety and the prevention of revictimization. The mothers were also briefly updated as to the children's group agenda for today and next week. The members were asked once again what remaining themes they want covered in group. The members stressed their desire to have a guest speaker to discuss offenders and why they sexually offend against children. In giving further mid-term group feedback, the members unanimously stated that they felt their families were benefiting from attending this treatment group.

SESSION EIGHT

Four members attended group this week with Donna-F coming a bit late. The group facilitators informed members that Ellen-e was moved once again to another foster home. The facilitators also explained that they had made a decision against Ellen-e's newest foster mother attending group due to the issues around late introduction into group as well as concern for the effects on group process (e.g., level of trust). (Note: Facilitators unilaterally made this decision based on confidential concerns on the appropriateness and longevity of this latest placement). All of the group members expressed concern for Ellen-e having to move yet again but also informed the facilitators that they would have been agreeable to the inclusion of the new foster mother. Members expressed that group would have been beneficial for her as it has been for them.

The facilitators also talked to the members about the number of weeks remaining and asked the members to make a decision as to which of two desired guest speaker topics they wished to have (i.e., offenders or the legal system). Two members stated a preference for a speaker on offenders and two said that they didn't have a preference. The decision was therefore to have a speaker come in to talk about offenders.

Check-in time was fairly balanced for all members this week. Carol-C informed the group that Connie-C will live with her until after she has her baby. She has tried to encourage Connie-C to come to group but has not been successful to date. Carol-C has also made it clear to Connie-C that she won't take care of her baby this time and surprisingly stated that she wasn't concerned about her raising the baby herself.

Donna-F continued to express her confusion with seeing other people for help outside of group yet expressed feeling calm today and found that the counselling was helpful. She stated that she was even" beginning to enjoy group" with which other group members concurred. During check-in, members were asked how the children were following their disclosures in group last week. Helen-B was misinformed by facilitators that Heidi-b had not given a disclosure. Helen-B didn't understand this as Heidi-b had told her that she did talk in group and has told her story to several people. Donna-F was concerned that Dee-f never says anything to anybody and keeps everything inside. (Note: Facilitors could not help but notice that Lori-D was wearing a large amount of new jewelery this week. She stated that she had received her child tax credit and was going to buy snowsuits for the kids). Lori-D was unsure if her children would remember what had happened to them as they had been quite young the first time they were abused. This member seemed to require constant assurance in group as demonstrated by her need to hear she had done the right thing. She continued to go off on tangents and said she had the same experience all the time as other group members.

Group members then discussed issues around talking to children about physical development and feminine hygiene which was initiated by Lori-D since her children were asking questions on this topic. The members talked about the difficulty they felt in discussing this topic. The facilitators emphasized the importance of disseminating appropriate information to their children. The facilitators discussed issues around menstruation and hygiene which reflect children's sense of shame around their sexuality as a result of their abuse (e.g., hiding used sanitary napkins).

The group then began the exercise of reviewing signs and symptoms of abuse. The facilitators had charted symptoms for the group to see and reviewed each symptom, often simplifying the language and asking group members which symptoms they had observed with their children. The charts were broken down into three areas: 1. Common signs of general problems/abuse/trauma 2. Signs specific to sexual abuse 3. Physical signs of sexual abuse. It was noted following this exercise that most of the children had physical symptoms and that group members were generally unaware of indicators. The group members were also provided with a handout of indicators for future reference.

Following this exercise, Lori-D talked about her feeling that her kids are angry as she had been absent in their lives due to her alcohol abuse and incarceration. This was a turn around from her presentation during the earlier part of the session where she was now being more open and self-disclosing. The members attempted to support her by stating that while kids may be angry, feeling that they weren't protected, they still generally love their parents.

Group then began to discuss what they did when they saw the signs of abuse. Helen-B modelled some ways that she talked to Heidi-b which was very helpful for the other members to hear. This topic was held over until the next week due to a time shortage. The final message that members discussed was that it is the caretaker's responsibility to protect children and if you see signs of abuse, you need to do something about it.

SESSION NINE

Three of four group members attended as Lori-D was absent without notice this week. Although check-in was intended to be brief, facilitators allowed digression from this as Donna-F returned to group this week anxious and needing to discuss individual issues. Fellow group members also accommodated her need to vent and receive support as they perceived her struggle as genuine. They also appeared to respect her willingness to show vulnerability and her general level of trust in group. Donna-F utilized group to debrief and review the feelings and insights resulting from her dyadic counselling with Derek-F at another agency. Her feelings, which focused on the theme of divided loyalites, included anger, hurt and ambivalence as to whether her family could ever bring the sexual abuse to a close (i.e., could her family ever live together again?, will Derek-F ever be cured?, will Dee-f feel safe or want him home?. will she ever be able to forgive her son?). Members, while empathizing with her struggle with divided loyalties (i.e., between her daughter and son and between her sister and son), challenged Donna-F to consider the truth of Derek-F's allegations (i.e., that his maternal aunt sexually abused him), as she has vacillated on this over the weeks. They also asked her to consider how this might change her attitude/feelings towards Derek-F.

At one point in the discussion, Helen-B asked Donna-F if she had ever discussed sexual abuse or sexuality with her son, seemingly to imply that this may have averted the abuse of her daughter. Donna-F, feeling blamed by this foster mother, defended herself saying "he was brought up well". The facilitators interjected to neutralize and

reframe the interaction, supporting Donna-F's efforts at parenting and clarifying that her son was ultimately responsible for his behavior. The dynamic of Helen-B seemingly blaming or criticizing a natural mother, which had not been an issue for awhile now, had again resurfaced. The natural mothers, each at some point, have also tended to react defensively to any hint of blame or responsibility for their child's abuse. This dynamic may in part be a reaction to their internalized sense of guilt. The facilitators then engaged members in a discussion how they each dealt with any of the indicators that they had noticed in their children, as general indicators were discussed in the previous session.

Donna-F expressed her frustration in that she had indeed tried, without success, to get Derek-F help for his anger and acting out behavior. She had not understood the meaning of this behavior, but knew that something was terribly wrong. Donna-F explained that a year and a half prior to the disclosure, she had sought help for her son both with CFS and the school system, and was simply told "not to worry" and that he would "outgrow" this behavior. She said, ironically, the disclosure of sexual abuse then suddenly resulted in her family having access to an abundance of counsellors and resources. The facilitators commended and validated Donna-F for her appropriate attempt to seek help. The facilitators commented on how often such behavioral indicators, which signify some sort of trauma or abuse, are often missed by even professionals and not just mothers. It was also pointed out that often victims need a safe and supportive environment before they disclose sexual abuse. This becomes even more of a paradox when the victim is also an offender.

The facilitators also attempted to expand the mother's knowledge of available

resources about general issues of safety, prevention and child abuse. It was noted in reality, that such resources are limited, and therefore, concerned mothers were encouraged to be assertive in pursuing help for their children as is their right and responsibility as a parent. Mothers were also encouraged to remain attentive to marked changes in their children's behavior, affect and physical health, as a means of protecting their children. Above all, the importance of mothers maintaining open communication with children was stressed, focusing on the need to relate in a "non-blaming" manner. Donna-F stated that all her children now know what to do to prevent further abuse. Helen-B stressed that when Heidi-B felt safe, knowing she was not going to be punished, she gradually disclosed her sexual abuse. She came close to tears expressing that she wanted to do as much as she could to help prevent Heidi-b from any further revictimization, which was part of her motivation for attending the parents group. Members were supportive of Helen-B in how difficult it must be for her to now let go of Heidi-b so that she may return to her natural family.

During the break, some of the mothers expressed concern about Lori-D's absence. The facilitator noted that overall group process seemed more limited and more individually focused with only three members. After break, the facilitators introduced the group exercise of letter writing to the children. The sentence completion format (see Appendix E) was displayed on the board and mothers were asked to begin to think about how they would respond. This exercise was postponed until next week due to a lack of time remaining in today's session. In the preliminary discussion of the exercise, Carol-C, in responding to what she would do differently now, said if Cindy-c came to her complaining of pain in her genital area, she would try

to "get it out of her and explain it is not her fault". She also stated that she in now "used to talking to CFS". The facilitators felt that the mothers have expanded their trust in outside helpers due to their positive experience post-disclosure.

The facilitators, in providing information of the children's group agenda, explained how the children have completed their disclosures and are completing the "release" phase of group, which has probably been the most trying and difficult for them. The facilitators commented how mothers, as a result, may experience or expect an escalation in their children's behavior and cited Heidi-b as an example as she was refusing to leave after group last week. Mothers were also informed that the children will slow down the pace this week and work more on learning to connect their feelings to their behavior.

Note: Following this session, children and parent's group facilitators discussed concerns about Lori-D and her children. These concerns were due to previous incidents of the children missing from home as reported by their mother. Therefore, two of the facilitators went to Lori-D's home and found that her two children had been left unattended for an extended period of time. Although the children initially attempted to protect Lori-D, they eventually disclosed that she was "out drinking". This exemplifies the paradox presented to children in such families with regards to their desire to be loyal and protective of their family, and yet, be safe and protected by an adult. The facilitators contacted CFS who made the decision to place the children in care overnight. The children seemed relieved in attaining safety, however, appeared anxious about being placed in foster care.

SESSION TEN

Three of four group members came to group this week. The facilitators passed on the message to group that Lori-D called to say she couldn't attend group as she was babysitting and the children's mother had not shown up to pick up the children.

The facilitators began group by talking about the letter writing process. Members were shown an outline from the previous week to which they could add their own thoughts. One of the facilitators said they would act as a "secretary" and write down what caregivers wanted to say to their children. The facilitators structured the exercise procedure as a means of: 1. providing an equal opportunity to members who had difficulty reading and writing 2. as a means sharing these thoughts and feeling openly within group. Members were asked to use words that their children would understand.

Prior to beginning the letter writing exercise, the facilitators informed group that check-in would be time-limited. The facilitators asked members how they were feeling about this being the tenth week of group and if they were finding group helpful or not. Helen-B stated that Heidi-b has been more stable since coming to group and has been able to talk more about her feelings. She expressed desire for Heidi-b to be able to communicate with her grandmother Hanna-B who will soon become her primary caregiver. The other two members said that their children don't talk to them about group or their abuse although Carol-C stated that Cindy-c does talk to her sister, Cheryl-C about group. Donna-F said that Dee-f just puts her off and won't talk to her.

Group members were informed that the children would also be writing a letter to

their caregivers. There was then a discussion of the purpose of these letters as a means of facilitating communication of feelings and opening up the topic of talking about abuse between parent and child. Members were told that there would be a mutual sharing of letters in a meeting with their case managers prior to the end of group.

Facilitators reviewed the letter outline for the group which was displayed on a chart. Each individual member was given the opportunity to complete their letter by dictating what they wanted to say to their children, while one of the facilitators wrote these thoughts down for them.

After completing her letter, Helen-B again raised a concern about Heidi-b being placed with her grandmother fearing that she may end up returning to her mother's home where she had been previously abused and neglected. This concern was supported by other group members who felt that Hanna-B should have come to group. Helen-B stated that her concern was that Heidi-b needed to be able to talk to Hanna-B and that Hanna-B needed the information on the previous abuse history of Heidi-b in order to provide safety and protection. The facilitators informed members that the case manager had already been meeting with Hanna-B for this purpose as she was not able to attend the caregivers' group.

Donna-F had more of a difficult time in completing her letter than other members as it was her son, Derek-F who had abused Dee-f whereas the children of other members in attendance had been abused by someone outside the immediate family. Overall, the letter writing exercise went fairly quickly as the group had been well prepared over a few previous weeks with regard to the purpose and content outline of the letters. The facilitators noted that the preparation for this exercise resulted in

thoughtfulness and ease in sharing feelings. The members responses also reflected supportiveness and an integration of issues addressed in group to date.

After the letters were written, members were told that they could add anything they wanted to their letters during this session or at a later time. This led to further discussion around the issue of what they would have done if they had known their child was being abused. Donna-F stated that she would not have done anything different with the exception of being more assertive in her pursuit. Despite that, others in her network had shared their distrust of CFS by stating that her children would be taken away if she reported the abuse. She continued to trust that the system would help her and did report the abuse to CFS. Facilitators validated her for her willingness to break the secrecy as her children had with her, and for taking action to protect her children. There was then some discussion and facilitators clarified the mandate of CFS (i.e. that children are not removed from their homes just because they have been sexually abused but are removed if parents don't act to protect). Members generally felt that it was better to tell CFS based on their positive post disclosure experiences.

Members were asked how they would like their letters signed. It was noted that none of the members signed "Love _____" but generally said to sign "mom". The facilitators hypothesized two possible explanations. Firstly, that simply due to the fact that they were not doing the actual writing themselves and were instead dictating the letters. Secondly, that this possibly reflected limited abilities of the caregivers to communicate appropriate affection to their children which is a common concern in sexually abusing families. Based on this, facilitators planned a joint Valentine's party for the purpose of modelling and encouraging appropriate affection exchange.

At the end of group, members previewed next week's agenda. Members were also reminded that in two weeks we were having our guest speaker, a male, to talk about offenders and abusive relationships followed by our last working session which will focus on supports and coping. Members were also reminded that their children might be anxious after todays group due to the end of group drawing closer.

SESSION ELEVEN

Donna-F was again absent this week. The facilitators began the session by explaining that the children had relocated to a smaller room adjacent to the mother's room. This was to allow the children's group facilitators a better opportunity to handle the children's behavior within this more controllable space. The facilitators explained that overall, the behavior of the children had escalated over the past few weeks, probably due to a concentrated focus on discussing their sexual abuse experience and sexual safety. As well, the facilitators felt that the children were reacting to major changes that were going on in their lives. (e.g. changing placements). In addition, the mothers were advised that one group facilitator may excuse themselves to assist the children's group facilitators should the need arise. The mothers were informed that the groups would conclude today with a joint Valentine's party. The members were very excited and supportive, commenting 'you ladies think of everything don't you".

The facilitators proceeded with check-in and Lori-D began by complaining about having difficulty controlling Laura-d's unruly behavior and reported headaches as a

result of the children not listening. The facilitators stressed the advantages of setting limits and consequences on children's behavior, both for the mothers and the children. Other group members offered suggestions to Lori-D as well. Lori-D dominated much of this week's session, explaining that she had not wanted to miss group last week but that she had been stuck babysitting for a friend who had unexpectedly stayed out all night. Lori-D was quick to say she would never 'fink to CFS on a friend" saying 'how do you think her kids would feel?". This statement appeared to be at a meta level of communication, an expression of her anger over the incident from two weeks ago when her own children were apprehended by CFS. The facilitators, knowing that Lori-D had since debriefed the incident with her case manager earlier in the week, waited to see if she would disclose the children's apprehension in group, however, she chose not to. The members empathized with Lori-D on how difficult it is to be assertive and confrontive with a friend. The mothers acknowledged this as a common problem for them and for women in general. Lori-D informed the group that she had now renewed a relationship with an old boyfriend and went on to discuss how helpful he was in parenting the girls and how much the girls themselves were requesting his presence. The facilitators addressed the parent/child boundary blurring and clarified the need for Lori-D to make her own relationship decisions without giving the girls so much decision making responsibility.

Carol-C informed the group that her daughter, Connie-C, just had her baby and will be staying with her until she finds her own accommodation. Carol-C continued to express "wishful thinking" in hope that Connie-C might finally decide to settle down and raise this baby herself. Carol-C, however, remained quite doubtful given Connie-

C's history of instability and alcohol abuse.

Lori-D mentioned that her girls seem hypervigilant to her being overtly affectionate with her boyfriend. This naturally led facilitators into this week's theme of setting sexual and physical privacy boundaries and limits. As well, the mothers were informed as to the children's parallel agenda of prevention and self-protection with discussions on good touch, bad touch, how to say "no" as reinforced in their theme song "My Body is Nobody's Body But Mine". The facilitators talked about how the mothers theme for this week will serve to reinforce the children's learning.

The members were asked to consider and respond to various exmples of physical and seuxal privacy (e.g. is it okay for children to bathe with other, if so with whom ,and until what age?). The members discussed what the rules or limits are in their homes and what they felt they should be as well as how to communicate these rules clearly to their children and others living/visiting in the home. The facilitators accentuated the need for mothers of sexually abused children to be especially vigilant to teaching, role modelling and reinforcing clear boundaries with a view to preventing revictimization.

As well, it was stressed that because these children had been prematurely sexualized, they are at some risk themselves to go on and victimize other children. Earlier in group, Helen-B said that Heidi-b had once touched a boy's penis at school. This was used as an example of how children are "at risk" to offend other children. In summary, the facilitators stressed that although the children are relearning that their bodies are private, it is important that this be modelled and reinforced within their own homes.

At the break, one of the facilitators was aked to assist in the children's group as the other facilitator proceeded with the remainder of group. The facilitator balanced the preceding discussion on restriction with the importance of mothers providing their children with appropriate nurturance and affection. Members were asked how affection is expressed in their own families and what was modelled in their families of origin. Helen-B said that she spends individual time with her children and values the importance of being openly affectionate (e.g. hugs and kisses). She said that her own family was very large and she did not get a lot from her parents but said she is doing things differently now with her own children. All members identified with Helen-B, as they, like her, had come from large families. Lori-D was in foster care and girl's homes as a youth and never felt she had received much in the way of nurturing in either her natural family or in her foster homes. She said that she now shows affection by spoiling her kids with material gifts and affection. Lori-D was self-disclosing in regards to her extreme anger towards her natural mother and resentment over her mother requesting money to keep her children while she was in jail or even just for babysitting.

Carol-C said Cindy-c always asks for hugs and kisses and that she responds in kind. Carol-C shared her experience of being raised in the residential school system for Native Canadians. She said that there was no affection shown towards her in either the residential schools or in her natural family. Carol-C was praised for her ability to do what she herself had never experienced (i.e., display openly her affection and warmth for her children).

The facilitator had the mothers prepare their Valentines cards for their children

and set up the party room. The children then joined the mother's group with their Valentines cards in hand and both cards and affection were mutually exchanged. Children appeared to be very excited and yet very settled by the activity and the presence of their mothers.

Note: The two children without mothers in attendance were nurtured by the group facilitators and given cake and cards to take home for their mothers. A few of the children fought over who would get to take the leftover cake home. This was indicative of a trend amongst the children as much of their neediness is exemplified through the consumption and acquisition of food. This party exercise proved most valuable in reinforcing and modelling the importance of nurturance and affection.

SESSION TWELVE

The need for co-facilitators was again reinforced this week as one of the facilitators was unable to join the session until later due to a crisis in one of her practicum family systems. Donna-F was absent without notice once again. Check-in was kept brief today. The remaining facilitator noted that case managers will be discussing the upcoming completion of the program and follow-up options available. Lori-D was quick to share that she has already secured a helping agency for follow-up which she finds more culturally syntonic. Carol-C talked about Connie-C continuing to live with relatives due to her inability to find housing. The facilitators continued to be concerned for the safety and well being of Connie-C's newborn baby due to knowledge of this mother's history of neglect and instability. These concerns were forwarded to

the case manager.

Members were asked to identify their questions for the speaker in advance of his arrival today to reduce any possible anxieties and to ensure that all of their question would be answered. Members were quick in coming up with questions and required no assistance from the facilitator. It appeared that members had had these questions unanswered in their minds for some time and were anxious for them to be answered. Both Lori-D and Helen-B asked an equal number of very thoughtful and comprehensive questions, while Carol-C again remained more quiet although intensively attentive. The questions generated were:

1. Why do offenders sexually abuse? Is it because it was done to them in their families?
2. Are offenders actually helped when they get out of jail, or through the criminal justice system, or do they just go on to reoffend?
3. How do offenders feel about having sexually abused a child?
4. Can offenders ever really be cured?
5. Do offenders live in a certain geographic area? Are they of a certain race, culture or socio-economic status?
6. Does the sexual abuse of children occur mainly with families?
7. Do offenders feel suicidal after they sexually abuse?
8. Are offenders afraid of the consequences when they sexually abuse?
9. How do offenders get access to victims?
10. After counselling/therapy, do offenders ever apologize to victims?

Upon the arrival of the guest speaker, he commended the members on the depth and scope of their questions. The speaker then proceeded to answer all questions, while also inviting further discussion and participation from members. He also emphasized the danger of secrets and social isolation with regard to any form of family violence. In closing, one member asked, if an offender knew her daughters have had treatment for sexual abuse, would the children then be safe from this offender.

