The Integration of Feminist and Systemic Principles

In the Treatment of

Intrafamilial Child Sexual Abuse

BY

ALLAN T. HOGAN

A Practicum Report
Submitted to the Faculty of Graduate Studies
in Partial Fulfillment of the Requirements
for the Degree of

MASTERS IN SOCIAL WORK

Faculty of Social Work
University of Manitoba
Winnipeg, Manitoba

(c) Allan T. Hogan, 1990

National Library of Canada
Bibliothèque nationale du Canada

Canadian Theses Service
Service des thèses canadiennes

Ottawa, Canada
K1A 0N4

The author has granted an irrevocable non-exclusive licence allowing the National Library of Canada to reproduce, loan, distribute or sell copies of his/her thesis by any means and in any form or format, making this thesis available to interested persons.

The author retains ownership of the copyright in his/her thesis. Neither the thesis nor substantial extracts from it may be printed or otherwise reproduced without his/her permission.

L'auteur a accordé une licence irrévocable et non exclusive permettant à la Bibliothèque nationale du Canada de reproduire, prêter, distribuer ou vendre des copies de sa thèse de quelque manière et sous quelque forme que ce soit pour mettre des exemplaires de cette thèse à la disposition des personnes intéressées.

L'auteur conserve la propriété du droit d'auteur qui protège sa thèse. Ni la thèse ni des extraits substantiels de celle-ci ne doivent être imprimés ou autrement reproduits sans son autorisation.

ISBN 0-315-63251-8

Canada

THE INTEGRATION OF FEMINIST AND SYSTEMIC PRINCIPLES IN THE TREATMENT OF INTRAFAMILIAL CHILD SEXUAL ABUSE

BY

ALLAN T. HOGAN

A practicum submitted to the Faculty of Graduate Studies of the University of Manitoba in partial fulfillment of the requirements of the degree of

MASTER OF SOCIAL WORK

© 1990

Permission has been granted to the LIBRARY OF THE UNIVERSITY OF MANITOBA to lend or sell copies of this practicum, to the NATIONAL LIBRARY OF CANADA to microfilm this practicum and to lend or sell copies of the film, and UNIVERSITY MICROFILMS to publish an abstract of this practicum.

The author reserves other publication rights, and neither the practicum nor extensive extracts from it may be printed or otherwise reproduced without the author's permission.

ABSTRACT

Systemic and feminist theories have been implemented in the treatment of intrafamilial child sexual abuse. However, most literature clearly identifies the inappropriateness of the systemic theory in the area of family violence. While working with four families, the author attempted to integrate both theories in a manner that would fit the author's particular style of therapy. The results of such attempt clearly found purpose and therapeutic effectiveness to integrate both theories.

CONTENTS

Dedication

Acknowledgements vii

Preamble 1

1 Feminist Theory and Therapy 5

Cultural Influences 6
Socialization Process 8
Power Structures 12
The Personal is Political 14
Pornography 15
Feminist Perspective on Intrafamilial Child Sexual Abuse 16
Feminist Treatment Approach to Intrafamilial Child Sexual Abuse 19
Feminist Approach to Treatment 23
Feminist Critique of Systemic Theory 26
Critique of Feminist Theory 27

2 Systemic Theory and Therapy 30

Key Concepts 30
Systemic Perspective on Intrafamilial Child Sexual Abuse 41
Systemic Approach to the Treatment of Intrafamilial Child Sexual Abuse 44
Critique of the Systemic Approach to Family Violence 46

3 Family Dynamics of Intrafamilial Child Sexual Abuse 48

Characteristics of the Victim, Nonoffending and Offending Persons 51
Characteristics of the Sexually Abused Child 51
Characteristics of the Nonoffending or Maternal Person 53
Characteristics of the Offending or Paternal Person 54
Family of Origin Issues 54
Relationship Issues 54
Other Characteristics 55
Siblings as Perpetrators 56

Social Factors Affecting Sibling Incest 57
Dynamics of the Brother-Sister Incestuous Relationship 58
Interpersonal and Family Dynamics 60
Treatment Issues 63
Short and Long Term Effects of Sexual Abuse 64

4 **Treatment Issues** 74

Basic Treatment Issues 74
Treatment Approaches 80
Individual Treatment with the Victim 81
Individual Treatment with the Nonoffending Person 85
Individual Treatment with the Offending Person 86
Dyadic Treatment with Family Members 88
Family Treatment 90

5 **Integration of Systemic and Feminist Theory** 95

6 **Personal Philosophy Regarding Intrafamilial Sexual Abuse** 99

7 **Intervention** 106

Clients 106
Setting 106
Personnel 106
Procedures 107
Stage One - Introduction to the Family 107
Stage Two - Treatment 108
Stage Three - Termination 109
Duration 109
Recording 110
Description of Families, Progress and Evaluation (Pre and Post Measures) 110
Family A 110
Family B 120
Family C 125
Family D 138
Results of Evaluation 146
Results of Evaluation Working with the Families 146
Evaluation of the Student - Self Evaluation 148

Appendix One - Description of Measures 150

Appendix Two - Pre and Post Measures of the Family 156

References 174

DEDICATION

To my wife Bernice and my son Sean. Thank you for your patience, understanding and love. You are the wind beneath my wings.