The speaker concluded by stressing that the education provided in groups is helpful but provides no guarantees in preventing future revictimization in itself. He stressed that overall, children need to be able to feel safe, able to communicate with their mothers, and must know that their mothers will adequately protect them.

Prior to this session, members had expressed apprehension about having a male speaker. This particular speaker, however, presented as gentle and non-threatening, but most competent and knowledgable in the field of child sexual abuse. As a result, members were extremely attentive to and comfortable with the speaker. Due to this and the advance stage of cohesion and group trust, mothers chose to disclose personal histories of family violence. Based on feedback from the members, the use of a guest speaker proved to be an effective way of providing education while enhancing and stimulating discussion.

Due to the last week's joint party, group concluded again this week with the children reuniting with their caregivers for a joint snack. There was also some initial discussion about group ending and the planning of a farewell/graduation celebration.

SESSION THIRTEEN

It is important to note that this is the first week since the mid point of group, that all four members attended group. This week was the last "working" session prior to the "graduation" party next week.

Check-in was very lengthy this session as two of the members had recently experienced many changes in their lives and were very needy of individual time in group. This recurring neediness was likely due to this being the last working group and/or missed/absence of meetings with their individual case managers. Lori-D began check-in before all members were in the room and sitting down. Lori-D stated that CFS-D was not her worker any more and that frankly, she didn't need CFS. She gave mixed messages about her being sick of them bothering her yet at the same time, stated that they were proud of her. The facilitators felt that her communicated mistrust of CFS indicated her level of trust within the group as opposed to always needing to say the "right thing". She also informed group that her boyfriend had moved his things out but felt that he would come back. Lori-D said that she felt lonely and had felt like going out and getting drunk today but then thought of her children and went and spent all her money instead. This was a relative improvement on past coping methods. Heler B offered verbal support as Lori-D continued to discuss the break-up and the difficult time that she was having. The members were asked generally by facilitators, about their own experiences in coping with the ending of a relationship which tied in to the theme of group closure. At this point, Donna-F who appeared very distressed this week, informed group that she and her boyfriend had just broken up and that he had

also moved out. Donna-F was very open in sharing with group that she had been avoiding meetings for the past two weeks as she had been having arguments with her boyfriend and was coping by isolating herself. She expressed feeling very "walked on" by him and taken advantage of. She also talked at length and utilized the group to vent pervasive anger she feels in regard to her son Derek-F abusing Dee-f and how it has been "eating at her inside". She disclosed that she had vowed not to miss group today or push helpers away. Donna-F said that she needs to talk to people and felt guilty about Dee-f missing group due to her isolating herself. Donna-F was given alot of verbal support from the group for making the decision that she did in coming to group.

Carol-C told the group that she had asked Connie-C to move to her sisters as CFS was "calling and asking a lot of questions" about the kids she herself was raising and Connie-C. She said that she didn't want CFS bothering her. Lori-D suggested that maybe CFS "wanted the baby" and said "they are bad for that". This was reframed by facilitators as maybe CFS could offer support that is needed so that the baby would be safe and could stay with Connie-C. Carol talked further about Connie-C wanting to give her baby to family instead of keeping it. Carol-C prefers family placement rather than the baby going into care with CFS. Helen-B and one of the facilitators had to leave the room for part of this discussion as Heidi-b was screaming in the group meeting in the next room. Helen-B informed group that Heidi-b had been acting out more so this past week.

The discussion in group around relationships and loneliness led naturally into this week's exercise of making lists of coping methods while distinguishing between positive and negative ways of coping. The group members used examples given earlier

in the discussion. Most of their current coping methods were considered "negative" or maladaptive means of coping. The group members added "positive" or adaptive means of coping to the list, however, appeared to have a more difficult time with these as most of the suggestions came from the remaining foster parent in the group who had reported the use of these methods herself (see Appendix F). The issue of coping with loneliness was discussed at length as it was pertinent to group members at the time as revealed during check-in.

Following the exercise on coping, the topic of support was discussed. Network inventory sheets were handed out to each group member. Each category, (i.e., practical support, emotional support, crisis, safety and trust) was defined by the facilitators. The group members were each asked to fill out the sheets listing people they had for supports in each category. The facilitators then assisted each member in filling out their network sheets and pointed out that it was important to have at least one person they could count on for each kind of support, who is safe and who can be trusted. All members were able to identify one or more supports in each category with the foster parent having the greatest number of supports and one of the parent's only having one person for support in each category (see Table 2). The importance of broadening current supports was also discussed.

Insert Table 2 about here

Table 2 **Latency Age Mother's Group - Social Networks***

	Family	Friends	Neighbours	Community	Professional
Lori-D	3	1	4	2	3
Donna-F	1	1	1	1	1
Helen-B	5	5	1	1	1
Carol-C	2	2	0	2	1

* Jointly prepared by Kathy Anderson and Barb Gajdek

The facilitators then asked group members for feedback on how they had found the group overall. Members generally stated that they found group helpful, had been able to take a look at themselves, had learned to talk to their children better, and had learned more about sexual abuse in general. All members except Helen-B stated that group was too short and felt that they needed more sessions. Most members expressed concern that they still hadn't talked to their children about the abuse. Facilitators discussed the follow-up being offered by the clinic for those who desire more ongoing therapy which would be arranged through their case managers. Donna-F stressed that group itself had not been enough for herself and Dee-f and that she really needed more for herself as she had "so much anger still inside".

Facilitators provided members with positive feedback and validation for coming to group and showing support for and commitment to their children. Group members generally stated that they felt better by coming to group. They had learned alot about sexual abuse, something they had not known much about before nor learned about in their own families. They stated that they learned something about safety plans and how to talk with their children.

Group ended with each member having an opportunity to state one wish they would like as a way of taking care of themselves. Helen-B stated that she does take care of herself but would like to go on a trip to Australia. Donna-F stated that she would like to go on a trip up north and lose weight. Carol-C told group members that she had gone on a trip to Hawaii one time when a relative had won a trip but is planning to go for a trip to her home town in the very near future. Lori-D said she would like a new wardrobe, have her hair done, and would like to lose weight.

The children's group then joined in with mother's group to make plan for next week's party. They made a guest list of what they would like to have at the party (e.g., cake, ice-cream, balloons etc.). The group facilitators offered to plan the party's activities.

Following group, one of the facilitators made a point of connecting Donna-F with her case manager to arrange for an individual meeting due to her obvious distress, anger and pervasive need to "talk to someone".

SESSION FOURTEEN - CLOSURE

The final celebration was jointly attended by all members from both the children's and parent's groups. Each member had invited guests attend with the exception of Heidi-b whose natural grandmother had apparently forgotten about the "graduation" party. The guests in attendance were either CFS workers or relatives of either the child or parent.

The "celebration" began with a magic show where group members and guests participated in various magic tricks. Heidi-b initially sat outside the group of children and then with a little encouragement from one of the facilitators, slowly moved into the group. Group members and guests alike appeared to really enjoy the magic show. The show was followed by organized games which were intended for parents and children. The parents chose to sit and socialize with each other and with their guests while the facilitators were involved in the games with the children. Each child received a prize and snacks were put out for group members and their guests.

The graduation ceremony was headed by the children's group facilitators. They presented each child with a graduation certificate and made a brief comment on positive change and progress observed for each child. The mothers were also commended for their efforts in participating in group and supporting their children. Both the children and the mothers appeared very proud as did their significant others. The ceremony was closed by the children singing "My Body is My Own" and the serving of the "congratulations" cake.

All participants appeared comfortable and relaxed throughout the closing session. Closing comments included information on availability of the clinic for service and a "resource information" table for the parents and guests.

GROUP OVERVIEW

Overall, the mother's group sessions focused on support and education. The sessions had an educational focus with regard to the symptoms and impact of sexual abuse, sex education and sexuality, normalization of behavior, secrecy, privacy, reinforcement of boundaries and role differentiation, safety plans, and general protection/prevention. The group also provided a safe environment which was utilized by the mothers for problem solving and expression and validation of feelings.

The mothers were encouraged and able to express their feelings in regards to their children's abuse and those who abused them. They were also encouraged to communicate with their children through such avenues as joint homework, modelling and the letter writing exercise. Appropriate affection and nuturance were modelled

and encouraged through joint time and discussion of children's needs. The use of joint time appeared to have a settling effect on the children and was successful as a means of exchanging appropriate affection.

The sessions also included themes of assertiveness, family violence and network development. The mother's were able to integrate learning and express in hindsight how they might better be able to protect their children and what resources may be useful to them in the future.

Each session began with a check-in which was often utilized as a problem solving time for the mothers. While appropriate in quickly addressing some ongoing concerns, this often reflected the chaotic nature of some of the families. This time often turned into a lengthy process as two of the mothers who were very needy, utilized this time to vent frustration which resulted in them monopolizing group time and impeding the group process. The facilitators attempted to utilize their concerns as a means to highlight and example some of the dynamics surrounding sexual abuse and generalize learning for the entire group. The facilitators also encouraged these mothers to address their concerns in more depth with their case managers.

The first group session illustrated some of the difficulties that can occur when mixing foster parents and natural parents. One of the foster parents initially took the role of a "group facilitator" which resulted in some of the natural parents feeling judged and inadequate. The facilitators would reframe some of comments made which resulted in the foster parent having as many questions as the natural parents. The third session, which focused on sex education and sexuality, proved to be a turning point in solidifying the mothers as a common group. This was as a result of all the

mothers reporting lack of sex education from their own families of origin and having many issues in common. Cohesion of the foster and natural parents developed throughout the sessions as illustrated by the foster parent's development of empathy for the natural mothers in regards to their own life difficulties and the natural mothers feeling safer to disclose these difficulties. During the latter sessions, one of the natural mothers was also able to support the foster parent in regard to her concerns about her child's natural family without personalizing these concerns.

In general, this group appeared to be focused and willing to learn. They showed a willingness to utilize ideas presented in group and increased self-confidence as illustrated in some advancement in problem solving abilities and safety planning. The mothers also developed insight into their children's behavior which enhanced their ability to empathize with and support their children.

CHAPTER EIGHT

Group Process - Preadolescent Mother's Group

All group sessions were held in one of the large family rooms at the clinic. The room had eight comfortable chairs, a coffee table, video-taping and viewing equipment. All five sessions were video-taped for the purpose of supervision. A snack was also provided by the facilitator for members at each session.

For each of the five sessions, the objectives, agenda and content notes were recorded on the Group Notes form on a weekly basis (see Appendix G). Each of the sessions will be described in detail so that the reader can receive an accurate impression of the group content and process as well as the ongoing treatment process of each individual.

SESSION ONE

This first session was attended by all three group members. One of the mothers, Gert-I, had declined any involvment in group and one mother, Rose-G had two daughters, Ruth-g and Rhonda-g in the parallel preadolescent group. The purpose of the first session was for the group members to get to know the facilitator and each other and begin the joining process. Name tags were given out and introductions made. Group rules were discussed at the beginning of the session as all group members smoked and were anxious to be able to smoke in group sessions. They also decided that attendance was important and that confidentiality was mandatory. The facilitator then

checked with group members as to whether the change in the time group began and ended was sufficient, as all group members had other children who were dismissed from school at 3:30 and needed to be home prior to their arrival from school. All members stated the need to have group end on time due to childcare needs and transportation arrangements, which had been made ahead of time for each of them.

The facilitator reminded the group as to the number of sessions (14) and provided the group with a handout which reviewed the philosophy of group and listed a number of topics for discussion during the groups ahead. All group members stated that they couldn't think of any additional topics that they wanted to discuss at this time but were told by the facilitator that they could bring topics in at any time. The facilitator then informed group of the purpose of the preadolescents' group and that many of the topics would parallel what their children were doing in group.

All members were then given the opportunity to talk about their families and own situations. The group members readily talked about their situations in detail which quickly led into some venting of frustration in dealing with their children's behaviors. This process became a lengthy, emotional check-in which was mainly monopolized by Pat-J who was visibley distressed at the onset of the session.

Rose-G initiated discussion in the group about her own situation, describing the abuse of her two daughters and then her own past abuse as well. Rose-G stated that Rhonda-g talks quite openly about her abuse but that her main concerns were about Ruth-g who won't talk and keeps everything inside. She talked about behavioral concerns she had in regards to Ruth-g, and Ruth-g's attempt to cut herself. Rose-G also disclosed her history of substance abuse problems and treatment at a local

treatment centre.

Pat-J shared numerous emotional descriptions of Pam-j's behavior including incidents around fire setting, difficulties in school, charging long distance calls to her mother, hygiene difficulties, (especially in regards to her period), difficulty showing respect and following rules, and hanging out with undesirable peers. Pat-J showed very little insight into Pam-j's behavior and repeatedly stated that she didn't see what all this had to do with being sexually abused once many years ago. Pat-J also talked about her own history saying that she didn't know if she had been sexually abused as she can't remember most of her own childhood. She told the group about her involvment in an abusive marriage with Pam-j's father and her past attempts at suicide and psychiatric involvement including hospitalization. At this point she rolled up her sleeves and showed the group her severe scars from slashing. Rose-G responded by showing her slash scar as well. Pat-J was very stressed saying that she didn't know what to do about Pam-j's behavior anymore. Other group members attempted to be supportive and offered suggestions on how to deal with behavior. Pat-J continued to vent anger and frustration and stated that she knew Pam-j was abused when she was a child but couldn't accept it as an excuse for all her acting out behavior.

Alice-H related some of the behavioral difficulties she had encountered with Ann-h, however, spent most of her time offering suggestions to Pat-J on how to deal with Pam j's behavior and stating that certain methods had worked for her. While other members bordered on being indiscriminate in the amount of information they were sharing for a first meeting, Alice-H gave very little information about herself and informed group a couple of times that she didn't have a history of abuse herself.

Some members expressed concerns common to all group members such as the issue around menstural periods and hygiene which became the focus of part of the discussion, and some concerns were unique to that individual. All members disclosed that their children had all been abused at a very young age (ages 3 - 5 years) and didn't understand how a past history of sexual abuse could account for the behavioral difficulties they were experiencing at the present time.

After discussing all the behavioral concerns and expressing their frustration, all members expressed concern to the faciliator that participation in group would only enhance their children's behavioral problems. The facilitator attempted to reassure members by informing them that children without treatment tend to act out instead of verbalize their feelings, and that while they may find some of the work in group difficult, it will be the beginning of a process of treatment for the purpose of enabling them to deal with feelings in ways other than acting them out. The facilitator also suggested that it may be desirable to spend some sessions dealing specifically with behavioral problems and parenting as the group members had expressed this as being one of their main concerns. It was apparent to the facilitator that all of these families were in crisis to varying degrees and had not felt that they had received much in the way of support in the past. Near the end of the session, Rose-G expressed that she felt "lucky" after hearing some of the problems Pat-J was having with Pam-j and did have a good support worker, Raylene-G, in the past, who had helped herself and her children.

Group members were asked to complete the pre-test measures at the end of this session. Alice-H stated that she didn't see it necessary to fill out some of the measures

such as the Beck Depression Inventory stating that they didn't pertain to her. The facilitator asked her to fill them out as it was helpful for the facilitator to have this information. Pat-J was also concerned about answering some of the questions on the BDI stating that she didn't want a psychiatrist brought in if she answered questions a certain way. Pat-J was reassured that that was not the purpose of the measures.

SESSION TWO

A couple of hours prior to group, CFS-J called and left a message that there had been alot of problems and that Pat-J was in "bad shape" and was not feeling that she could attend group. Only two of three members attended this session. As soon as Alice-H and Rose-G entered the room for group, they asked where Pat-J was. The facilitator informed them that she was having a difficult time and would not be attending group this week. Both members expressed concern pointing out her obvious distress last session and stated that she should come to group where she can get some support. The facilitator brought up the issue of continuing with group due to the low number of members and possible drop-out. The members were also informed that they would be offered systemic work in addition to any group work. Both Alice-H and Rose-G stated that they wanted group to continue even if there were low numbers. Rose-G expressed that she felt that it was helpful to her children to see that she is also coming to group and wants to offer them that support. She said that she also found it helpful to be with others whose children had also been abused and who were experiencing similiar problems.

The film "Finding Out: Incest and Family Sexual Abuse" (Caulfield and Haig, 1984) was then shown in group. The film provided facts around sexual abuse such as incidence of, symptoms of, types of abuse and family dynamics. The film focused on an adult survivor of sexual abuse and her mother, who had acted to support her daughter after discovering that her husband had been abusing her.

After the film, the facilitator noticed that Alice-H was visibly "ill" in appearance and quiet, reacting differently than expected given her previous statments of not having a history of abuse herself. Rose-G expressed that she really liked the film and found it helpful as she could relate personally to the experience with the exception of the maternal support and treatment following the abuse.

In discussing symptoms, the discussion focussed on the symptoms of their own children. Alice-H then spoke more openly about the difficulties she was experiencing with Ann-h in regards to Ann-h's anger and the acting out of this anger in verbally and physically destructive ways. Alice-H seemed to be more willing at this point to admit that she couldn't deal with some of the behavior as opposed to giving advice to other members. She also discussed difficulties that Ann-h was having in school with regard to relating to others and shared that she was failing in every subject. Alice-H said that Ann-h had no friends and overacted the "clown" for attention which resulted in others being turned off by her behavior.

At this point, Rose-G pulled out Ruth-g's report card and showed it to the group. Ruth-g had received an A+ in Art and a C in PE but had failed every other subject. Ruth-g had also missed a tremendous amount of school. Rose-G said that ever since Ruth-g has started group, that she has not missed any classes. Rose-G stated that she

was feeling really good about her family coming to group and felt that in some ways, it had already helped.

At the end of group, both members asked the facilitator to let Pat-J know that she was missed at group and that they would really like to see her there next week.

SESSION THREE

Note: A few hours prior to this session, Alice-H contacted the facilitator and stated that she and Ann-h wouldn't be coming to group as Ann-h was sick. In discussing further with her, and with some gentle confronting, she disclosed that she was actually feeling uncomfortable stating that she had been in the psychiatric ward at the same time as Pat-J several years ago but that Pat-J hadn't recognized her. She also disclosed that she had just discovered during last week's group, that she had been sexually abused as a child. She stated that she hadn't realized that what had happened to her was abuse. Alice-H stated that she would come to group, however, didn't trust anyone in talking about her past due to her "status" as a caregiver. The facilitator, who was also this systems' case manager, set a separate time to follow up with Alice-H even though she was encouraged to be more open with the group.

All three members attended this week's session. Pat-J came to group visibly angry and upset and in obvious crisis. She stated that she had just about had it with Pam-j and went on to give a detailed description of all the behavioral difficulties she had encountered during the past few days. Pat-J said that all was okay for a couple of days

and then, for no apparent reason, Pam-j threw her $600 vaccuum cleaner down the stairs. She then went on to describe other behavioral difficulties and redescribed past behaviors. Pat-J was very angry, frustrated and upset. Group members and the facilitator were very focused on her and worked very hard to offer support and suggestions for dealing with behavior. While Alice-H offered empathy and some suggestions, she also described concerns she had in regards to Ann-h's behavior. She described Ann-h as having temper tantrums, that while they had subsided since she initially came into care, they continued to disrupt the household.

Rose-G was very attentive during Pat-J's venting and then informed group that she had taken Parent Effectiveness Training twice and had found it very helpful. Rose-G gave some examples of how she had implemented this training with her own children and then utilized some of Pat-J's situations in exampling other suggestions. Rose-G emphasized the importance of being calm, talking to kids, and offering alternatives to them. The discussion then focused on different ways to deal with behavior and the level of acting out these parents were experiencing. Pat-J initially expressed feeling hopelessness and felt that nothing would work to change the present stiuation. She stated that she gave up on her oldest daughter, Penny-J, by placing her into care and felt that Pam-j was wanting to be in care so that she could "hang out on Main Street" like her sister. Pat-J said that she thought Pam-J was intentionally pushing buttons in order to have Pat-J put her in care. While Pat-J was able to show and share how she was feeling in group, she was not able to empathize with what Pam-j might feel or show any insight into her behavioral acting out.

Group members questioned Pat-J in regards to the supports she had and stated that

she needed a break and some help. They also empathized with her feeling that she wasn't getting much in the way of practical support from CFS-J. Alice-H even offered to take her daughter for a weekend as Ann-h and Pam-j had become friendly in group. While almost the entire group session focused on Pat-J, it was apparent that other group members were wanting to "take care" of Pat-J and offer support. It was due to the group's need to take care of Pat-J and her obvious state of crisis, that the facilitator didn't refocus on the agenda and allowed the supportive group process to continue. Pat-J did eventually seem to be more calm and stated that she didn't want to "give up on this one".

During the end of group, the facilitator briefly reviewed the incidence and definition of sexual abuse. During this discussion Rose-G talked about the extent of sexual abuse in her own nuclear and extended family. Both Pat-J and Alice-H were very quiet during this latter discussion. The facilitator informed members that the children's group were reading a story about a girl who had been sexually abused and were then going to discuss feelings in regards to the sexual abuse via a third party exercise in preparation for sharing their own stories.

Group members were also asked as to their feelings about FSW-H joining group. All members stated that they had no difficulty with this and would welcome her into the group.

SESSION FOUR

The facilitator planned to have this session begin without a check-in and provided

a high degree of structure for the most part of the session as it was very apparent from previous groups that members needed to work on being able to connect present behavior with past abuse. The goal was to have members defocus on behavior in order to develop some empathy and be able to better support their children. It was noted that in previous sessions, one member in particular, Pat-J tended to monopolize group time and turn group into an endless check-in. While Pat-J was very needy of support, she avoided establishing any immediate systems meetings with her case manager. The facilitator's rationale was that the planned structure would allow for learning and more of a group process, rather than an individual crisis oriented focus.

The new group member, FSW-H was introduced to other group members. The facilitator informed the members that the film "No More Secrets" (O.D.N. Productions, 1982) would be shown to the preadolescents' group after the parents' group had viewed it and then both groups would be talking about feelings around sexual abuse. The film, which was then shown to group members, focused on live interviews with preadolescent aged girls who were sexually abused by their father/father -figures. In the film, the girls tell their stories about their abuse, the feelings they had and subsequent events and process of treatment. After the film, Rose-G commented that the movie brought back alot of old feelings, like the feeling of being dirty. She added that when kids act up and fight, its because something is bothering them. She said that she couldn't say anything and felt so ashamed, so got involved in drinkinging and drug abuse. The facilitator exampled this as behavior that was an expression of feelings.

The group members were then asked to list feelings they thought kids who have

been sexually abused have. Pat-J said that Pam-j never says anything to her about how she feels. Members were told they could use examples from the film or from what they have observed in their own children or themselves. The group then made a list of feelings which included the following: feeling dirty and ashamed; guilt; anger; lack of trust; fear; hatred towards their mom, dad and themselves; not believed; low self-worth; unsafe; mixed feelings around loyalty; lonliness; stigmatized; and rejected, especially if not believed by their mothers. During the discussion of feelings, some of the dynamics of abuse which lead to these feelings were pointed out by the facilitator and some of the group members (e.g., physical pleasure, day to day treatment of the victim by the offender, relationship etc). In making this list, Rose-G provided many examples from her own feelings around her abuse. Pat-J had a difficult time identifying feelings and would give examples of behaviors instead. This reflected the difficulty that Pat-J was having in understanding why Pam-j was acting out.

The facilitator emphasized the point that children who are not able to talk or express themselves verbally, tend to express themselves through behavior and act out. After making the list of feelings, group members were asked if they could identify which of their children's behaviors stemmed from which feelings. Rose-G was the member best able to do this while Pat-J attributed acts of anger and hurt to attention seeking. The facilitator and other group members then assisted her by using examples of behaviors she had given in previous groups, and linking these behaviors to feelings. The facilitator reinforced the message given by the children in the film, that support from their mothers and the fact that they were believed, was central to their healing.

Group members then discussed the fact that all of the fathers of the girls in the

film had admitted to the abuse, which helped alleviate the blame. Rose-G then informed group that she hated her father for what he did to her, the kids and her sisters. She said that she had to testify next week against her sister, who allowed and knowingly facilitated her own child to be sexually abused. This led into a discussion about loyalties in families and guilt. Pat-J said that she still didn't understand why Pam-j acted out so much stating that the girls in the film had been abused for a long period of time and Pam-j had only been abused once. The facilitator pointed out that abuse still hurts children in any form and also talked about the possiblity that maybe more happened to Pam-j but that she wasn't ready to say more at this time.

The group took a break at this point. It was noted after group by the facilitator, when reviewing the video tape, that Alice-H was talking to Rose-G, telling her that she couldn't "relate to this stuff" and only knows how kids feel from books. Although Alice H had disclosed sexual abuse in a systems meeting with the facilitator after the second session, she was still not willing to share any of her own past with the group members. This was related to her need to be seen differently as a foster parent and her lack of trust in group and fear and mistrust of the child welfare agency.

After break, Alice-H brought up the question of how caregivers deal with a child, for example, Ann-h, who's mother reminds them every day that they are a victim even though they don't remember the abuse. Rose-G wanted to answer the question, notably frustrated with the lack of insight of some of the other group members. She told that group that they didn't have to say anything, and that its "all in the actions of the mother". She told the group that they needed to be gentle with their children. Pat-J spoke in disagreement saying that she didn't give her daughter Penny-J the excuse of

being abused for her behavior and felt that that was what she was doing with Pam-j. This led to further group discussion about the importance of recognizing feelings from behavior and that their kids are in group to learn how to identify and express feelings rather than acting them out. The importance of identifying feelings to the children was discussed and ways of drawing these out were role modelled. This became quite an intense discussion as Pat-J had very little understanding of this concept and said that the kids were only fooling around in group and eating and asked when they were going to start treatment. The facilitator stated that they had started and explained that treatment was a process. The first part of the process being the establishment of a safe place to share feelings. Some of the "fooling around" which is behavior, is an indication that they are not comfortable in talking about sexual abuse. The facilitator needed to utilize an example of her having to talk about her own sexuality in group in order for her to understand the difficulty that the children might have. Other group members also attempted to assist Pat-J in recognizing the importance of group. Rose-G stated that Ruth-g has never talked before and is now talking in group. She has also been openly affectionate towards Rose-G which did not happen before. Other members reinforced that although the abuse may never be dealt with in court, they can still get help for themselves. Members also pointed out that the kids will see that their mothers are coming to group and know that they are supported.

This led to some disclosure by Pat-J that she had no support from her mother and that when her mother had a breakdown when she was 14, she didn't want to live with her father and then lived on her own. She described having abusive relationships with men and her first child at age 17. Pat-J claimed that she couldn't remember her

childhood at all, and therefore what had led to her involvement in abusive relationships. She did inform group that she found out later that her older sister had been sexually abused by her father.

The group discussion then focussed on how modelling can be used to facilitate children in expressing feelings. Members also discussed the children's needs for attention and how to change some of the negative attention seeking into positive attention. The facilitator modelled different conversations on how to set quality time with the children. Pat-J had a difficult time with this and would always find reasons why this wouldn't work and focused more on the positive relationship and closeness she had with her son, Peter-J. Other members also gave examples and ideas of how to talk to kids and find ways of spending positive time with them. Again, Pat-J's lack of insight and empathy for Pam-j was illustrated. She also continued to monopolize the latter part of group, however, at this stage members appeared to be frustrated with her lack of empathy and self-defeating statements.

SESSION FIVE

Note: Prior to session, the facilitator received a message from Pat-J's mother stating that she was ill and couldn't make it to group. When Pam-j arrived for group, it was noticed that her face was bruised and swollen. When asked what happened, she stated that her mother had beaten her up two days previously and that she was presently staying with her grandmother. She also stated that her mother wasn't ill and was playing Bingo.

Three of four members attended this session. Group members immediately questioned where Pat-J was and the facilitator passed on the message that she was ill. Group members questioned whether she would return to group and there was discussion in regards to the continuation of the group format as the facilitator was presently meeting individually with the two systems represented. Group members appeared to be frustrated with Pat-J's absence and were unsure whether they should continue as a group. Their anxiety in this regard appeared to set the tone for the rest of the session.

During check-in, Rose-G seemed preoccupied and stated that Ruth-g hadn't come home from school and wasn't at group today. Rose-G stated that Ruth-g had been out with some friends last night, something which she hasn't done since group started and was concerned that maybe she had taken off with her friends. Members talked about their plans for Christmas and Alice-H informed group that Ann-h was going to visit her natural father for a week. In discussing the possibility of some problems occurring on the visits, the facilitator checked in regards to a saftey plan. Alice-H and FSW-H had already established this as part of past practice on visits.

The facilitator then provided group members with a handout of behavioral and physical indicators of sexual abuse. In reviewing the indicators with group, members were easily able to identify syptoms that they had observed, however, did not recognize all of them as symptoms of abuse. Rose-G identified a majority of the symptoms in her own children and stated that there were many more indicators for Ruth-g than Rhonda-g. Alice-H and FSW-H also identified a large number of indicators in Ann-h. All of the children had their own unique set of indicators, with none having had any physical

signs. Most of the behavioral signs noted were quite severe such as running, self mutilation, physical aggression etc.

The facilitator reviewed a simplified version of Finkelhor's Traumagenic Dynamics model (Finkelhor and Browne, 1985), reviewing dynamics such as traumatic sexualization, betrayal, powerlessness and stigmatization.

Individual members then focused on concerns and questions they had in regards to their own children and issues. The session took the form more of dual individual therapy rather than a focus on group issues and process. Members expressed many needs within their own systems and talked further about the continuation of the group feeling that it was difficult to meet as a group with unpredictable attendance. The facilitator agreed to verify whether or not Pat-J would reattend group and make a commitment to attendance. Members were told that the facilitator would then discuss continuation of group with each of them.

GROUP OVERVIEW

Session five was the last "group" session as two of three parental members (Pat-J and Alice-H) no longer had physical custody of their children and had dropped out of group. Of all the preadolescent age caregivers, only Rose-G continued to have care of her children.

It was apparent from the onset of this group, that most of these families were in crisis. The mothers generally had difficulty in linking behavior to feelings and lacked an understanding of the eitiology of these feelings which was the focus of most of the

group sessions. They expressed concern that treatment of their children may result in further acting out. All of the mothers also had unresolved issues of their own (e.g., childhood sexual abuse). In addition, there was an issue of trust for two of the mothers due to past experiences with the mental health system and one having the need to appear "superior" to the natural mothers due to her status as an "alternate caregiver". These factors contributed to an impaired ability of the mothers to empathize with their children and look beyond their own needs. As a result, two of the children continued to be at risk by either act or omission and were removed from their homes.

All of the preadolescents, however, continued to attend group. The facilitator continued working intensively with Rose-G and her family as well as Ann-h and FSW-H on an individual basis which is described in the proceeding case studies.

CHAPTER NINE

CASE STUDY

SYSTEM - G

Demographics

Sytem-G consists of a native single parent mother, Rose-G, age 38, and her 6 natural children, Randy-G, age 20; Rob-G, age18; Ruby-G, age15; Ruth-g, age13; Rhonda-g, age12; and Ron-G, age 9. The 6 children have 3 different biological fathers. One of the fathers has sporadic contact with one of the children, Rhonda-g. At the time of intake, Randy-G, a diagnosed manic-depressive, was incarcerated, Rob-G was living out of town, and Ruby-G was in care in a residential treatment facility under the care of Child and Family Services. Ruth-g, Rhonda-g and Ron-G all lived at home with their mother, Rose-G whose only source of income is social assistance.

Background Information

This multiproblem family presented with a history of multigenerational incest and family violence. Rose-G is the eldest of four sisters who were all chronically sexually abused by their father who is a well known community leader. Rose-G's mother was

often physically and emotionally absent due to a lengthy history of illness which resulted in the parentification of Rose-G. Rose-G stated that her mother was aware of the sexual abuse but was unwilling and unable to do anything about it.

Rose-G herself has had a history of suicidal ideation, substance abuse and abusive relationships with men. All of her children have been in care at one point or another and Rob-G and Randy-G spent most of their years in their maternal grandfathers' care. While Ruby-G, Rhonda-g, Ruth-g and Ron-G were living with Rose-G, she reported a history of severe physical and emotional neglect and sexual abuse of her children by family members, including Rose-G's father and other trusted parties. Rose-G's father sexually abused Ruth-g, Rhonda-g and Ruby-G. Rose-G's father was convicted after the time of disclosure and sentenced to 7 years in jail, of which he only did 10 months. Ruby-G was also revictimized by a trusted family friend over a year ago as was Ron-G when he was 2 1/2 years old. Ruth-g was also revictimized by two different trusted family friends prior to her mother's entry into residential treatment, one of whom was convicted and sentenced to time in jail. Rhonda-G, besides being sexually abused by her maternal grandfather, witnessed a violent murder at her paternal grandmother's home when she was six years old.

Approximately five years ago during the time of Rose-G's substance abuse, neglect and the sexual abuse of her children, all of her children were taken away by Child and Family Services on a permanent basis. This appeared to be a turning point in Rose-G's life whereupon she entered a local residential substance abuse treatment facility. This treatment program and subsequent programs for substance abuse and parenting skills, enabled Rose-G to effectively halt her abuse of substances and make many positive

changes in her life.

Three years ago, following Rose-G's involvement in residential treatment, she regained guardianship of her four youngest children with the exception of Rhonda-g who spent some time living with her natural father in a different province until about one and a half years ago at which time she also came to live with Rose-G. Ruby-G, who had been the parentified child in the family, had difficulty readjusting and began involvement in substance abuse, running, self-mutilation and sexualized behavior with older men. Ruby-G was then placed in the care of Child and Family Services at a residential treatment centre apporximately 10 months prior to the initial involvement of this family at the clinic.

Rose-G has maintained sobriety and has continued her involvement in A.A. beyond her initial treatment program. None of the family, with the exception of Ruby-G in residential treatment, have been involved in any form of family counselling or treatment for sexual abuse or any other issues.

Presenting Problems

Of all the families involved in the Parallel Treatment Program at the clinic, in both the latency and pre-adolescent age groups, this was the only one which was self-referred. Prior to the onset of the program, Rose-G had requested treatment for herself and her two daughters, Ruth-g and Rhonda-g for their sexual abuse. Rose-G and her two daughters attended the intake interview with Raylene-G, Rose-G's old family support worker and friend, who had accompanied them for support.

Rose-G requested help for herself in regards to her own sexual abuse as well as to be better able to support her children. While Rose-G had effectively maintained sobriety, she continued to experience difficulties in her own life by having ambivalent feelings towards her father and family of origin. She had been exiled by her family as she had been the only one to expose the incest and seek help. She had limited supports with the exception of a network of A.A. friends, her past FSW and CFS-G. Rose-G had feelings of guilt, anger and betrayal about her own abuse and the abuse of her sisters, nieces and own children. She had also developed a fear of leaving her home, had a lack of self-confidence and trust in others. Rose-G also expressed a desire to explore the issue of her relationships with men, where she was rejecting of those who were safe and caring, and became involved with those who were abusive.

Ruth-g was very quiet, withdrawn and non-verbal. Ruth-g had been multiply victimized, however, denied "remembering" any of the abuses even though she had given evidence on a couple of occassions. Ruth-g internalized her feelings, however, was a very talented artist and was able to communicate through her drawings. Ruth-g had difficulties with peers, hygiene, communication and school, both academically and through truancy. She had also cut herself with a razor a couple of months prior to involvement at the clinic.

Rhonda-g was traumatized by the sexual abuse and also the murder she had witnessed. She was quite verbal and able to talk about her experiences, however, was not able to discuss feelings. Rhonda-g experienced nightmares and also had trouble with peers, hygiene and school.

Summary of Contact

Rose-G and her two daughters attended one intake interview, and missed one of two scheduled pre-group sessions. Rose-G, Ruth-g and Rhonda-g were involved in the parallel group treatment program. Rose-G attended 5 of 5 parents group sessions, Ruth-g attended 13 of 15 pre-adolescent group sessions and Rhonda-g attended 14 of 15 group sessions. Rhonda-g and Ruth-g missed the one group session during a crisis time when their home had burned down.

As part of the systemic work, the therapist had 14 phone contacts with Rose-G, 12 of them prior to referral for further treatment. Three of 14 were less than 15 minutes in duration and 11 of 14 lasted 15 minutes to 1 hour.

The therapist also had a total of 15 sessions of a minimum of 90 minutes each with this system. Three of the 15 sessions were in the home, 2 of these being individual sessions with Rose-G and 1 included Ron-G and Ruby-G. Two of the sessions were held at an emergency shelter which included individual time with Rose-G and time with Ruth-g and Ron-G. Eleven of the 15 sessions were individual sessions with Rose-G, 2 of them being in her home and 9 at the clinic. There was also 1 session with her youngest sister and a total of three sessions with different children and Rose-G. There was 1 transfer meeting following the completion of the systemic and group work.

Systems/network contact consisted of 6 major contacts with CFS-G, one letter of advocacy, and numerous contacts with various systems and resources during a time of crisis in order to coordinate emergency food, shelter and clothing.

Goals of Systemic Intervention

In general, the initial goals of the systemic intervention which focused on individual sessions with Rose-G were:

1. Develop a trusting therapeutic relationship and provide support in expressing feelings and begin a process of resolving issues around Rose-G's history of sexual abuse (e.g. guilt, anger).
2. Address issues of depression, low self-esteem, low self-confidence, and fears of leaving the home.
3. Empowerment of Rose-G in regard to protecting and parenting her children.
4. Facilitate communication within the family in order to enable the expression of feelings.
5. Support Rose-G in enriching and expanding her resource base/network in order to provide for basic needs and emotional support.

Summary of Intervention

Beyond the parallel group treatment of Rose-G, Ruth-g and Rhonda-g, of which the parent's group is described earlier on in this practicum report, the systemic intervention which focused mainly on individual sessions with Rose-G was interspersed with ongoing crisis intervention. The therapeutic intervention with this system is difficult to describe as the therapeutic process often mirrored the chaotic

and multiproblem nature of the family. It was, therefore, necessary to be eclectic and flexible in order to be able to focus on the actual stated goals.

In general, the main issues addressed in individual therapy with Rose-G included:

1. Self-confidence, self-worth, and depression. Sense of failure and hopelessness. Fear of leaving her home.

2. Pervasive sense of guilt: Guilt about her sisters being sexually abused and her not taking the full brunt of the abuse, feeling responsible for the resulting effects of the abuse; guilt regarding her children being abused by her father who had abused her as well as aquaintances of hers; and guilt for past issues of drinking and neglect and not being there for her children.

3. Ambivalent feelings towards her family of origin, her father in particular for abusing her and most of her own and extended family. Feelings of anger and betrayal in regards to her own sexual abuse and denial of the entire family system, especially given her father's position of power and "respect" within the community. Sense of loss regarding family support and contact, and need to reach out and protect family members.

4. Relationships with men: Involvement in abusive relationships and rejection of those which are supportive and caring.

5. Issues of recent family reconstitution: Role reversal; establishing a new role as the parent; establishing boundaries; and meeting the needs of her very needy children including physical care and emotional needs.

6. Communication within the family. Openess and expression of feelings.

Throughout the four month involvement in the parallel treatment program, this system experienced many changes and crises. The major changes and crises include:

1. Rose-G having to testify against her youngest sister as her sister had aided in the sexual abuse of Rose-G's niece.
2. The family home burning down and loss of the basic necessities of life (e.g., food, shelter, clothing etc.)
3. Ruby-G moving back home prematurely from residential treatment care.
4. Rob-G moving in with the family for the first time since he was a child due to his loss of shelter and income.
5. Rose-G's home being broken in to and vandalized by a family member including threats to her and her children's physical saftey.
5. Rose-G's father having a stroke.
6. Rob-G's attempted murder of Rose-G.
7. Randy-G's, who is diagnosed manic-depressive and who has a history of neglect of medication, upcoming release from jail.

System intervention varied in style and took the form of:

1. Focus on concrete issues such as providing transportation and accomodating child supervision and care needs.
2. Day to day problem solving - pro-active vs reactive.
3. General empowerment - supported and enabled Rose-G to begin to take control over her own life and family.
4. Validation for accomplishments - e.g., breaking the "silence', achieving sobriety,

regaining guardianship of her children, seeking treatment and supporting her children in treatment.