Acknowledgements

There are many people to thank and to acknowledge for the part they played in helping me achieve my Masters. An accomplishment like this is never done completely alone.

First of all, thanks to my parents and siblings. I always knew you were behind me and were willing to help in any way that you could. Thank you for providing me with a sense of family when I really needed it. A special mention to my parents who provided my family and I with a place to go to be nurtured, for sending us surprises in the mail and for making the many trips to visit us just 'to see how we were doing'. My love to mom and dad, Donna, Diane, Jane, Mary, Jennifer, Paula and John. Part of this degree is also yours, but I will keep the biggest part!

Maureen J. MacMillan, you have been an influential person in my life. And to Alan G. Hart, who was there to offer his 'medical assistance' to my warn out body or mind. Both of you have been a major source of support.

Joyce Helmer and Wayne Granger, thank you both for your help, your concern and your friendship. You are always in my thoughts.

Gran (Elaine Parent), you can get up off your knees, for now. Thank you for love and prayers. You will always have a special place in my heart.

To Kenora-Patricia Child and Family Services; not only did you provide me with the financial assistance to make this all possible, but your friendship and support was strongly felt. In particular I would like to thank Director, Skip Gryschuk and the Board of Directors who provided me with financial assistance and the opportunity to obtain my Masters. There are many agency personnel that helped me through these two years however I would like to specifically identify those at the Sioux Lookout Office, the best office in the agency. These people include Kerry Fair (thank you for making yourself available to my family. Your friendship and concern has helped us through many stressful situations), Esther Hicks, Lori White, Maureen O'Rourke and Milco de Graaf. Other staff no longer working for the office that need to be mentioned are Joan Best, Joan Guevara, Cathy Love, Jeanette Grennier, Tammy O'Donnel-Glover, Terri-Lyn White and Rob Cosco. Thank you all for your support and friendship.

Thank you to North West and Eastern Child and Family Services for your continued involvement while I worked with the families. In particular I express my thanks and appreciation to Claudette Dorge of Eastern Child and Family Services, who played an instrumental role in referring three of the four families. Due to your initiative, I was able to complete my practicum within my time schedule.

To the four families that assisted in my training. Thank you.

My practicum would not have been possible if not for Psychological Service Centre. The students and staff have been supportive and I feel I have benefitted from their clinical expertise and their investment in me. In

particular, I would like to thank Dr. John Shallow, Director, for supporting my practicum at PSC. I would also like to thank the support staff, Denise Whynot and Audrey Langlois. Your humor, encouragement and support were greatly appreciated. Both of you provided me with an immediate source of support when I needed it and a kick in the pants when I was dragging my drawers. Thanks!

Finally, but not lastly, I want to thank my committee members. Marjorie Gazan, thank you for taking the time to review my work and for your consultation. Elizabeth Hill, you have given me a new view on life and therapy. Thank you for sharing your professional expertise, your spirituality and yourself. I will take part of you when I leave. Walter, Walter, Walter Driedger. You played a critical role in my practicum. You bent over backwards trying to get me to finish by my deadline and were there to advocate on my behalf. I appreciate that. You also provided me with a new view and gave me a foundation on which to build. I thank you for your investment in my professional development and for your support.

PRACTICUM PREAMBLE

Committee Members

Chair-person/Advisor: Walter Driedger

Members: Elizabeth Hill
Marjorie Gazan

A. Objectives

i) Aim of Intervention

The theoretical basis of the intervention will combine the integration of systemic and feminist perspectives. Intervention will focus on working with families where intrafamilial sexual abuse has occurred. The aim of the intervention will be 1) to deal with the presenting issues and other possible fall out to the abuse, 2) to educate the family members about sexual abuse, 3) to decrease the chance of future victimization within the family, and 4) to promote family stability and awareness in order for the family to utilize their strengths to enhance future healthy functioning.

ii) Educational Benefits to the Student and to the Profession

There will be many benefits in doing this practicum. These would include; 1) increased knowledge of the systemic and feminist approaches to family violence, 2) consolidation of present knowledge about sexual abuse and developing an approach to treatment that I can use upon returning to work at a Child and Family Services agency, 3) developing new knowledge, awareness, insight, skills and expertise in working with this client population 4) to critically examine what approaches are feasible and most effective in

working with these families considering the lack of community resources and other restraints that are found in the practice setting and 5) to contribute to the body of practice literature at the School of Social Work.

B. Introduction to the Literature Review

Sexual abuse is not a new phenomena. As a result of the feminist movement and a strong voice of child advocates, sexual abuse has been identified as an important social problem (Hechler, 1988 and Finkelhor, 1979). Finkelhor (1979) states that sexuality in the family is a given as all family members are sexual beings, however it is the manner in which the family's sexuality is expressed that is the cause for great concern. Not all members of society believe that there is this concern. In fact, the North American Man/Boy Love Association (NAMBLA) believes that child sexuality should be liberated and that laws restricting sex with a child be abolished (Hechler, 1988). Fortunately, this group and others like it are very rare. Child sexual abuse is not condoned and is the subject of active study by professional service providers.

This literature review will focus specifically on intrafamilial child sexual abuse, due to the focus of this practicum. Intrafamilial sexual abuse, otherwise known as incest, is said to one of the few universal taboos (Rist, 1979). Rist (1979) reviews the origin of this taboo by looking at four perspectives: anthropological, biological, psychoanalytical and clinical. Rist states that the anthropological view of the origin of incest is due to society prohibiting sexual relationships between mother and child , as incest was most likely to occur due to the strong and close ties during the child's younger years. Father and child incest was believed to have a lower "natural

probability of occurrence" (Rist, 1979, p. 682-683) and was therefore less strongly prohibited and as a result, "in practice occurs more often" (Rist, 1979, p. 683). From a biological perspective it is simply that incest or inbreeding decreases the survival rate of the family group. In order to prevent abnormalities in the offspring, incest was prohibited. The psychoanalytical perspective relies on the belief that "all affectional ties have sexual origins, even though no specific sexual acts have occurred" (Rist, 1979, p. 682). Cuddling and fondling of the child, seen as needed ingredients to form an attachment, was viewed as being erotically charged. To avoid acting on one's instinctual drive for sexual gratification with a child, the incest taboo evolved. Finally, Rist (1979) states that a clinical orientation sees the origins of incest as a result of triangulation of one of the parents with a child. There is a breech of generational boundaries. The clinical perspective appears to be the one most used in developing treatment strategies for the intrafamilial sexual abuse case. Rist (1979) further states that the "incest taboo encourages the child's concept of self as an individual separate from the family (p. 682). The prohibition of sexual relationships between family members caused members to become dependent on non family members to satisfy their intimacy needs. As one will note, isolation of family members from society is a central dynamic of intrafamilial child sexual abuse.

Although there has been an increased awareness and emphasis on the treatment of intrafamilial child sexual abuse, "not much [of the information] is clear cut" (Hechler, 1988, p. 3). Haugarrd and Reppucci (1988) believe that there is no one correct way to work with families of intrafamilial sexual abuse and that there is a lack of empirical evidence to assist one in making a

decision about how a family can be treated. Bolton and Bolton (1987) state that "today practitioners must juggle competitive and unsupported theory [and] inadequate research ... in their attempts to benefit violent families" (p. 25). They further state that the practitioner often has a problem choosing a theoretical basis to working with family violence. I also need to deal with this dilemma. My decision to combine systemic and feminist perspectives in dealing with child sexual abuse appears contradictory, as systemic and feminist approaches are distinctfully different. The following is an attempt to integrate these two theoretical basis and identify an approach that will fit with my beliefs and an approach that will be effective in the treatment of intrafamilial child sexual abuse.

In chapter one of this document, feminist theory and therapy will be addressed which will include the feminist approach to working with intrafamilial sexual abuse. Chapter two will discuss systemic theory and therapy and the systemic approach to working with intrafamilial sexual abuse. Included in chapter three will be family and individual dynamics of intrafamilial child sexual abuse. Chapter three will also address the dynamics of sibling sexual abuse and the long and short term effects of sexual abuse. Chapter four will identify treatment issues while chapter five attempts to integrate systemic and feminist principles in the treatment of intrafamilial child sexual abuse. Chapter six identifies my personal philosophy and finally, Chapter seven discusses the intervention and evaluation components of my work. There will be two appendixes. Appendix One will include a description of the measures used in this practicum and Appendix Two will include the actual pre and post measures of the Family Assessment Measure.