5. Validation of feelings.

6. Family of origin work - in regard to connecting learning (e.g., parenting) and feelings to family of origin.

7. Establishing parent-child boundaries, personal boundaries, roles and family rules.

8. Resource awareness and empowerment of use.

Due to the extent and nature of crises in this system, intervention also took the form of addressing many concrete needs through advocay for resources and basic needs. This included networking with mutiple systems and the coordination of re-establishing a home and obtaining the basic necessities of life for Rose-G and her children.

Summary of Changes

This system experienced many positive changes over the four months they were involved in the Parallel Treatment Program. Change was evaluated through the use of measures, self-report and clinical observation. Pre/posttest measures for system-H are provided in Appendix H. Some of the most noted changes in this system include:

1. Rose-G - Decreased level of depression from the severe range (BDI=21) to the none or minimal range (BDI=3). Also reflected in physical appearance, attitude and mood.

2. Rose-G - Self-report of increased sense of "felt support".

3. Rose-G - Although guilt wasn't relieved during the course of the program and was often reported to be enhanced by ongoing crisis with family members, Rose-G was better able to connect her guilt to the past and have a better understanding of the origin of her feelings.

4. Rose-G - Self-report of increased confidence which was reflected in her increased ability to problem solve and take better control of her family.

5. Rose-G - No further fears of leaving the home. Rose-G purchased a car and went out for appointments and with her children on a daily basis. She also never missed an appointment.

6. Rose-G - Established a clearer role as the parent by initially meeting basic needs such as making medical, dental, academic and other appointments and establishing some basic rules in her home. This is likely reflected in the FAM score which went from high (FAM=40) to the mean range (FAM=30) for clinical families. These changes also came at a time when two of her older children moved back home which meant taking care of the needs of five needy children as a single parent. This change also resulted in Ruth-g being moved from the oldest in the home to the third oldest. Ruth-g showed a change in pre-posttest scores on FAM from the mean (FAM=32) to high range (FAM=37) respectively. Both Ruth-g and Rhonda-g reported feeling safer and better protected upon the completion of the program.

7. Communication increased significantly in the family. The sexual abuse and individual family members plans for treatment were discussed openly. Rose-G also established rules for family time and encouraged the children to talk about feelings by modeling this herself.

8. Both Ruth-g and Rhonda-g reported an increase to a moderately high level of self-acceptance (SES=31; SES=29 respectively). Both girls also changed dramatically in appearance in regards to hygiene and dress (e.g., not wearing as many layers of baggy clothes).

9. Ruth-g quit being truant at school which was a serious problem for her prior to the onset of the program.

10. The family began to spend "family time" together and go on outtings.

11. Ruth-g, who was initially non-verbal and withdrawn, took on a leadership role in the preadolescent group. She also became openly physically affectionate with Rose-G.

During the course of the program, there were issues that were not addressed to the point of resolution. The most noted was that of Rose-G's own abuse. Due to the neediness of her five children at home and ongoing crisis, the focus was often on day to day problem solving. As many of the crises centered around extended family and areas of past guilt, these crises often only reinforced her feelings of guilt. While Rose-g showed an increased ability to act and was able to seek out and utilize resources within the community, the ongoing crises maintained her stress level. This is reflected by an extremely high IES score, indicating high levels of Post Traumatic Stress Disorder, at both pre- and posttest times (IES=56; IES=55 respectively). The establishment of boundaries, roles and rules in the family were only addressed in regard to basics due to ongoing crises, the increase in family size, and decrease in physical living space. While both girls reported that group was helpful in talking about problems, Ruth-g showed a vast improvement in the way of communicating and expressing feelings while

Rhonda-g remained limited to giving intellectualized reports of her experiences.

Follow-up and Referral

Due to the multiproblem and chaotic nature of this system, it was necessary to refer the system for further treatment following the end of the Parallel Treatment Program. Rose-G was referred for further individual treatment specifically focusing on issues around her own abuse and family of origin. The family was referred for family counselling in order to continue addressing issues of roles and family rules. Ruth-g and Rhonda-g are also to be involved in an open ended pre-adolescent group which was established at the request of the initial group members. All referrals were accomodated within the clinic where the parallel program took place due to the need for continuity and the connectedness of the family.

CASE STUDY

SYSTEM-H

Demographics

Ann-h is the 12 year old foster child of Alice-H who is married and has two natural children of her own as well as three other foster children. Ann-h is the natural daughter of Andrea-H and has a half-brother Alex-H, age 11 and two step siblings Ashley-H, age 4, and Allan-H, age 3. (Note: Andrea-H married her common-law partner, Alvin-H, during the term of this practicum). Ann-h also has another half-sister from a third biological father, Abe-H, who was adopted at birth by relatives of Andrea-H. Ann-h is the only natural child of Art-H whom she only met a couple of years prior to this time and with whom has had sporadic visits since that time. For the purpose of the parallel treatment program, the focus of intervention was on Ann-h and her foster mother, Alice-H.

Background Information

Ann-h presented with a history of multigenerational family violence, substance abuse and sexual abuse. Although there were many abusers in her family of origin, most of the sexual abuse was perpetrated by "uncles". There is a known history of sexual abuse for at least four generations. Ann-h's mother, Andrea-H, was sexually

abused by an uncle and a neighbour and was involved in the mental health system during her adolescence. Andrea-H has a history of substance abuse and multiple partners and was described by CFS-H as having a borderline personality. Ann-h comes from a family environment which can be acurately described as "pan-sexual" (Larson and Maddock, 1986). There is little privacy, few sexual boundaries and Andrea-H openly states that she likes being "sexy" .

Ann-h is the oldest of three biological children of Andrea-H. Abe-H sexually abused Ann-h when she was two or three years old. Ann-h stated that she told her mother a year after the abuse occurred and her mother" kicked him out". Ann-h initially stated that Abe-H was the only one that abused her. Alex-H was also sexually abused, apparently by a cousin, and in turn, sexually offended some younger children. Some of these children included Ashley-H and Allan-H, Ann-h's step siblings.

Andrea-H and her children have a fairly lengthy history of fragmented involvement with various child welfare agencies. Three years ago, Andrea-H requested that Ann-h be placed into care of CFS due to her "behavior". In alternative, a family support worker, FSW-H, was placed to work with the family. Eleven months ago, Ann-h was placed into care with CFS with no apparent explanation to Ann-h or CFS-H. Ann-h was placed in foster care with Alice-H who just lives down the road from Andrea-H. While Ann-h visits her mother weekly, the proximity of the placement has been troublesome due to Andrea-H's need to control. While Ann-h acted out quite severly (e.g. tantrums) when she first came into care, she reportedly has settled down in the foster home. FSW-H has also continued involvement with Ann-h on a more one-to-one supportive basis.

Presenting Problems

Ann-h was the only child in the program who had requested that her CFS worker find a treatment group for her. CFS-H then referred her and Alice-H to the Parallel Treatment Program and attended with them for the intake interview.

Ann-h presented as very bright, verbal and demonstrative. It was apparent that she enjoyed being the center of attention throughout the entire interview. She spoke openly about her family and being "abused" and stated that she wanted to get counselling and "break the chain" of abuse in her family. She stated that she thought about the abuse all of the time, however, it was questionable as to whether the memories were her own, or as a result of constant reminders from Andrea-H. Ann-h stated that while she visits her mother weekly, she knows when to leave.

CFS-H stated that the plan for Ann-h was to be in care long term. While Ann-h was making some gains, Andrea-h wasn't and would attempt to sabotage any gains made by Ann-h. Andrea-H had wanted to attend the parent's group as a means of control but was not involved in treatment with Ann-h during the course of this program.

Alice-H reported no concerns but stated that she was willing to be involved in the program in order to support Ann-h. Alice-H reported having weekly "meetings" with Andrea-H for the purpose of taking some control over Andrea-H's need to control and sabotage.

Summary of Contact

This system attended one intake meeting to which CFS-H also attended. Alice-H, FSW-H and Ann-h were involved in the Parallel Treatment Program. Alice-H attended 5 of 5 parents' group sessions, FSW-H attended 2 of 5 parent group sessions, and Ann-h attended 15 of 15 preadolescent group sessions. FSW-H was only introduced to the program at session three and Alice-H dropped out of the program after session five.

As part of the systemic work, the case manager had 4 phone contacts with Alice-H, 1 that lasted lass than 15 minutes and three that ranged from 30 - 60 minutes. There were also 15 sessions with this system. One was with Alice-H and 1 with Alice-H and FSW-H which were both in the home; 6 with FSW-H; and 7 with Ann-h. All sessions with FSW-H and Ann-h were held at the clinic and were generally 60-90 minutes in duration. There were also 7 phone contacts with FSW-H that ranged in duration from 30 - 60 minutes. There were 5 phone and 2 in-person contacts with CFS-H.

Goals of Systemic Intervention

Specific goals of intervention for this system were not readliy apparent at intake beyond Ann-h's request for counselling for her abuse. After two group sessions, however, the needed focus of intervention became readily apparent.

Ann-h was extremely disruptive in the group setting and and sought attention in negative ways. Alice-H also disclosed that she had come to the realization after the second session, that she had been sexually abused as a child. She also had had a mental

health history and recognized one of the parents in group from her involvement in treatment in the past. Alice-H was very mistrusting of the group and CFS and was unwilling to share this in the group setting. There were also concerns that Ann-H had been sexually involved with Alex-H and had more to disclose. This was a treatment issue as Ann-H had ongoing contact with Alex-H. There were other concerns with regard to Alex-H sexually abusing Ashley-H and Allan-H on an ongoing basis. The goals of the systemic intervention were then specified as:

1. Provide support to Alice-H in regard to her own abuse and encourage her to utilize the support of the group.
2. Address ongoing protection concerns with CFS-H.
3. Develop a trusting relationship with Ann-h in order to facilitate further disclosure.
4. Support Ann-h in developing appropriate social skills and positive ways to seek attention and channel anxiety in order to facilitate her involvement in group.

Summary of Intervention

Beyond the parallel group treatment of Alice-H which is described earlier on in this practicum report and Ann-h in the pre-adolescent group, intervention by the case manager took several forms in accordance with the needs of this system. The initial focus was on the primary concern of ongoing protection needs. This was dealt with by making CFS-H aware of the concerns and acting as a "catalyst" in ensuring

these concerns were addressed.

Alice-H continued to be mistrusting in regards to her own abuse and history due to her caregiving position in the system. Near the end of the parent group sessions, it came to the case managers' attention that the mental health concerns were not just of the past as stated by Alice-H, but were ongoing and resulted in Alice-H being physically absent from the home due to treatment needs. This led to the concern in regards to adequate support and supervision of Ann-h as Alice-H was not willing to obtain support from any other systems. Alice-H attempted to triangulate the case manager with CFS in keeping secrets which required that the case manager clearly set boundaries and define roles. Although CFS-H began a process of addressing the placement concerns, Ann-h intervened and set herself up to be removed from the home stating that she did not feel safe as her mother had control and contact and also felt that she needed to protect the mental health of Alice-H. Ann-h was then moved to an out-of-town foster placement where she continued to attend group and individual sessions at the clinic.

Ann-h made it clear from the onset of individual therapy that she needed "separateness" from her mother and family in order to feel safe in talking. The case manager assured this separateness and confidentiality with the exception of any protection concerns which would only be reported to CFS-H. The focus of Ann-h in individual sessions was twofold:

1. Development of appropriate social skills through role modeling and practice. Exploration of ways in which to seek attention and have needs met in a positive way.

2. Family of origin work, validation and normalization of feelings. Ann-h stated that she didn't remember her childhood from age 6 to 10 and blocks out unpleasent memories as a means of coping. Visual exercises utilizing genograms were incorporated into sessions for the purpose of focusing Ann-h and helping her piece together some of her childhood.

Sessions and contact with FSW-H were mainly for the purpose of information sharing and suggestions for support. This contact was necessary as FSW-H had been involved with Ann-h for 3 years and had been her only appropriate and consistent support. FSW-H also transported Ann-h for all sessions from out-of-town on a weekly basis.

Summary of Changes

Pre/posttest measures and outcomes used for the pupose of evaluation with this system are as indicated in Appendix I. The systemic intervention proved to be more "catalytic" in nature and acted to enable and begin the treatment process. Protection concerns initially known and then discovered where addressed. Ann-h was moved to a safer environment although this occurred more quickly through her own orchestration. Contact with Andrea-H, which had been emotionally abusive and controlling in nature, was limited and supervised. Ann-h reported feeling safer and happer in her new environment. This is reflected by the change in her FAM scores from high, indicating family problems (FAM=35), at pretest in her initial foster home, to low, indicating family strength (FAM=21), at posttest in her new foster

home, as these scales were marked in relation to her respective foster families. This is also reflected in a change in her level of depression from severe (BDI=22) to none or minimal (BDI=3).

During the course of individual sessions, Ann-h also began to disclose "flashes of memory" of sexual involvement with her brother Alex-H. It was unclear as to the degree of repression of these memories as her ability to disclose was impaired by her sense of guilt, shame and felt physical pleasure, especially given that she is a year older than her brother. She did state, however, that she did remember being abused by Abe-H at a younger age which was likely related to her learning that "it was not her fault" in group. It was apparent that Ann-h needed to feel safe and have a long term trusting therapeutic relationship which was not afforded by the Parallel Treatment Program in itself.

During the course of treatment, Ann-h also improved her physical appearance and began to dress more appropriately. The group facilitators of the pre-adolescent group reported a dramatic change in Ann-h's behvior in group as she became more settled, mature and sought attention in more positive ways. At the termination of the individual sessions and group, Ann-h expressed anger to FSW-H and escalated in her acting out. She coped with the last individual session by denying that she had any need for further therapy, however, was able to channel her anger at the group by appropriately making a formal request to have group continue at the clinic. Ann-h's report of greater moderately high self-acceptance (pretest SES=23.5; posttest SES=30) was likely more in reaction to termination and denial of problems, than her actual degree of self-acceptance as she continually stated that she was "stupid" amongst

other negative adjectives. During a later session, Ann-h was also able to verbalize her difficulty in endings and fears in developing new therapeutic relationships.

Follow-up/Referral

As it was readily apparent that Ann-h required long-term treatment, a recommendation for such was made to CFS-H at the onset of individual sessions. Ann-h was then referred for long-term individual therapy which was accomodated within the clinic following the completion of the Parallel Treatment Program. She was specifically referred to a female therapist as she expressed feeling uncomfortable with the male facilitator. The request of the preadolescents for further group as expressed and initiated by Ann-h was followed up on by the clinic. Ann-h was also referred for further open ended group treatment which began in May 1992

CHAPTER TEN

EVALUATION

Method of Evaluation

All latency group members completed pre and posttest measures as well as group evaluation forms with the exception of one of the mothers who had dropped out of group due to the child being moved. Pretest measures were administered by the respective group facilitators during the first week of group while posttest measures were completed in sessions with individual case managers and sometimes facilitators, following the last group session.

Pretest measures for the preadolescent groups were also administered by the respective group facilitators. The mother's group completed measures during the first group session while the preadolescents completed their's during the first one to five group sessions. Only one mother completed the posttest measures and group evaluation form as only one mother remained involved in the program due to the children of the other mother's being moved for protection reasons. The preadolescents completed posttest measures and group evaluation forms during their final group session as administrated by their group facilitators.

The measures selected for evaluation will be reviewed and the respective strengths and limitations of each measure will be outlined.

Impact of Events Scale

The impact of Events Scale (IES) was chosen as a subjective measure of stress. The IES (Horowitz, Wilner & Alverez, 1979) assesses two common responses to stressful life events: intrusion and avoidance. Intrusion includes "unbidden thoughts and images, troubled dreams, strong pangs or waves of feelings and repetitive behavior" while avoidance includes "ideal constriction, denial of the meanings and consequences of the event, blunted sensation, behavioral inhibition or counterphobic activity and awareness of emotional numbness" (Horowitz et al, 1979, p. 210). The literature on the effects of sexual abuse describes intrusive thoughts or dreams and denial as common responses to the experience of sexual abuse. While the experience of sexual abuse impacts the whole family, this scale is not recommended for use with children. The IES was only used with parents as opposed to caregivers, and was only administered at pretest times for the latency age mothers. The remaining mother in the pre-adolescent group, was given the IES as a pre/posttest measure.

The 15-item self-report measure requires respondents to note the frequency of these responses during the last week. The scale is constructed to measure the central features of DSM III's post-traumatic stress disorder and has been used successfully with both clinical and nonclinical populations. Clinical studies for persons with stress response syndromes show mean scores of 39.5 (SD = 17.2, range 0-69); a mean intrusion subscale score of 21.4 (SD = 9.6, range 0-35); and mean avoidance subscale score of 18.2 (SD = 10.8, range 0-38).

The IES has a high item endorsement and consistent pattern of results that supports

the theoretical underpinnings of the scale, and both its reliability and validity. The IES is able to delineate stress subsequent to an event and in assessing treatment outcomes. The subscales, which are based upon clinical observation and inference, were found to have empirical validity by the emergence of coherent clusters. The reliability is supported by adequate test-retest results (.87 for the total scale; .89 for intrusion; .79 for avoidance), and high split-half correlations (r = .86) and alpha coefficients (Chronbach alphas - .79to .92). Sensitivity is supported by indications in change in population where clinical impressions by experienced observers suggest such change (t tests, $p<.025$). Sensitivity is also demonstrated by relevant differences in the response to discrete life events of varying magnitude (t tests, $p<.01$).

The IES possesses the properties essential to single system research and clinical practice. Given its suitability for repeated administration, the IES would not only provide pre- and post-test measures, but can be utilized in the monitoring and modification of the treatment process. One potential difficulty in utilizing the IES as a measure with sexual abuse victims and multiproblem families is the common occurrence of multiple trauma and ongoing crisis events. Although the scale is "anchored" to a specific event by indication, the response given may not accurately reflect the "experience" felt solely by this event.

Index of Parental Attitudes

The Index of Parental Attitudes (IPA) was developed by Walter Hudson (In Corcoran & Fisher, 1987). The IPA was chosen to measure mother's relationship problems

with their children. The literature on sexual abuse emphasizes problems with the mother-daughter relationship as contributing to the occurence of the sexual abuse and stresses the importance of this relationship as an indicator for recovery. The IPA was utilized as a pre/posttest measure for both the latency and pre-adolescent mothers. The IPA is a 25-item scale which was designed to measure the extent, severity or magnitude of parent-child relationship problems as seen and reported by the parent. The IPA has a cut off point at 30 (SD = 5), with scores above 30 indicating the parent has a clinically significant problem and scores below 30 indicating no such problem.

The IPA has a mean alpha of .97 indicating excellent internal consistency and an excellent Standard Error of Measurement (3.64). The IPA also has excellent known-groups validity, significantly distinguishing between groups of clients designated by themselves and their counsellors as having or not having relationship difficulties with their children. The IPA also has fair construct validity, correlating moderately with the variable with which it is predicted it would correlate moderately and correlating highly with other measures which it should including other measures of parent-child and family relationships.

Child's Attitude Toward Mother Scale

The Child's Attitude Toward Mother Scale (CAM) was also designed by Walter Hudson (In Corcoran & Fisher, 1987). The CAM was chosen to measure the relationship problems the children perceive to have with their mothers. As mentioned above, there is much emphasis in the literature regarding the nature and strength

of the mother-daughter relationship. Child victims are also reported to feel unprotected and betrayed by their mother's often resulting in anger and hate towards them. The CAM was designed to measure the extent, degree, or severity of problems the child has with their mother. The CAM also has a cut off point at 30 (SD = 5) with scores above 30 indicating a clinically significant problem and those below 30 indicating no such problem. The scale is not recommended for children under the age of nine, however, it was chosen for use with the latency age children as well as the pre-adolescents.

The CAM has a mean alpha of .94 and a Standard Error of Measurement of 4.57. The CAM has excellent internal consistency and stability with a one-week test-retest correlation of .95. The CAM also has excellent known-groups validity distinguishing between children who rate themselves as having relationship problems with their mothers and those who do not. It also has good predictive validity, significantly predicting children's responses to questions regarding problems with their parents.

Family Assessment Measure-III - Brief Form

The Family Assessment Measure - III (FAM-III), was developed by Skinner, Steinhauer and Santa-Barbara (1983). The FAM-III is a self-report instrument which provides quantitative indices of family strengths and weaknesses. The FAM-III is based on a process model of family functioning which integrates different approaches to family therapy and research. The basic concepts as assessed by FAM-III include: task accomplishment; role performance; communication; affective expression;

involvement; control; values; and norms. Based on the literature describing specific areas family dysfunction , this measure was seen as an appropriate and valid pre/post measure. The FAM-III is reliable and has high internal consistency (coefficient alpha: adults - .93; children - .94). The Brief FAM (Skinner et al, 1984) is a 14 item scale, taken from and highly correlated with the FAM-III. The Brief FAM, which is less time consuming and easier to administer, was utilized as a pre/posttest measure for both the latency and preadolescent mothers as well as the preadolescents themselves. The Brief FAM scores range from 14 to 56 with a low score indicating family strength and a high score indicating family problems. The scale also provides norms for both adults and adolescents in both normal and clinical families.

Beck Depression Inventory - Brief Form

The Beck Depression Inventory (BDI) was developed by Aaron Beck (1967). The BDI consists of 21 symptom categories describing behavioral manifestations of depression such as fatigue, sadness and social withdrawel. Because depression and associated behavioral manifestations are a widely occurring family symptom of sexual abuse, the brief version of this scale (BDI-BF) (Beck & Beck, 1972) was chosen as a pre/post test measure for mothers of both latency and pre-adolescents and the pre-adolescents themselves. The BDI-BF consists of 13 items and is highly correlated with the longer scale (r=.96) and also shows close correspondence to in-depth clinical assessments (r=.61). Beck and Beck (1972) provide the means and standard deviations for groups categorized according to clinical ratings of depression. A one-

way analysis of variance over the means was significant beyond the 0.001 level. The depression scores range 0 to 39 with 0-4 being none or minimal; 5-7 being mild; 8-15 being moderate; and 16 and above indicating severe levels of depression.

The Children's Depression Inventory

The Children's Depression Inventory (CDI) was modeled after the BDI and developed by Maria Kovacs (In Keyser & Sweetland, 1987). The CDI is a 27-item self-report symptom-oriented scale designed to assess depression in children ages 8 to 17 years. The items describe different symptoms of childhood depression including disturbances in mood and hedonic capacity; vegetative functions; self-evaluation; and interpersonal behaviors. Several of the items also evaluate the child's functioning in various contexts such as school. Childhood depression and associated symptoms, are commonly cited in the literature with regard to the effects of sexual abuse on children. The CDI was chosen as an instrument to identify the severity and nature of depressive symptoms in the children.

The CDI yields a potential score ranging from 0 to 54. A CDI score of 9 is considered to be mean for nonclinical samples, while the cutoff score suggested ranges from 13-19 as a mean for clinical samples of children diagnosed with DSM 111 Major Depressive Disorder. Reliability of the CDI is acceptable and has been evaluated through internal consistency (coefficient alpha = .82-.86), and test-retest reliability (.82 - .84) which has been variable across different populations and time intervals. It is suggested that the CDI measures constructs other then depression, such as anxiety

for example. While anxiety is another symptom of sexual abuse, this inventory may not measure depression in the pure sense.

Self-Esteem Scale

The Self-esteem Scale (SES), was developed by Rosenberg (1965) for use with junior and senior high school students and is a self-report measure of self-acceptance. The SES (In Robinson & Shaver, 1973), was utilized as a pre/posttest measure of the degree of the self-acceptance aspect of self-esteem in the pre-adolescent group members. Low self-esteem is cited in the literature as a common effect of sexual abuse due to such dynamics as stigmatization. The SES consists of ten items answered on a four point scale with a high score indicating relatively high self-acceptance and a low score indicating low self-acceptance (range 10 - 40). Test-retest reliability is good (r = .85 over two weeks) and mean concurrent validity with other self-esteem measures is .60.

Group Evaluation Forms

The Group Evaluation Forms were designed by the group facilitators. This report will focus on the Parents Group Evaluation Form (PGEF) administered to the latency age non-offending parent's/caregiver's group (see Appendix J). As only one of the preadolescent mother's remained in the program, the feedback from this form has been provided in the case study of that particular system (see Appendix K).

The PGEF contains ten questions which are either open ended or marked on a three point lickert-scale. The feedback provided by the mothers who completed group is shown in Appendix L. All group members reportedly found the group to be very helpful, provided them with a greater understanding of sexual abuse and how to protect there children, and felt that they were better able to talk with their children. Most members reported that it was easy to talk to group leaders and that they generally knew what their child was learning or doing each week. Half of the group members felt that there should have been more sessions and half felt that the number of sessions should stay the same. This was not related to whether or not they were in the position of parent or caregiver as there was a split. The group members reported two aspects of the group that they found most helpful. One, "knowing that you were not alone", and two, "having someplace to talk about problems". None of the members gave feedback on things that were the least helpful with the exception of one caregiver who reported that check-in was the least helpful. This was likely due to the lengthy nature and monopolization of time by some members during the check-ins. All of the members reported that the mixing of parents and caregivers was good, fine, or interesting. This, however, is in contrast to some of the comments made by one of the natural mothers who, at a different time stated that she felt uncomfortable having foster parents in the group. One member also stated that she liked having a small number of members in group.

LATENCY GROUP INDIVIDUAL DATA

Individual data is presented for both the mothers and children as they were both involved in parallel treatment. The original premise that support and treatment of the mother is necessary and will result in improvement in the child based on the strength of the mother-daughter relationship and ability of the mother to support her child, necessitates evaluation of both change in mother and child. Data for both mothers and children are presented in Appendix M.

There are few general trends in data. Overall, all mothers scored higher on the FAM on posttest than on pretest indicating the presence of more family problems. All showed a decrease in the level of depression with the exception of one. Half of the mothers scored higher on the IPA, indicating more relationship difficulties, at posttest than pretest and half remained about the same. CAM scores show a varying trend with two children showing a parallel increase in problems in the relationship with their mother and the rest showing a decrease.

Depression scores for mother generally showed a decreasing trend with the exception of one who went from none or minimal on pretest to mild on posttest. Depression scores for the children's group varied greatly. Two showed a decrease in level of depression, four showed an increase and one maintained the same level at pre- and posttest.

Individual interpretation of data, will take into consideration self-report in systemic work, self report on group evaluation forms and clinical observations. For this purpose, individual systems will be discussed in more detail. As this practicum

focuses on the mother's support groups, emphasis will be placed on the maternal information and with only the systems in which the mother attended and completed group discussed. Detailed feedback with regard to other systems and particularly the children's group can be found in the practicum reports of other team members.

System-B

Helen-B is the foster mother of Heidi-b. Helen-B reported consistently low FAM scores at both pre (FAM=21) and posttest (FAM=24) indicating family strength. Both Helen-B and Heidi-b scored in the non-problematic range on the IPA and CAM at pre (IPA=19; CAM=28) and posttest (IPA=21; CAM=15) indicating strength in their relationship. While Heidi-b's CAM was low to begin with, it improved at posttest showing the biggest improvement overall. This coincides with clinical impression of the strength of the relationship as Helen-B appeared to be very nurturing, consistent and encouraged communication. It was also apparent that Heidi-b felt safe and cared for by Helen-B.

Both Helen-B and Heidi-b showed an increased level of depression, Helen-B from none or minimal (BDI=4) to moderate (BDI=8) and Heidi-b, reporting the largest increase in level of depression, to being "clinically depressed" (pretest CDI=7; posttest CDI=15). This is likely a reflection of several events happening in the system which created anxiety for both Helen-B and Heidi-b. Both the groups and Voluntary Placement Agreement were coming to an end. Heidi-b began to realize that she was never moving back to her natural family, however, at the same time she was in the

process of leaving Helen-B to live with her grandmother. Given their relationship and Helen-B's reported concerns about Heidi-b moving, these events likely contributed to the increased level of depression moreso than that of the group treatment.

Overall, Helen-B showed insight and proved to be a positive role model in the group. She also appeared to develop empathy for the natural mothers. She reported that she learned alot about sexual abuse and is better able to communicate with and protect Heidi-b as a result of her involvement in group.

System-C

Carol-C is the maternal grandmother of Cindy-c. Pre (FAM =19, 3 items not rated) and postest (FAM=25) scores on the FAM indicate little change and consistent family strength. The IPA, which is the lowest of the group (pretest IPA=11; posttest IPA=10), reports a strong relationship between herself and Cindy-c. Carol-C showed the least change in the FAM and IPA scores overall. This was possibly a reflection of her lack of ambivalence toward the offender as Carol-C was clearly in support of Cindy-c. Cindy-c showed an overall improvement in her relationship with Carol-C (pretest CAM=24; posttest CAM=6). This improvement was likely facilitated by the fact that Carol-C, who was in the worst economic/environmental situation, was the only mother who consistently attended group with her child. This likely contributed to Cindy-c's sense of felt support as Carol-C tended to be a non-demonstrative/ communicative person beyond that of meeting basic needs.

Measures of levels of depression proved to be interesting. Carol-C had the second

highest level of depression and stress response at pretest and reported that she felt like a "failure". This was not reflected at an overt level. She reported a dramatic decrease in level of depression from moderate (BDI=13) to none or minimal (BDI=1) at which time she reported that group was helpful in knowing she was not alone. Cindy -c reported an increase in level of depression from none or minimal (CDI=4) to moderate (CDI=9) which was also not reflected through clinical observation. On the contrary, she improved in her level of confidence and social skills and had the greatest capacity of all the children to handle the content and structure of group. The lack of clinical observation in this regard likely reflects internalized methods of coping for both Carol-C and Cindy-c.

Carol-C was generally the most nonverbal member of group. Although her role was clear, it was mainly geared towards meeting Cindy-c's basic needs. She stated that she left the other things (e.g. sex education) for Cindy-c's natural mother, who is a transient. Group reportedly was helpful in facilitating Carol-C's awareness of sexual abuse and improved her ability to protect Cindy-c. She also had stated a goal of increased communication between herself and Cindy-c which was facilitated by the "letter sharing" exercise and her increased awareness of the dynamics of sexual abuse. At that time of letter sharing, Cindy-c was able to take some risks and tell Carol-C that she hadn't told her about the abuse because she was afraid that she would be mad.

System-D

Lori-D is the natural mother of Lucy-d and Laura-d who have been in and out of

care and have only come to live with their mother for the past year and a half. Lori-D reported a consistently high FAM score, indicating family problems, at pre (FAM=32) and posttest (FAM=35) which was congruent to clinical observation in regards to Lori-D's reports of feeling overwhelmed, and the observation of lack of clear rules, roles and boundaries within the family. She did, however, report an increased ability to recognize feelings. Although Lori-D reported a pretest IPA score indicating no problem in the relationship with both Lucy-d (IPA=27) and Laura-d (IPA=14), the score for Lucy-d was almost double that of Laura-d. This was consistent with Lucy-d being the "identified patient" in the family at the beginning of the program. As Lucy-d became more mature and developed social skills during the course of treatment, Laura-d began to act out more. This was not reflected at posttest as both IPA scores showed a significant increase, indicating problems in both relationships (Lucy-d IPA=52; Laura-d IPA=40), with Lucy-d and Lori-D's being the most problematic. Both Lucy-d (pretest CAM=35; posttest CAM=43) and Laura-d (pretest CAM=24; posttest CAM=31) showed a parallel increase in CAM scores reflecting problems in their relationship with their mother, although Lucy-d's was high from the onset. It should be noted that this is the only system that showed an increase in problems in both the IPA and CAM reports. These measures are not in support of clinical observations in the final systemic session in which Lori-D was very appropriate and open, however, they are consistent with the inconsistent nature of Lori-D. Lori-D often denied the existence of problems and showed a pervasive need to "say the right thing" in group. The change in reporting may simply reflect an increase in trust and more honest reporting. They also likely reflect some of the ongoing crises in this system. There

were ongoing concerns in regards to substance abuse, which at one point resulted in a temporary apprehension of the children; arrest of the natural father who had re-offended half-siblings; three changes in partners for Lori-D; and Lucy-d being physically abused by Lori-D toward the end of the program.

Lori-D's level of depression was reportedly none to minimal (pretest BDI=6) and unchanged during the course of the program (posttest BDI=5). This again was inconsistent with clinical observation of need for inappropriate coping mechanisms and statements of feeling overwhelmed. Both Lucy-d (pretest CDI=25; posttest CDI=17) and Laura-d (pretest CDI=9; posttest CDI=3) reported feeling less depressed, however, Lucy-d remained in the "clinically depressed" range. This was likely due to the events that occurred in the system and Laura-d's change due to externalization of symptoms.

Overall, Lori-D's reporting is inconsistent, and inconsistent with her behavior. Although Lori-D had come a long way over the years, it is unclear to what degree she benefitted from the program beyond learning what were the "right things to say". While this indicates an increase in awareness, it doesn't necessarily indicate an ability to implement such learning. Lori-D did report being more aware of issues about sexual abuse and felt better able to protect her children, however, this system continued to be a concern. It would be necessary to deal with issues of substance abuse and protection concerns before this system could benefit further from treatment. This family was self-referred to a treatment resource which utilized "traditional healing" following the completion of the program.

System-F

Donna-F is the natural mother of Dee-f, who was abused by her brother, Derek-F. Donna-F reported a higher FAM score at posttest indicating a move from family strength (FAM=17) to the mean (FAM=30) for clinical families. Of most concern was the increase in IPA scores from the cutoff for problems in the relationship (IPA=30) to increased problems in the relationship (IPA=43). Donna-F reported feeling ashamed of Dee-f and wishing that she was more like other children at both pre and posttest. As Dee-f's feelings became more externalized, this likely contributed to the increase in both the IPA and FAM scores. This also likely reflects ambivalence toward the offender as the offender was her own son. In contrast, Dee-f reported a significant decrease in problems in her relationship with her mother (pretest CAM=44; posttest CAM=7). The fact Donna-F had only been involved in treatment relating to Derek-F prior to the program, and then showed concrete support and involvement with Dee-f during the program, likely contributed to Dee-f feeling more positive about their relationship.

Donna-F reported the highest level of depression and IES scores of all group members at pretest (BDI=14). This is supported by clinical observations and self-report of pervasive anger towards her son and the need to "talk to someone". She reportedly often coped with this anger by avoiding helpers as reflected in her high avoidance subscale score. While her level of depression did drop, it remained within the moderate range (BDI=10). Dee-f reported a slight increase in her level of depression from just below (CDI=12) to just above the cutoff for "clinical depression"

(CDI=15). Her depression was also reflected in verbalizations of wanting to hurt/kill herself. Dee-f was also the most "uninvolved" child in group and was more into individual play.

In summary, the overall scores for this family reflect the ongoing difficulties encountered. While Donna-F was the only parent to act immediately and appropriately in protecting her daughter once the abuse was disclosed, she was left with intense anger and ambivalence due to the offender being her son. Donna-F often coped with these feelings through avoidance which likely resulted in a lack of connection and ability to empathize with her daughters feelings. She did, however, report that group was helpful in "feeling less alone" and in "getting things off her mind that bothered her". Due to strong indications for the need for follow-up and individual therapy, this family was referred for ongoing treatment at the clinic.

Preadolescent Group Data

Data for the preadolescent age groups is presented in Appendix N. As the focus of this report is on the mother's groups, and the mother's group was terminated after five sessions, general trends in data will not be discussed. It should be noted, however, that the children of the three mothers were abused at an early age (age 2 - 6 years) and were untreated until the time of the program. Due to the lack of treatment, the symptomology increased in severity and became the focus of the mothers and other systems. Each of the families were multiproblem in nature and came to the program in crisis. All of the mothers themselves had histories of untreated sexual abuse which

is in contrast to that of the mothers in the latency age group. This only served to exacerbate the problems and interfere with their ability to meet the needs of their children with the exception of the only remaining parent.

As I provided intensive systemic work for two of the four preadolescent systems represented, including the one which completed the program in its entirety, the individual data is reviewed in detail in the case studies in Chapter Nine of this report.

CHAPTER ELEVEN

SUMMARY

Conclusions

I would conclude overall, that the Parallel Treatment Program had varying degrees of benefit to the systems served. Of minimal benefit, was the development of awareness for further treatment and attention to outstanding or ongoing protection needs. The family's ability to benefit beyond this, was largely dependent on their initial readiness and receptivity to treatment, appropriateness for group, and the scope and type of issues that needed to be addressed overall. Other factors which would influence the level of benefit to the family would include support received during ongoing crises, skill level of group facilitators, level of supervision provided to group facilitators, and level of case management and system (e.g., CFS) involvement versus needs of the family.

Indicators of the ability of a family to benefit included stability of placement, relationship between mother and child, and level of communication. The length of time from disclosure to treatment was also an indicator in regards to the intensity and scope of treatment required. As observed in these families, many of the dynamics described in the literature (e.g., degree of denial and support available), which contribute to differential effects of sexual abuse, played a role in indicating success for treatment (Server and Janzen, 1982). It was also noted that mothers of children who have been sexually abused, suffer similar trauma to that of the children (Strand, 1990).

Finkelhor's "traumgenic dynamics" (Finkelhor and Browne, 1985) were germane to both with the exception of traumatic sexualization for the mothers.

It is also concluded, that the degree and severity of abuse was relatively less significant than the stability of placement and sense of support (Steele and Alexander, 1981). This was illustrated in systems where there was multiple abuse showing a greater overall degree of improvement versus those where the sexual abuse in itself was minimal. Issues such as substance abuse, ongoing protection concerns, untreated parental abuse and lack of support versus need tended to impair the treatment process (Mandall and Damon, 1989; Friedrich, 1990) and lead to placement breakdown.

Learning and Recommendations

One of the major difficulties encountered during the initial process of this practicum was in securing referrals. Difficulties were encountered in obtaining enough group members and ones who were appropriate for the program as determined by the pre-established criteria. The program was initally open to the Central area of Child and Family Services as the clinic generally serves the Inner City area. This agency provided only three referrals, of which none were appropriate. Once the program was opened up to the bordering areas, as well as the Child Protection Centre, Child Guidance Clinic and Marymound, there were more referrals, however, still not enough to fill both the parallel age groups. This was especially problematic for the preadolescent age group. Interestingly, there were a larger number of referrals from the 4 - 6 age group which was outside of the criteria for the program.

In speculating as to why these difficulties were encountered, especially in light of the incidence of sexual abuse as reported in the literature review, it would appear that there were a number of possible reasons Although initial contacts were through the Abuse Coordinator, I would question the degree of ongoing communication between the coordinators and social workers about treatment needs, especially given the recent change in coordinators. Child protection workers are often so overwhelmed, that referrals for treatment and additional work beyond basic protection, often becomes a burden and is precluded due to ongoing crisis intervention and lack of time.

Also, when the program was opened up to other areas, it was done by word of mouth as opposed to written notice. I would recommend the use of a simplified referral form and written notice to each of the protection workers and agencies when setting up such treatment programs. It is also possible that, especially for the older age group, the focus of CFS workers is on containing behavioral symptoms as opposed to dealing with the cause of the problem (i.e., treatment for past history of sexual abuse). While all group members had been sexually abused at an early age, (2-6 years) regardless of the age they entered the program, none had been involved in treatment prior to this time. Untreated victims of sexual abuse tend to compound symptoms or develop more severe symptoms (e.g., chronic running behavior, mental health issues) over time which may place them outside the criteria developed for this program (Coker 1990; Berliner and MacQuivey, 1982; Conte and Berliner, 1981). This program, therefore, would not meet the needs of these victims. It is also possible that some workers don't recognize symptoms as related to early sexual or ongoing sexual abuse as children don't often disclose until they are in a safe environment. This theory is also supported

by the larger number of referrals for younger children outside the age criterion. Public awareness, professional education and early education within the school system, has led to an increase in the rate of early disclosure and early detection and has resulted in an increased number of "recognized" victims of an early age (The Child Protection Centre, 1984). It is more often true that young children are still with parental figures and tend to "act out" at a more manageable level. This would allow for the focus to remain on the sexual abuse as opposed to severe behavioral symptoms such as running, substance abuse, self-mutilation and prostitution. The recommendation becomes obvious: families experiencing sexual abuse should be provided with therapeutic intervention beginning at the time of disclosure (Sgroi, 1982).

There were two main problems encountered as a result of the difficulty in securing referrals. Due to time constraints in completing the practicum , the treatment team could not complete an adequate screening and priorizing process which resulted in the knowing and/or unknowing acceptance of referrals that were either borderline or outside of the criteria (e.g., placement stability, untreated substance abuse). In addition, one of the mothers in the latency age group refused to participate in the program. Issues around children's comfort level with the context and content of the program were also not adequately addressed in the screening process. This is exemplified by the situation of Heidi-b, who was reportedly advanced intellectually, however, developmentally, she was not able to handle the group setting. This resulted in a decreased ability to benefit from group treatment and the disruption of treatment for others in the group.

Screening became even more of a problem for the preadolescent parallel groups. Again, one of the mothers refused to participate in the mother's group. The criteria of placement stability, while being stated as such initially, needed to be assessed more carefully prior to involvement in the program. This was obviously important because, as the group progressed, two children of two of the three mothers in group, were moved for protection reasons which resulted in these two mothers dropping out and leaving only one mother in group.

The other main problem encountered was only exacerbated by the above. While the latency age group was able to secure seven members in children's group, and five in the parents, these numbers did not allow for the effects of attrition on the group process. As there were fewer members, there was more of a focus on individuals rather than that of group process. This was further exemplified in the preadolescent age group which was only able to secure five referrals for the children's group and three for the mothers group. Drop-out in this group resulted in the termination of the mothers' group.

It was important to address concrete issues of transportation and child care in working with these families (Kitchur and Bell, 1989; Strand, 1990). All of the natural mothers were on social assistance and required arrangements for transportation. Different CFS workers gave different responses in regard to the issue of transportation. The facilitators were told by some that there was only funding for children who were in care and not for those who lived with their families. This is contrary to the general philosopy of the Child and Family Sevices Act which favors

maintaining children in their natural families whenever possible. As a result of this, some families experienced ongoing difficulties. For example, one family missed a session due to lack of transportation in the cold weather and facilitators sometimes "took up a collection" to provide bus fare for another family. The times for the preadolescent groups were also changed to accomodate other children in the family who required supervison when arriving home from school. It is imperitive, therefore, that a commitment be obtained from the referring agency in this regard. I would recommend that the agency also sign a contract of commitment and not just the clients. In the alternative, I would recommend having a fund for transportation which would allow for more therapist control in regards to consistency and reliability.

The importance of the kind of facility used was also recognized during this practicum. While the clinic provided a good central location and easy access for these families, there were often difficulties in regards to noise. For example, using an adjacent room to the children's group, who often expressed their anxiety in a very verbal way, resulted in anxiety on the part of some of the mothers.

The "joint time" spent with the parallel latency groups together proved to be beneficial. For example, the Valentine's party, which was a planned "nurturance" activity, allowed for modelling and encouragement of appropriate show of affection. This joint time also proved to have a settling effect on the children who were often very anxious within their group setting. It would be recommended that beyond this, it would be beneficial to have some dyadic "play sessions" with mother and child in order

to model and encourage appropriate nuturance and affection (Damon and Waterman, 1986).

In working with these families, it was also learned that the use of simple language and concrete examples were needed. As most of the group members had lower levels of education, understanding and comprehension, the group facilitators took extra precautions when it came to the use of language and written exercises. Concepts were often explained in terms of examples and visual materials were simplified and used whenever possible. The example most illustrative of this need was in the use of the measures. Even though facilitators assisted with reading and filling out of the measures, many of the members did not fully comprehend some of the concepts, questions, instructions or even words used. This was exemplified by individual members responding differently to a question in writing than in speaking. Some of the measures were difficult in themselves due to use of double negatives and alternating positive and negative responses. The most noticable was the IPA which often left the mothers confused. Also, some of the strong language (e.g., "I hate my child") was offensive to the mothers, who would often mark the extreme opposite answer more in reaction to the wording than to indicate any ambivalant feelings they may have. For the measures themselves, I would recommend the use of behavior/symptom checklists and revised measures which would be more concrete and clear in wording and less complicated in marking. The utilization of self-report measures also presents a difficulty when working with resistant families and/or families in denial (Sagatun, 1982). This was noted in some of the preadolescent pre/posttest scores which

indicated almost "perfect" family functioning which was incongruent with clinical observation. It is necessary, therefore, to account for social desirability when utilizing self-report measures as a measure of clinical change. I would also recommend the use of "mid-point" evalution for the purpose of addressing incongruent observation with the client as a treatment issue.

Development of communication between the mother and child was one of the overall goals for group and is generally a focus of treatment and indicator of a family's ability to benefit from treatment (Hildebrand and Forbes, 1987; Vancouver Incest and Sexual Abuse Centre, 1989). In particular, the development of communication was stated as a goal by the parents of the latency age children, especially with regard to the sexual abuse. While mothers and children came to the facility together and attended parallel groups, this in itself would not necessarily promote communication. Within the course of group itself, the "letter writing" exercise was developed as a means to initiate this process. While this was successful overall, it would be recommended that this occur somewhat earlier on in the process to allow for time for follow-up and generalization. The use of joint "homework" such as the coloring books given out prior to Christmas, can also help facilitate communication through a non-threatening activity. It is also recommended that the issue of communication be addressed in additional work provided to the system.

In discussing the length of group, this will be viewed as different from the length of treatment required. I view group treatment as one component in a needed treatment

process. Both the facilitators and group members felt that fourteen weeks was generally not enough time for group. The group was affected by the individual needs of some members to monopolize group time. This resulted in some planned agenda items not being covered (e.g., needs of children, assertiveness and the legal system). It is my view that fourteen sessions would be the absolute minimum required for the latency age groups based on "all going well" and individuals having crisis needs being met outside the the formal group. It is also important to consider the ability of young children to focus on treatment (Friedrich, 1990). When utilizing parallel treatment groups, the length of groups for parents is limited to the length of group treatment appropriate for the age of their children. It is often necessary to offer treatment in "allotments" based on the different needs of the child at varying developmental stages.

Recommendations would be different for the preadolescent age groups. This age group has an increased capacity to focus on treatment and often takes on a more psychotherapeutic nature than strictly education/prevention focuses. There are often more ongoing crisis issues and need for problem solving which interferes in a brief time-limited approach. As occurred in this program, the preadolescents themselves requested the continuation of group beyond the fifteen weeks offered. Based on this request, the group was reconvened during the month of May 1992 as a service provided by the clinic. It would be recommended, therefore, that group sessions be more in the range recommended in the literature i.e., 20 - 30 sessions (Mandall and Damon, 1989; Damon and Waterman, 1989) or that group be open ended (Friedrich, 1990). This would also benefit the mothers of these children as there were many more issues to address, greater strains on relationships and time required to link

behaviors to feelings due to the severity of acting out. The increased time would better allow for mothers to understand the effects of abuse, develop empathy, and offer support to their child.

The literature has done very little in addressing the issue of mixing foster with natural parents. There were mixed impressions of this through the experience of both mothers groups. Foster parents can act as role models and also benefit for themselves in developing empathy for natural parents of children who have been sexually abused, especially if they have little awareness of the effects on the family. Group can also provide them with much needed education in caring for sexually abused children. The mix, however, can also create difficulties in group. Natural parents can feel defensive and guarded if they feel that they are being judged by foster parents, especially if the foster parent presents in a patronizing manner. As learned in the preadolescent mother's group, foster parents may also feel obligated to limit self-disclosure and play the role of the "perfect parent" given their status as "alternate caregivers" to those parents who "have problems" or who are not able to protect their children. A natural mother in this group commented that it made her angry that the foster parent told everybody how to do things the "right way" especially when she then had her foster child removed and dropped out of group. Overall, this speaks to the need for careful screening prior to group and ongoing guidance and monitoring by group facilitators within the group structure (Mandall and Damon, 1989).

Overall, involvement in this practicum was helpful in increasing my general knowledge in the area of intrafamilial sexual abuse and working with multiproblem/multiserviced or chaotic families in a treatment setting. One of the most noted issues is that of the conflict between therapeutic roles versus protection roles. As many of the families had outstanding and/or ongoing protection concerns, it was often necessary to address these issues before being able to move on to treatment issues. It was found that it was sometimes difficult to have CFS workers respond to these issues and facilitators were often left in a conflicting role. This would result in the client perception that we were "threats" or "allies" with CFS, which further impaired their ability to trust (Herman, 1981). It is truly an art to find the balance between what is often termed as being the "hammer and the velvet glove". That is, there are often conflicts in balancing the roles of "enforcer" and "support or advocate" when working with these families.

In working with multiproblem families, I have also learned that the systemic family work provided was essential. Many of these families experienced ongoing crises which required that their unique individual needs be met (Van Scoyk et al., 1988; Pescosolido and Petrella, 1986). As a clinician, I have a tendency to be somewhat of a perfectionist, desiring to meet "all needs of all families". While I have learned that this is unrealistic through working in child welfare, this was further reinforced through my work with these multiproblem families. This realization and learning has required that I learn to priorize. Working with these families has taught me that it is primarily important to deal with concrete issues (Strand, 1990; Sgroi, 1982; Kitchur and Bell, 1989) as a means of establishing trust, increasing the sense

of felt support, and maintaining stability in the family. Sgroi's recommendation of providing "total life support" certainly developed meaning within the frame of this practicum. The systemic work, therefore, often requires outreach to the family (Sgroi, 1982) and involvement with the community and other agencies (Steward et al., 1986) in providing for the basic needs of the family. For example, the family whose home burnt down was in immediate need of food, shelter and clothing. If these needs hadn't been responded to quickly as part of the service provided, the family would not have continued in the program. It was also apparent that individuals, whose needs were not met through group alone or work outside of group, would often monopolize group time and impede the group process.

The question of when to start the systemic work can now be answered with more knowledge. It is necesary to complete a more intensive screening and assessment process prior to the onset of the program (Mandall and Damon, 1989; Friedrich, 1990). It would be beneficial to develop an individual treatment plan, based on the assessment of each individual family including other systems affecting the family. This would be the logical point of the beginning of systemic intervention. It would be beneficial to have the concrete issues and needs of the individual family addressed prior to the onset of proup. It is recommended, therefore, that while initial screening be completed through the group facilitators, that needed pre-group sessions be with the assigned case manager.

In working with the families in this practicum, the importance of social networks was stressed (Steward et al., 1986; Berliner and MacQuivey, 1982; Cornman, 1989; Friedrich, 1990, Mara and Winton, 1990; Kitchur and Bell, 1989). As these

families often have multiple needs and multiple helpers, it would be valuable to have a network meeting prior to the onset of treatment in order to clarify the needs of the family and roles within the system as part of the development of a treatment plan. While the issues of resources and network support was addressed in a session in the latency age mother's group, it would have been valuable to use the "network exercise" as a pre/posttest measure of the goal of expanding supports and resources. The use of communication and networking by therapists, also provides modelling for clients in how to advocate for themselves.

I also learned that it was important never to "assume" that the mothers had enough basic skills and knowledge in the way of parenting. Many of these mothers had acquired inappropriate or scanty information from their own families of origin (Mara and Winton, 1990; Gelinas, 1983, 1986; Koch and Jarvis, 1987; Sgroi, 1982). This was especially apparent during the latency group sessions on appropriate sex education for children as none of the parents had been given information on their own sexuality as children or even as adolescents, and were often misinformed.

The Parallel Treatment Program entailed the use of a team approach to treatment. Due to the number of families treated, complexities of the program and use of parallel themes, there was a strong need for ongoing communication and planning. This is imperative as a team of this nature operates very much as a family system in that all members are affected by each other. I learned that it is imperative that all team members have a commitment to and understanding of the needs of running such a

program. A program of this nature requires a team approach due to the logistics alone, (e.g,. parallel time of groups, co-facilitation) and the need for systemic work as all of the families had individual needs outside of the group context. If these needs are not met, whether as basic as transportation and physical needs, to individual therapy, it clearly interrupts the group process.

In working with multiproblem families and using a team approach, there is a need for ongoing supervision, including individual, team and peer supervision. This type of program also requires a great deal of commitment on the part of the clinical supervisors. It would be recommended that there be one overall team supervisor for the purpose of assuring follow-through of commitment and consistency in meeting treatment needs of individual families. Regular full team meetings on a bi-weekly basis would be recommended as well as weekly supervision by the individual clinical supervisors. It is also recommended that video-tapes made for the purpose of supervision, be viewed by the students and supervisors on a weekly basis for the purpose of ongoing feedback and direction as opposed to consultation which has limitations when considering group process and dynamics.

I found a vast difference in working with mothers of latency age children and mothers of preadolescent children. As previously mentioned, all of the children in both groups had been sexually abused at an early age (2-6 years). The children in the preadolescent group, however, had been left untreated for a longer period of time. The most notable difference was in the degree or type of symptoms experienced by the

children (Coker, 1990). This, in turn, affected the stability of placement, ability of the mother to empathize, and ability of the mother and the system to focus on treating the problem and not just on containing the symptoms. Another significant factor affecting this was that all of the mothers in the preadolescent group were victims of childhood sexual abuse as opposed to none disclosed in the latency age mother's group. All of these mothers had also had a history of either phychiatric illness/treatment or substance abuse, and also had histories of suicidal ideation. This information was only known for one of the mother's prior to the onset of group. This added dynamic also affected such things as the ability of the preadolescent mothers to empathize, meet the emotional needs of their children and be honest in group (Rosenzweig, 1985; Everson et al., 1989; Vancouver Incest and Sexual Abuse Centre, 1989).

The latency age mother's group members were generally more able to focus on learning, developing insight and group process. In contrast, the mothers in the preadolescent age group were either in constant crisis and venting their frustrations or were mistrusting and withholding. Due to all of these factors, I found it very difficult to maintain any semblance of learning in the preadolescent group. Sessions were very emotional and draining and there was a constant need to reframe and refocus. The level of anger and lack of empathy, often precluded any new learning within this setting and required that I become more structured and directive in group. Being the sole facilitator for this group only served to make the process more difficult. I would strongly recommend the use of co-facilitators when working with mothers especially when the mothers themselves have been victims of childhood sexual abuse (Mandall and Damon, 1989; Hildebrand and Forbes, 1987; Nelki and Watters, 1989;

Kitchur and Bell, 1989; Barret et al, 1986; Steward et al, 1986; Strand 1990). It was also apparent in hind sight, that two of the mothers in particular, required individual intervention prior to group, in order for them to be able to benefit from a group. The ability of a mother to empathize appeared to be a strong indicator of ability to benefit from the program and provide support to their children (Everson et al.,1989; Server and Janzen, 1982). I would also recommend that part of the group focus for this age group should include effective parenting of children who have been sexually abused (Mara and Winton, 1990).

In conclusion, there is a general need to emphasize the mother's contribution to "recovery" as opposed to contribution to the incest. I believe that this type of treatment program can be considered successfull if viewed as one component of an overall treatment process. There doesn't appear to be an "easy solution" to treating intrafamilial sexual abuse. This approach requires a great deal of time and commitment. Families affected by sexual abuse often require "total life support". Individuals often have treatment needs which need to be addressed prior to group intervention. There is also the need to follow up on unique issues and integration of learning within the family. Parallel treatment by nature, adds to the sense of the child's felt support and serves to strengthen the mother-daughter relationship. It is unclear, however, in this particular program, as to the "degree" of effect the treatment of the mother had on the child. It would be necessary to have comparative control group studies in order to ascertain this. The "group" format was successful in reducing the sense of stigmatization and loneliness felt by both the mothers and the

children (Steward et al., 1986; Berliner and MacQuivey, 1982; Mara and Winton, 1990; Kitchur and Bell, 1989; Cornman, 1989; Sgroi, 1982; Friedrich, 1990; Hildebrand and Forbes, 1987). It is also useful and efficient as a means of educating and empowering the mothers (Hildebrand and Forbes, 1987; Friedrich, 1990; Mandall and Damon, 1989; Mara and Winton; 1990). After all, "knowledge is power"!

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APPENDIX A

INTAKE CHECKLIST

Date: ____ ____ ____
Yr. Mo. Day

Intake Checklist

Client _____ Interviewer _____

Check 'Y', 'N' or 'Don't Know' for each question.

LEVEL ONE: ISSUES TO BE ADDRESSED IN EVERY INTAKE INTERVIEW.

			Don't Know
Is there current contact with other therapeutic professional or agency?	Y___	N___	___
Has there been previous therapeutic contact regarding the current problem?	Y___	N___	___
Is the client on medication, psychotropic or otherwise?	Y___	N___	___
Are there legal implications to therapy participation or outcome?	Y___	N___	___

LEVEL TWO: ISSUES TO BE SELECTIVELY ADDRESSED DEPENDING ON SITUATION.

			Don't Know
Is this situation a crises, requiring immediate response?	Y___	N___	___
Is there reason for concern about physical abuse of family members?	Y___	N___	___
Is there reason for concern about incest?	Y___	N___	___
Is there reason for concern about suicide?	Y___	N___	___
Is there reason for concern about the safety of the client or others?	Y___	N___	___
Is there concern, by yourself or others, about the client(s) misusing nonprescription or prescription drugs (including alcohol)?	Y___	N___	___
Is it necessary to receive written consent to engage in therapy?	Y___	N___	___
Is anyone expecting feedback on therapy progress?	Y___	N___	___
Have you requested further information from anyone regarding the client?	Y___	N___	___

For each positive response, a description or explanation should be included in report. Include any emergent or short term interventions initiated during intake.

APPENDIX B

CONSENT FOR TREATMENT

THE UNIVERSITY OF MANITOBA

COMMUNITY RESOURCE CLINIC

301-321 McDermot Avenue
Winnipeg, Manitoba
Canada R3A 0A3

(204) 956-6560

I hereby consent to allow the Community Resource Clinic of the University of Manitoba to assess and/or treat the following minor child:

_____

Signature: _____
(Parent or Guardian)

Witness: _____

Date: _____

APPENDIX C

DEMOGRAPHIC INFORMATION

INTAKE INFORMATION FOR LATENCY GROUPS: CHILDREN AND CAREGIVERS												
	Child's Age	Number of Offenders	Age(s) when Offend-ed	Relationship of Offender to the Victim	Most Recent Disclosure to Whom	Reported and Investi-gated	Police Disposition	Duration of Sexual Abuse	Nature/ Type of Abuse	Child has History of Physical Abuse/ Neglect	Caregiver Relation-ship with Child at Time of Group	Care-giver's Marital Status
Laura d.	8	2	2 and 6	biological father aunt's boyfriend living in home	Child & Family Services	✓	no charges	unknown	medical evidence of penetration fondling	✓		
Erica E.											foster mother	married
Ellen e.	10	1	9	biological father	police	✓	no charges	4-6 months	fondling, digital penetration, fellatio	✓		
Donna F.											biological mother	single parent
Dee f.	9	1	6	adolescent brother	mother (after older sibling disclosed)	✓	charges laid	4 times over few months	fondling and penetration	✓		
Fiona a.	8	1	3-1/2	biological father	CFS social worker	✓	no charges	several times	fondling	✓	Note: foster mother did not attend group	married

* Jointly prepared by Kathy Anderson, Barb Gajdek and Karen Gamey

INTAKE INFORMATION FOR LATENCY GROUPS: CHILDREN AND CAREGIVERS												
	Child's Age	Number of Offenders	Age(s) when Offend-ed	Relationship of Offender to the Victim	Most Recent Disclosure to Whom	Reported and Investi-gated	Police Disposition	Duration of Sexual Abuse	Nature/ Type of Abuse	Child has History of Physical Abuse/ Neglect	Caregiver Relation-ship with Child at Time of Group	Care-giver's Marital Status
Helen B.											foster mother	Divorced single parent
Heidi b.	7	3	5-6 all over a one-year period	unidentified	foster mother	✓	charges pending	once	exposure	✓		
				mother's friend				?	fondled			
				adolescent uncle				once	oral sex			
Carol C.											maternal grand-mother	widow single parent
Cindy C.	8	1	7	cousin's boyfriend - living in home	commun-ity program volunteer	✓	charges pending	one incident disclosed but more suspected	fondling, digital penetration	none known		
Lori D.											biological mother	single parent
Lucy d.	10	2	4 and 8	biological father	Child & Family Services	✓	no charges	unknown	alleged penetration	✓		
				caregiver; maternal aunt's boyfriend					penetration and fondling			

* Jointly prepared by Kathy Anderson, Barb Gajdek and Karen Gamey

INTAKE INFORMATION FOR EARLY ADOLESCENTS AND CAREGIVERS

	Child's Age	Number of Offenders	Relationship of Offender to the Victim	Age(s) When Offended	Most Recent Disclosure to Whom	Reported and Investigated	Police Disposition	Duration of Sexual Abuse	Nature/ Type of Abuse	Adolescent has History of Physical Abuse/ Neglect	Adolescent in Care of .... at Time of Group	Mother/ Caregiver has History of Sexual Abuse	Caregiver's Marital Status
Rose G.												✓	single parent
Ruth g.	13	3	two - family friends	unknown	biological mother	✓	two - convicted	single events	fondling	✓	biological mother		
			maternal grandfather					more than once					
Rhonda g.	12	1	maternal grandfather	6	biological mother	✓	convicted	few weeks	fondling	✓	biological mother		
Alice H.												✓	married
Ann h.	12		mother's common-law	2-3	biological mother	✓	no charges laid	approx. 1 year	fondling and digital penetration	✓	one foster home, then moved to another		
Gert I.				8-11								✓	single parent
Gail i.	13	2	mother's boyfriend		school counsellor	✓	no charges yet laid	5 years	digital penetration, fondling, cunnilingus by offender	✓	biological mother		
			unidentified adolescent			✓		one occasion	penetration				

* Jointly prepared by Kathy Anderson and Barb Gajdek

INTAKE INFORMATION FOR EARLY ADOLESCENTS AND CAREGIVERS													
	Child's Age	Number of Offenders	Relation-ship of Offender to the Victim	Age(s) When Offend-ed	Most Recent Disclosure to Whom	Reported and Invest-igated	Police Disposition	Durat-ion of Sexual Abuse	Nature/ Type of Abuse	Adoles-cent has History of Physical Abuse/ Neglect	Adoles-cent in Care of .... at Time of Group	Mother/ Care-giver has History of Sexual Abuse	Care-giver's Marital Status
Pat J.												✓	single parent
Pam j.	13	1	boarder living in the home	6	older sister who reported to CFS	✓	no charges laid	?	penetration	✓	biological mother, then to grandmot her, then into foster care		

* Jointly prepared by Kathy Anderson and Barb Gajdek

APPENDIX D

LATENCY AGE MOTHER'S GROUP - AGENDA/CONTENT NOTES

LATENCY AGE NON-OFFENDING PARENT'S/CAREGIVER'S GROUP

GROUP NOTES

SESSION # One DATE: November 19, 1991

GROUP FACILITATORS: Kathy Anderson/Barb Gajdek

ATTENDANCE: Five members attended, one child's foster mother declined to join group.

SESSION OBJECTIVE: Joining

AGENDA

- Introduction, Names
- Purpose/Philosophy of Group
- Group Goals - support, education, parenting
- Goals of Children's Group
- Group Rules
- Group Member's Agenda's/Situation - discussion
- Completion of Pre-Test Measures

CONTENT

- Group members were each given name tags and introductions were made
- Issue of transportation to group was discussed
- Discussed issue of times frames and length of group - 14 weeks
- Pointed out similarities of group members all being caretakers of children who had been sexually abused although two were natural parents, one the grandmother, and two, foster parents.
- Reviewed purpose of group - support, education, parenting - group to help answer questions and offer mutual support as they also have alot to share - self help. Asked for imput re: issues they would like to discuss.
- Reviewed purpose of children's group - support, sharing of feelings, education re: prevention.
- Discussed purpose and importance of parallel theme. Facilitators will keep them informed of what is happening in the children's group.
- Each member given an opportunity to say who they were and who was in their family.
- Group established rules - smoking only at break, full attendance is required, confidentiality.
- Further discussion in regards to each member's situation and the abuse of the children they care for.
- Completion of pre-test measures.

LATENCY AGE NON-OFFENDING PARENT'S/CAREGIVER'S GROUP

GROUP NOTES

SESSION # Two DATE: November 26, 1991

GROUP FACILITATORS: Kathy Anderson/Barb Gajdek

ATTENDANCE: All five members attended

SESSION OBJECTIVES:

1. To further the joining process.
2. To build a foundation for peer support and trust between facilitators and members and between members.
3. To emphasize acceptance amongst members and desensitize parents in their difficulty in talking about their child's sexual abuse and their feelings about the abuse.

AGENDA

- Check-in
- Review of children's group agenda - to build the foundation for peer support and trust between group facilitators and children - to emphasize acceptance and believability in regards to their sexual abuse and to allow for expression of feelings.
- Group exercise - "Myth about Sexual Abuse" - discussion
- Definition and examples of sexual abuse - group exercise and discussion
- Incidence of sexual abuse in the general population
- Film "Finding Out: Incest and Family Sexual Abuse" and discussion
- Assignment of Case Managers and discussion of their roles with the families

CONTENT

- Group facilitators began the session by incorporating a "check-in" with each individual member, asking them to comment on any of their week's activities or to use the time to bring forward any questions or concerns appropriate to group. Note: This exercise will constitute the beginning of every group session.
- One parent, in particular, tended to dominate this week's check-in, sharing in detail, her confusion and feelings related to her daughter's abuse by her son. For this reason, very little of the intended agenda was actually covered.
- Facilitators informed members of the children's group agenda. Most of theparents indicated that their children were anxious and excited about returning for this week's group. Note: The sharing of the children's group agenda will also occur on a weekly basis.
- Parent's were shown the film "Finding Out: Incest and Family Sexual Abuse". - This film focused on a mother's discovery of her daughter's sexual abuse by her father and the mother and daughter's reactions as well as the mother's subsequent support of her

daughter.
- Very little time was left for discussion of the film
- Facilitators advised each mother as to whom their individual case manager was. The role of the case manager was described as assisting in anything from transportation to further counselling/therapy in addition to group such as individual and family counselling.

LATENCY AGE NON-OFFENDING PARENT'S/CAREGIVER'S GROUP

GROUP NOTES

SESSION # Three DATE: December 3, 1991

GROUP FACILITATORS: Kathy Anderson/Barb Gajdek

ATTENDANCE: Four members attended, one was absent.

SESSION OBJECTIVES:

1. Identify their feelings and their children's feeling around the sexual abuse.
2. Enable linking of behavior to feelings.
3. Increase responsiveness to children's behavioral cues.
4. Increase awareness of how verbalization of feelings in encouraged or discouraged at home.
5. Discuss how to listen to children and express empathy.

AGENDA

- Check -in with each group member
- Review of children's progress from last week and their group agenda for today.
- Discuss Myths in regards to sexual abuse - have group respond true or false and discuss each.
- Provide definition of sexual abuse and put together list of examples with group input.
- Discuss incidence of sexual abuse
- Review film seen last week and promote discussion in regards to their feelings around their children having been sexually abused.

CONTENT

- Brief check-in with group members - focus was more on one member
- Discussed children's group agenda for this week - will be talking about feelings, identifying feelings and encouraging the children to talk about them.
- Tied film in that they watched last week in that the mother supported her daughter and that they all all here to support their children.
- Reviewed their feeling about the abuse as well as what their children might be feeling.
- Discussed children's behaviors and what feelings they may be connected to. Also discussed more details around the abuse.
- Discussed briefly some issues around boundaries, indiscriminate behavior.
- Discussed issue of unusual fears children may have as tend to be "symbolic" and are reminded of abuse by similiar features.
- Discussed how to deal with some of the behaviors and negative attention seeking.

- Discussed issues of children showing "psuedomaturity" due to adult responsibilities they have had in the past - issue of last childhood.
- Group asking why one member was absent.
- Reviewed "Myths" handout with group. Had group answer true of false to each question and discuss.
- Group requesting to hear more about offenders at a future date.
- Defined sexual abuse in a very concrete way - defined as not being a normal activity between an adult and a child. Then went by way of example.
- Group then made a list of types of sexual abuse
- Facilitators presented information in regards to the incidence of sexual abuse.

LATENCY AGE NON-OFFENDING PARENT'S/CAREGIVER'S GROUP

GROUP NOTES

SESSION # Four DATE: December 10, 1991

FACILITATORS: Kathy Anderson and Barb Gajdek

ATTENDANCE: All five members attended.

SESSION OBJECTIVE:

1. To appropriately sexually educate mothers re: human reporduction and human sexuality while emphasising developmentally appropriate information.

AGENDA

- Check-in
- Review of children's group agenda for this week
- Discussion of topic of age appropriate sex education - Discussion on who taught them about human sexuality.
- Film - "Where do I Come From?" and discussion
- Askability Questionaire -discussion
- Discussion of chapter from "Questions Children Ask"
- Discussion of Christmas party for next week.

CONTENT

- Check-in - focus on the criminal justice system in regards to the sexual abuse of the girls afte one of the caregivers initiated this discussion.
- Group discussion in regards to individual situations pertaining to charges being laid or any legal proceeding in process. Discussed feeling about the leagl system and views on punishment of the offender.
- Discussion of the need for appropriate sex education as the victims often have distorted views due to experiencing sex/sexuality before being educated in regards to the topics.
- Introduced the film 'Where Do I Come From?" and asked mother whether they were in support of the children being shown this in group next week for the purpose of age appropriate sex education. All mothers were in support of this film.
- Discussed children's agenda and provided parents with a copy of the handout provided to children utilized in labeling of body parts. Childrens agenda also covering topic of their bodies being their own.
- Discussion on importance of the mothers role in ehlping children to build pride in their body images which have been distorted by the experience of sexual abuse. Discussion issues of natural curiosity and need to answer questions that children have.
- Discussion of good and bad touches including examples - focus on privacy and

appropriateness.
- Introduction of the Askability Questionaire which will be reviewed next week.
- Discussion of individual meanings of Christmas and the challenges it might present with respect to family gatherings. Mothers agreed to a celebration next week for christmas.

LATENCY AGE NON-OFFENDING PARENT'S/CAREGIVER'S GROUP

GROUP NOTES

SESSION # Five DATE: December 17, 1991

FACILITATORS: Kathy Anderson and Barb Gajdek

ATTENDANCE: All five members attended

SESSION OBJECTIVES:

1. To continue last week's theme of educating mothers on how to provide age appropriate sex education.
2. To facilitate the mothers' ability to communicate with their children.
3. To stress the importance of connecting values and responsiblity with sexual activity.

AGENDA

- Check-in
- Review of children's group agenda (i.e. film "Where Do I Come From?) - Review holiday assignment for mothers
- Discussion of importance of values and responsiblity as a part of sex education - discussion of good touches and bad touches with examples provided by the mothers
- Review of the askability quiz - Refer to question and answer handout from last week
- Discussion of themes that mothers and facilitators want to cover in the New Year e.g. boundaries, prevention, coping.
- Discussion of the meaning of Christmas for each individual member

CONTENT

- Check-in was fairly brief today
- Review of the children's group agenda i.e. seeing the film "Where Do I Come From?"
-Discussion of the issue of providing children with appropirate information and education in regards to human sexuality
- Discussion with parents in regards to how they could open up communication and reinforce their children's learning in group by assisting them in completing their "good touch, bad touch" coloring books over the holidays.
- Discussion of the definition of good touch and bad touches and review of examples with imput from group members.
- Utilization of the film shown last week in facilitating discussion around issues of values and responsibility to incorporate in discussions with their children around sex education and sexuality
- Exercise using the "askability quiz" which focuses on age and developmentally appropriate responses to questions in regards to sex asked by children

LATENCY AGE NON-OFFENDING PARENT'S/CAREGIVER'S GROUP

GROUP NOTES

SESSION # Six DATE: January 7, 1992

GROUP FACILITATORS: Kathy Anderson/Barb Gajdek

ATTENDANCE: Three members attended, one member was absent, one member was no longer in the group as the child in her care was moved.

SESSION OBJECTIVES:

1. Discuss caregiver's feelings in regards to the abuse of their children and the person or persons who abused them.
2. Prevention - understanding why kids keep secrets.

AGENDA

- Check-in - review how Christmas was for each family
- Explanation to group of absent member and reason for drop out
- Review goals of children's group
- Discuss caregiver's feelings around the abuse of their child and towards their child since the time of abuse
- Discuss feeling towards the abusers
- Discuss feelings towards the different systems they have had to deal with
- How do they express and cope with feelings
- Discussion of why kids keep secrets about being abused

CONTENT

- Discussed issue of losing one group member as the child had been moved from the home - group discussion ensued around the issuing of caring for abused children
- Check-in was fairly lengthy as group members talked about the Chritmas holidays and any difficulties they encountered as well as any changes their family was experiencing
- Facilitators informed group members that the children were being prepared this week for telling their own stories about abuse by hearing a third part story about abuse and filling in blanks in regards to feelings. Also told them that the children would be discussing the issue of keeping secrets.
- Group then discussed question of why kids keep secrets. Group members shared their ideas of why and talked about the situation with their own children
- Question of how members feel about the kids being abused was then discussed. This then led to a discussion of caring for abused children and priorities.
- Discussion of incidence of abuse including females and males
- Discussion of how members feel towards the offenders and the legal system and how

they perceive their children feel.
- Group requesting to have guest speakers in to talk about the legal system and offenders.
- Discussion then focussed around one member and her life experinces. Other group members offered support.
- Facilitators introduced subject of the caregivers wrting a letter to their children as a means of opening up communication and expressing feelings

LATENCY AGE NON-OFFENDING PARENT'S/CAREGIVER'S GROUP

GROUP NOTES

SESSION # Seven DATE: January 14, 1992

FACILITATORS: Kathy Anderson/Barb Gajdek

ATTENDANCE: All four members attended group. One of the facilitators and one member left group at the start and did not return until an hour later.

SESSION OBJECTIVES:

1. To facilitate communication between mothers and their children in regards to their feelings about the sexual abuse.
2. To support mothers in expressing feelings they have with regards to the sexual abuse.

AGENDA

- Check-in
- Mid point evaluation
- Review of children's group agenda
- Letter writing exercise - use of sentence completion sheet as a tool to direct/guide mothers on critical topics to address with their children

CONTENT

- One of the mother's presented a crisis for the facilitators as she didn't know where her children were. One of the facilitators went out looking for the children with her and returned by the break time of group once having found the children.
- Review of children's group agenda - further completion of their sexual abuse disclosures within group and beginnig to diacuss their feelings towards their offenders.
- Discussion of the effects of sexual abuse and the factors which mediate the impact on the children
- Discussion of the issue of secrecy - stressed the importance of avoiding the use of secrets in communication
- Discussion of responses and reactions to the children's disclosures at the time they disclosed
- Discussion of "safety plans - importance and benefits of having a saftey plan for the children was discussed. Each member shared their safety plans and those not yet having one, such as the member who couldn't find her children initially, were helped to create one in group.

LATENCY AGE NON-OFFENDING PARENT'S/CAREGIVER'S GROUP

GROUP NOTES

SESSION # Eight DATE: January 21, 1992

Group Facilitators: Kathy Anderson/Barb Gajdek

ATTENDANCE: All four members attended group - one member was late.

SESSION OBEJCTIVES:

1. Enhance caregiver's ability to protect their children.
2. Facilitate communication between caregiver and child.

AGENDA

- Review issue of why no replacement member for lost group member
- Group decision on which guest speaker they would like for session 12
- Check-in - discuss the children's anxiety levels around disclosures given last week
- communication of disclosure to caregiver.
- Review of what the children are doing in group this week
- Group exercise re: Behavioral and physical indicators of sexual abuse
- Group provided with a handout
- Group list of indicators, what they saw for their children, what they did at the time, and what they would do differently next time
- Group exercise - writing letters to their children to express their feelings around the abuse, what they would have like to have done differently, and their feelings towards the offenders. Have letters written in words the children can understand. Describe process of sharing of the letters

CONTENT

- Facilitators explained decision around not replacing the caregiver of one of the children in group as the child had moved yet again since the last group. Group discussed this decision.
- Group members were asked for their preference of guest speakers for session 12 - group members chose speaker on offenders and offending.
- Check-in was fairly lenghty as group members had had alot of changes going on in their lives.
- Facilitators utilized charts with indicatators written on them to facilitate discussion of each sign of abuse. Each indicator was reviewed and all group members indicatated which signs they had observed in each of their children.
- Group members were given a handout which listed behavioral and physical indicators of sexual abuse.
- Group began discussion of what they did at the time when they saw signs of abuse.

This discussion was brief as time ran out. Group decided it would resume this discussion next week and also work on the letters to their children at that time.

LATENCY AGE NON-OFFENDING PARENT'S/CAREGIVER'S GROUP

GROUP NOTES

SESSION # Nine DATE: January 28, 1992

FACILITATORS: Kathy Anderson/Barb Gajdek

ATTENDANCE: Three of four members attended group

SESSION OBJECTIVES:

1. To increase mothers wareness of physical, psychological and behavioral indicators/symptoms of sexual abuse for the purpose of prevention.
2. To increase mothers awareness of social and professional resources and supports.
3. To facilitate communication between mothers and their children in regards to feeling around the sexual abuse.

AGENDA

- Check-in
- Review of children's group agenda
- Review of indicators of sexual abuse from last week focusing on what they might do differently now and how to help protect their children from revictimization
- Letter writing exercise.

CONTENT

- There was an extended check-in again this week with one member donimating most of the session. Facilitators utilized this opportunity to educate mothers re: dynamics of intrafamilial sexual abuse, offenders and feelings.
- Review of the indicators of sexual abuse and available resources within the city were discussed and advocated
- Discussion of prevention of sexual abuse
- Members were introduced to the letter writing exercise using the sentence completion form
- Children's group agenda was reviewed - completion the release phase of group

LATENCY AGE NON-OFFENDING PARENT'S/CAREGIVER'S GROUP

GROUP NOTES

SESSION # Ten DATE: February 4, 1992

GROUP FACILITATORS: Kathy Anderson/Barb Gajdek

ATTENDANCE: Three of four group members attended

SESSION OBJECTIVES:

1. Communication - To facilitate the caregiver's ability to express and share feeling in regards to the abuse of their children with their children.
2. Saftey - To integrate learning from group in regards to future saftey planning.

AGENDA

- Check-in - brief and time limited
- Review of agenda for children's group
- Hindsight question - what would members do differently in protecting their children
- Group exercise - Group members to each write a letter to their children in regards to their feelings about the abuse, what they would like to have done differently, and their feelings towards the offenders. Fill in the blank format.

CONTENT

- Group was given explanation of why one member was absent
- Discussed process of writing letters to the children. The group was provided with an outline only to be used as a guide to filling in their own thoughts. Facilitators offered to act as secretaries to write for the caregivers. Members were reminded to use words the children can understand.
- Discussed process of sharing the letters which will be done in sessions with their individual case managers.
- Prior to the actual writing of the letters, the group had check-in and discussed how they were feeling about this being the 10th session already
- Group members were informed that the kids would be writing a letter to their caregivers this week in their group which will be shared with them at the same time they share their letters with their case managers.
- Letters were then begun with each group member having a turn. Facilitators review the outline of the letter which was posted and then read out each part for each member as they were dictating their letter.
- After finishing the letters, group members were given the opportunity to add to the letters at that time or at a later date.
- Group then discussed the issue of what they would do differently and each member was given a turn at saying what they did and what they might have done differently.

- Facilitators then asked each member how they would like their letter signed
- Members were told that the letters would be passed on to Ron and Karen for the sharing meetings
- Group informed that next session would focus on issues around boundaries, privacy and roles in the family and purpose of this session.
- Group was then also reminded that their were only 3 working sessions left. The week after next we will have our guest speaker on offenders and abusive relationships and then the last working session will focus coping and supports.
- Facilitators also informed members that the children may be hyper after group due to their writing exercise and the fact that it's getting close to termination.

LATENCY AGE NON-OFFENDING PARENT'S/CAREGIVER'S GROUP

GROUP NOTES

SESSION # Eleven DATE: February 11, 1992

FACILITATORS: Kathy Anderson/Barb Gajdek

ATTENDANCE: Three of four group members attended.

SESSION OBJECTIVES:

1. To educate and reinforce the need for boundaries and privacy for the purpose of clarifying rules, roles and preventing revictimization.
2. To encourage appropriate affection exchange between mothers and their children.

AGENDA

- Check-in - time limited
- Review of this week's children's agenda
- Review of last weeks letters - provide opportunity to add to the letters if wished
- Discussion on privacy and boundaries through the use of examples
- Joint Valentine's party
- Review of the basic needs of children i.e. security, consistency, safety, self-esteem, nurturance and affection

CONTENT

- The children's group relocated to the adjeacent room today which proved to be somewhat disruptive
- Children's group agenda - discussion of sexual safety, self-protection, and good and bad touches
- One needy member dominated check-in and much of group in general today - Facilitators utilized her issues to clarify how to set parent-child boundaries and the necessity of these in families
- Parallel theme of sexual and physical privacy - presnted questions for group members to answer and intervened only to assure the appropriateness of group learning.
- Mothers shared their own sexual naivety growing up and their lack of accurate sexual information
- Group concluded with the children joining their mothers for a Valentine's party hosted by the mothers. Two hear shaped caked wer served by the mother as well as a mutual exchange of Valentine's cards between the mothers and children

LATENCY AGE NON-OFFENDING PARENT'S/CAREGIVER'S GROUP

GROUP NOTES

SESSION # Twelve DATE: February 18, 1992

FACILITATORS: Kathy Anderson/Barb Gajdek

ATTENDANCE: Three of four members attended.

SESSION OBJECTIVE

To increase awareness in regards to offenders and offending and family violence in general.

AGENDA

- Brief check-in
- Review of children's group agenda
- Discussion of follow-up services offered
- Formulation of questions regarding sexual offenders and family violence
- Guest Speaker - Aaron Klein, MSW

CONTENT

- Check-in was brief - one of the facilitators was called away to a crisis for the first half of group
- Discussion of follow-up services offered which can be accessed through planning with their case managers
- Members easily created a long list of question in regards to offenders for the guest speaker to answer
- The speakers presentation primarily focused on answering all members question which promoted further discussion with group members.

LATENCY AGE NON-OFFENDING PARENT'S/CAREGIVER'S GROUP

GROUP NOTES

SESSION # Thirteen DATE: February 25, 1992

FACILITATORS: Kathy Anderson/Barb Gajdek

ATTENDANCE: All four members attended

SESSION OBJECTIVES:

1. Support and Coping - positive and negative means of coping and utilization of positive support.
2. Positive Parenting - identifying and meeting the needs of children.

AGENDA

- Check-in - to be brief
- Discussion of how to cope with stress - identify past maladaptive ways of coping and examples of positive ways of coping
- Social supports and networking exercise - define different kinds of supports such as practical and emotional supports and different people they can obtain these supports from. Have each group member fill out a network table and identify which kind of supports they have and whether or not that particular support is someone who is safe and someone that they trust.
- Review the four main emotional needs of children: 1. Consistency and predictability 2. Protection - saftey and security 3. Self-esteem - positive reinforcement 4. Nuturance - affection
- Discuss how these needs were or were not met in their families of origin
- Feedback to group members in regards to their attending group and showing support for their children
- Children to join in with parents to plan the party for next week

CONTENT

- Check-in was very lengthy as two of the members had just had their relationships end and utilized group in discussing their feelings around this.
- The topic of coping was then introduced initially utilizing some of the examples provided by members during check-in
- Members then made a list of "good" vs "bad" ways of coping
- Group discussion then focused on ways of coping with lonliness as all members are single parents
- The topic of coping then lead to a discussion of who they have for support and who can they utilize for support. Different kinds of support were discussed and then each

group member was given a network sheet to fill out with the help of the facilitators.
- The importance of having at least one person in each category was pointed out.
- Facilitators then asked members for feedback on how group has been for then, specifically on how it has been helpful and how it could have been more helpful.
- Each group member then had a turn to say what one wish they had as a way of taking care of themselves.
- The children then joined in with the parents and plans for the final goup party was made, including a list of guests they wanted to bring.

LATENCY AGE NON-OFFENDING PARENT'S/CAREGIVER'S GROUP

GROUP NOTES

SESSION # Fourteen Date: March 3, 1992

FACILITATORS: Kathy Anderson, Barb Gajdek, Karen Gamey, Ron Kane

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ATTENDANCE: Note: This was a joint celebration and graduation of the children's and caregiver's groups. All caregivers, children and their guests attended.

OBJECTIVES:

1. To provide a celebration for the children, parents and their significant others as the formal graduation/closure of parallel treatment.
2. To acknowledge the accomplishments of the group participants.
3. To facilitate support in each individual system.
4. To facilitate play between caregivers and their children.

AGENDA

- Welcome to group members and significant others.
- Dr. Joe's "Magic Show"
- Organized games
- Snacks and prizes
- Free play and socializing time
- Graduation ceremony for children
- Congratulations cake
- Closing comments
- Resource table

CONTENT

- Graduation party took place in the large conference room which was decorated as per the request of the children.
- The group members and the guests they had brought were welcomed
- "Dr. Joe's Magic Show" - included participation of children in some of the magic tricks.
- Two groups of games were played including pin the tail on the donkey and Garfield's hamburger. Games were run by the facilitators.
- Each child received a prize and snacks were put out for all members and guests
- Socializing and free play time
- Graduation ceremony - each child was presented with a certificate by Karen and Ron who included positive general comments in re: gains made by each child. This was followed by a graduation cake which was served by two of the parents.
- Closing comments were made and each child was given a card. Members were

informed of availability of the clinic for future use. Parents were provided with a resource table which had many pamphlets concerning issues that were pertinant or may be pertinant in the future

APPENDIX E

LATENCY AGE MOTHER'S GROUP - LETTER FORMAT

DEAR

WHEN I FOUND OUT THAT YOU HAD BEEN SEXUALLY ABUSED, I FELT

NOW, I WISH I HAD

FROM NOW ON I WILL

I WANT YOU TO KNOW THAT I FEEL

TOWARD FOR HAVING SEXUALLY ABUSED YOU.

YOU NEED TO KNOW THIS IS NOT YOUR FAULT AND THAT I BELIEVE THIS WAS FAULT.

SOME OTHER THINGS I WANT TO TELL YOU ARE

* Jointly prepared by Kathy Anderson and Barb Gajdek

APPENDIX F

LATENCY AGE MOTHER'S GROUP - COPING METHODS

Latency Age Mother's group - Methods of Coping

"Positive" Methods	"Negative" methods
seeking professional help	drinking
talking about problems	overeating
getting a hobby	avoiding helpers
seeking spiritual help	isolating self
using friends as support	keeping feelings inside
meditation	revenge
relaxation	violence or aggression
exercise	

* Jointly prepared by Kathy Anderson and Barb Gajdek

APPENDIX G

PREADOLESCENT MOTHER'S GROUP - AGENDA/CONTENT NOTES

PREADOLESCENT NON-OFFENDING PARENT'S/CAREGIVER'S GROUP

GROUP NOTES

SESSION # One DATE: November 20, 1991

GROUP FACILITATOR: Kathy Anderson

ATTENDANCE: Three members attended, one mother declined to join group.

SESSION OBJECTIVE: Joining

AGENDA:

- Introduction, Names
- Purpose/Philosopy of Group - handout
- Group Goals - support, education, parenting
- Review of goals of the parallel preadolescents' group
- Group rules
- Group members' agendas/situations/goals - discussion
- Completion of pre-test measures

CONTENT

- Group members were each given names tags and introductions were made
- Discussion of group rules - smoking is allowed, attandance and confidentiality is mandatory.
- Issues of transportation and childcare were discussed - group time had been changed to accomodate child care arrangements as all members had younger children who were dismissed from school at 3:30 p.m.
- Facilitator provided information on the length of group (14 weeks) and purpose - support, education and sharing - group members were provided with a handout of topics for group and asked for their imput
- Reviewed purpose of having parallel groups and goals for the preadolescents' group
- Each group member was given the opportunity to talk about their own situations and who was in their family
- Group members got into a fairly lengthy discussion in regards to concerns they had about behavior of the children they cared for as well as their own backgrounds. This discussion was mainly monopolized by one of the members who was very frustrated with her daughter's behavior
- Completion of pre-test measures.

PREADOLESCENT NON-OFFENDING PARENT'S/CAREGIVER'S GROUP

GROUP NOTES

SESSION # Two DATE: November 27, 1991

FACILITATOR: Kathy Anderson

ATTENDANCE: Two members attended, one was absent.

SESSION OBJECTIVES:

1. To further the joining process
2. To build a foundation for support and trust between the facilitator and members and between members
3. To refocus group to issues of sexual abuse and begin process of linking behavior to the abuse.

AGENDA

- Check-in
- Review of the preadolescents' group agenda- continue to establish trust and a supportive environment for the expression of feelings around their abuse
- Discussion re: small size of parent's group and group decision re: continuation as a group
- Film "Finding Out: The Incest Secret" - discussion

CONTENT

- Group members brought up concern re: absence of one of the group members
- Facilitator brought up issue of continuing group with low numbers which was highlighted by the absence of one of the members - members made decision to have group continue with low numbers even in light of the fact that systemic work was going to be offered
- Film "Finding Out: The Incest Secret" was shown - film provided factual information about sexual abuse (incidence, symptoms, types of abuse, family dynamics etc.) and had an adult survivor of abuse and her mother relate their story
- Discussion of the film then led to a discussion of the symptoms that the pre-adolescents had been showing.
- Members then discussed issues around school and how there children were doing academically
- Members asked the facilitator to pass on a message to the missing member that she was missed and that they would like to see her next group

PREADOLESCENT NON-OFFENDING PARENT'S/CAREGIVER'S GROUP

GROUP NOTES

SESSION # Three DATE: December 4, 1991

GROUP FACILITATOR: Kathy Anderson

ATTENDANCE: All three members attended

SESSION OBJECTIVES:

1. Identify their feelings in regards to the sexual abuse of their children.
2. Increase group awareness and knowledge of sexual abuse.
3. Increase awareness of abuse symptomology

AGENDA:

- Check-in with each group member
- Review agenda of this weeks' preadolescent's group
- Members to update member who missed last week on the film
- Continued discussion on the film - focus on symptoms
- Discuss "myths" in regards to sexual abuse - Handout
- Definition of sexual abuse and incidence
- Group exercise - list examples of sexual abuse

CONTENT

- This weeks agenda was barely covered as one member came to group in crisis and monopolized most of the session venting concerns in regards to her daughters' behavior
- Group members also discussed some behavioral concerns in regards to their children and a large amount of time was spent on issues of effective parenting
- Facilitator provided information on this weeks agenda of the preadolescents' group and gave brief information in regards to the definition and incidence of sexual abuse

PREADOLESCENT NON-OFFENDING PARENT'S/CAREGIVER'S GROUP

GROUP NOTES

SESSION # Four DATE: December 11, 1991

FACILITATOR: Kathy Anderson

ATTENDANCE: Four member attended this session, one being new to group.

SESSION OBJECTIVES:

1. To enable parents to identify feelings associated with sexual abuse.
2. To facilitate the linking of these feelings with the resulting behaviors in order to enhance parental ability to understand their children and therefore offer support.
3. Discuss feelings they have in regards to their children's abuse.
4. Discuss how to listen to children and encourage them to express feelings.

AGENDA

- Introduction of new member to group
- Review of preadolescents' group agenda for this week
- Film "No More Secrets" - discussion
- Group exercise - make list of feelings children have
- Discussion of behavioral indicators of feelings and how to encourage verbalization of feelings as opposed to acting them out
- Discussion of parent's feelings in regards to the abuse

CONTENT

- New group member was introduced - new member is the Family support Worker for one of the preadolescents
- Agenda for preadolescents' group was reviewed - will be seeing the film "No More Secrets" after the parent's group sees it - (note: check-in was postponed due to time contraints in having the film available)
- Film "No More Secrets" - film focuses on interviews of several preadolescent aged girls who were sexually abused by their father/father figures - the girls tell their stories about their abuse, feelings they had and subsequent events and process of treatment.
- Group discussion of film
- Group exercise - members made a list of feelings that children have when they have been sexually abused - list contained feelings expressed in the film and those they felt their children were experiencing.
- Group discussion of dynamics of abuse which lead to feelings and also the behavioral indicators of these feelings
- Discussion of how to talk to kids about feelings and how to deal with behavioral

problems on a feeling level

PREADOLESCENT NON-OFFENDING PARENT'S/CAREGIVER'S GROUP

GROUP NOTES

SESSION # Five DATE: December 18, 1991

GROUP FACILITATOR: Kathy Anderson

ATTENDANCE: Three of four members attended.

SESSION OBJECTIVES:

1. To increase awareness of behavioral and physical indicators of sexual abuse.
2. To enhance understanding of dynamics of sexual abuse and resulting effects on children.
3. To develop and enhance communication skills.

AGENDA

- Check-in
- Review of preadolescents' group agenda for this week
- Discussion of the meaning of Christmas for each member and plans
- Group exercise - Behavioral and Physical Indicators of sexual abuse - members to identify indicators observed in their own children- handout
- Traumagenic Dynamics - Review of Finkelhor's model
- Communication skills - "How to talk so kids will listen"

CONTENT

- Issue of one group member being absent and the question of her returning to group was discussed. Members discussed the possiblity of terminating group as only two systems were represented and the facilitator was the case manager of the two remaining systems who were already involved in systems work.
- Christmas was discussed with members who shared their plans. Saftey plans were reviewed for one of the preadolescents who would be spending Christmas away.
- Facilitator reviewed behavioral and physical indicators of sexual abuse - handout
- Group members indicated which symptoms they had observed in their own children.
- Faciltator briefly reviewed effects on children utilizing Finkelhor's model - traumatic sexualization, betrayal, powerlessness and stigmitization
- Discussion focused back to the issue of discontinuation of group and members feelings about this

Note: This was the last "group" session as two of three parental members no longer had physical custody of their children and had dropped out of group. Of all the pre-adolescent age caregivers, only one group member continued to have care of her children. All of the preadolescents, however, continued to attend group. The

facilitator continued working intensively with the remaining member and the remainder of the other system for which they were the case manager.

APPENDIX H

SYSTEM-G - MEASURES

Pre/posttest Measures - System-G

	Pre-test	Post-test
Rose-G		
FAM	40	30
BDI	21	3
IES	I-27 +A-29 = 56	I-25 + A-30 = 55
IPA-Rh-g	32	22
IPA-Ru-g	37	21
Rhonda-g		
FAM	22	23
BDI	not done	0
Self-esteem	25	29
Ruth-g		
FAM	32	37
BDI	not done	12
Self-esteem	not done	31

APPENDIX I

SYSTEM-H - MEASURES

System-H - Individual Measures

	Pre-test	Post-test
Alice-H		
FAM	28	not done
IPA	15	not done
BDI	5	not done
Ann-h		
FAM	35	21
BDI	22	3
Self-esteem	23.5	30

APPENDIX J

PARENT'S GROUP EVALUATION FORM

LATENCY AGE MOTHER'S GROUP - EVALUATION FORM

1. Was group helpful to you?

   Very helpful Somewhat helpful Not helpful

2. What was the most helpful?

3. What was the least helpful?

4. The number of sessions should have been:

   Fewer Same More

5. How easy was it to talk with the group facilitators?

   Somewhat easy Easy Hard

6. Did you feel that you knew what your child was learning or doing each week in the children's group?

   Always Sometimes Never

7. Are you more able to talk with your child now?

   Yes Somewhat No

8. Ny understanding of sexual abuse and its effects now is:

   Greater Same More confused

9. My ability to protect my child from further abuse now is:

   Greater Same Less

10. How did you feel about mixing foster mothers and natural mothers?

* Jointly prepared by Kathy Anderson and Barb Gajdek

APPENDIX K

ROSE-G - CLIENT FEEDBACK INFORMATION

ROSE-G'S EVALUATION FORM

1. **Was group helpful to you?**

   Very helpful

2. **Were individual sessions helpful to you?**

   Very helpful

3. **What was the most helpful?**
   Reassured me on things that I had learned - validating in regards to my kids behavior - learned that my kids were not different - the concern shown for my family

4. **What was the least helpful?**
   Discouraging when other mothers dropped out of group

5. **The number of sessions should have been:**

   More

6. **How easy was it to talk with the group facilitator/case manager?**

   Easy

7. **Did you feel that you knew what your child was learning or doing each week in the children's group?**

   Always

8. **Are you more able to talk with your child now?**

   Yes

9. **My understanding of sexual abuse and its effects now is:**

   Greater

10. **My ability to protect my child from further abuse now is:**

    Greater

11. **How did you feel about mixing foster mothers and natural mothers?**

    Good except the foster mother acted like she knew everything and then dropped out of group and had her girl moved.

APPENDIX L

PARENT'S GROUP EVALUATION INFORMATION

Latency Age Mother's Group Evaluation *

Helpful?
Lori-D - Very Helpful
Donna-F -Very Helpful
Helen-B - Very Helpful
Carol- C - Very Helpful

Most Helpful?
Lori-D - Talking about problems
Donna-F - Feel less alone - Getting this off my mind
Helen-B - Discussing Heidi-b's problems and problems of other children
Carol-C - Listening to others and knowing its not just you

Least Helpful?
Lori-D - nothing
Donna-F - nothing
Helen-B - Weekly check-in
Carol-C - nothing

Number of sessions?
Lori-D - Same
Donna-F - More
Helen-B - More
Carol-C - Same

Talk with group facilitators?
Lori-D - Easy
Donna-F - Somewhat easy
Helen-B - Easy
Carol-C - Easy

Knew what children were doing?
Lori-D - Always
Donna-F - Always
Helen-B - Always
Carol-C - Always

More able to talk with child now?
Lori-D - Yes
Donna-F - Yes
Helen-B - Yes
Carol-C - Yes

Understanding of sexual abuse?
Lori-D - Greater
Donna-F - Greater
Helen-B - Greater
Carol-C - Greater

Ability to protect?
Lori-D- Greater
Donna-F - Greater
Helen-B - Greater
Carol-C - Greater

Mixing foster mothers and natural mothers?
Lori-D - Good for foster moms - need to learn to cope
Donna-F - Fine for my first experience with mixing
Helen-B - Mutually beneficial
Carol-C - Interesting - good ideas

* Jointly prepared by Kathy Anderson and Barb Gajdek

APPENDIX M

LATENCY AGE - MEASURES

LATENCY AGE - MEASURES

	FAM	BDI	IES	IPA	CAM	CDI
Lori-D						
Pretest	32	6	35	Lu-27,La-14		
Posttest	35	5		Lu-52,La-40		
Lucy-d						
Pretest					35	25
Posttest					43	17
Laura-d						
Pretest					24	9
Posttest					31	3
Carol-C						
Pretest	19*	13	43	11		
Posttest	25	1		10		
Cindy-c						
Pretest					24	4
Posttest					6	9
Helen-B						
Pretest	21	4		19		
Posttest	24	8		21		
Heidi-b						
Pretest					28	7
Posttest					15	15
Donna-F						
Pretest	17	14	49	30		
Posttest	30	10		43		
Dee-f						
Pretest					44	12
Posttest					7	15
Erica-E						
Pretest	29	4		27		
Posttest						
Ellen-e						
Pretest					**11	3
Posttest					***23	3
Fran-A						
Pretest	31			19		
Posttest						
Fiona-a						
Pretest					16	0
Posttest					32	3

* Three items not marked
** Re: Erica-E
*** Re: New foster mother

Note: Jointly prepared by Kathy Anderson, Barb Gajdek and Karen Gamey

APPENDIX N

PREADOLESCENT MEASURES

Preadolescent Age - Measures

	FAM	IPA	BDI	IES	Self-Esteem
Rose-G					
Pretest	40	Rh-32,Ru-37	21	56	
Posttest	30	Rh-21,Ru-22	3	55	
Rhonda-g					
Pretest	22				25
Posttest	23		0		29
Ruth-g					
Pretest	32				
Posttest	37		12		31
Alice-H					
Pretest	28	15	5		
Posttest					
Ann-h					
Pretest	35*		22		23.5
Posttest	21**		3		30
Pat-J					
Pretest	36	41	15	49	
Posttest					
Pam-j					
Pretest	38		9		28
Posttest	39		17		27
Gert-I					
Pretest	31		0		
Posttest					
Gail-I					
Pretest	20		10	46	33
Posttest	16		6		34

* Re: Alice-H
** Re: New foster mother

Note: Jointly prepared by Kathy Anderson and Barb Gajdek