FEMINIST THEORY AND THERAPY

Feminist theory is a framework that provides a world view from the perspective of women. Bergh and Cooper (1986) state that the feminist perspective 1) values all classes of people as having the same worth, 2) understands women's pathology as a social and not as a personal issue (as women's pathology is said to be caused by social and sexual influences), 3) opposes the view that women should adjust to a situation, instead the feminist position advocates the need for change in social and political forces that cause female oppression, 4) believes that a relationship should be equal in all dimensions, 5) emphasizes that other women and the male gender are not the enemies to a feminist perspective (instead it is the social context that encourages a view detrimental to women that is the concern), 6) the major differences between the appropriate sex role behavior for each sex must disappear as differences encourage the power differential between men and women and finally, 7) the feminist perspective believes that women are to have economical and psychological autonomy. Traditional world views (such as those presented by psychoanalytic, behavioral and systemic theories) are "sexist, demeaning, contemptuous, extrinsic and often ... dangerous to the health of women" (Brickman, (1984, p. 49). The traditional world views are said to be patriarchal and promote the masculine perspective of the world. As therapy is influenced by world views, and since most therapy subscribe to the traditional world view, most therapies promote the masculine perspective. The feminist movement has provided an alternative world view and approach to therapy, one that promotes not only the perspective of the women but also looks at the following issues and their affect on the mental health of people of all ages and of both sexes. The issues to be

discussed in this chapter include cultural influence, socialization process, power structures, 'the personal is political' and pornography. In addition to this, the feminist perspective of incest will be reviewed along with treatment issues. Finally, there will be a look at the therapeutic relationship from the feminist perspective.

Cultural Influences

Cultural values and norms influence the behavior of the people within that culture. Therefore examining the cultural values and norms is crucial. Rakow (1986, p. 21) states "the cultural creation of two distinct and asymmetrical genders serves as an organizing principle that operates at multiple levels". Her article discusses how communication is one of those organizing principles that facilitates gender role construction and how communication, up until recently, was from the male perspective. Walker (in Lystad, 1986) states that cultural influences have sanctioned the use of violence. Weinbach and Curtiss (1986) state that abuse has been normalized, is a routine way of dealing with issues and requires little justification for its use. Check and Malamuth (1985), state that violence is perpetuated by myths held by women and men that are socially reinforced. Bograd (1982) identifies myths such as as; if a woman gets beaten it is her fault and any problems a woman has is due to her own psychopathology. Bograd (1982) states that "the uncritical acceptance of these myths blocks clinical understanding of the cause and dynamics of battering, rationalizes conventional interventions, and functions to maintain the violence and the privileged position of the male partner" (p. 75). Cultural norms are said to

define one's sense of maleness and femaleness and provides one with a view about what is the expected family form (Gordon, 1986).

Recognizing the effects of cultural influences, feminists have advocated for social change and not only change in the individual or family unit. Many feminists (such as Hooks, 1984, MacLeod, 1987, and Schechter, 1982) believe that patterns of behavior between the sexes are reinforced by social structures and institutional rules. Therefore focus on the individual and/or family is not sufficient. A wider perspective of the problem is necessary and must be addressed. Hooks (1984) and Schechter (1982) specifically identify the influence of the capitalistic social structure on the sexes. Schechter (1982) states that women's inferior status in a capitalist society is due to women having lower paid jobs, unequal division of labour between men and women and that women who work at home do not have any economic status. They are not considered to be productive within a capitalist framework. Hooks (1984) believes that "by condoning and perpetuating male domination of women to prevent rebellion on the job, ruling male capitalists ensure that male violence will be expressed in the home and not in the work place" (p. 121). Expressing feelings in the work place would obviously slow down progress and productivity. Therefore the male is to wait until he gets home to deal with his frustrations, thereby projecting his feelings regarding work onto his family. This practice is supported by the capitalist state. Therefore it will not be efficient to consider only family and/or individual dynamics when engaging in a therapeutic relationship with a family as their symptoms will be reflections of a dysfunctional social structure (such as the capitalist state). Burton (1985) emphasizes the need to reorganize expected arrangements (ie. stereotypes) and to understand the wider factors in order

to understand what goes on in the family. Wider factors in society could include the effects of poverty, patriarchal (powerful and dominating) institutions, ethnic and class status and stereotyping (which includes the invalidation of the women's perspective).

Cultural norms and values are not tangible in and of themselves. It is how these norms and values are played out in all aspects of life that are important. By reviewing issues such as the socialization process, the norms and values will be become clearer.

Socialization Process

Feminists believe in the social learning theory (Reilly and Gruszski, 1984) which states that behavior is learned and reinforced. This theoretical base is reflected in feminist recommended treatment. Therefore family of origin (where behaviors are learned, reinforced and socialized) is also a key issue in the feminist perspective. Much of the work done in the area of socialization has been on how sex role behavior has shaped the individual's behavior. Learned sex role behaviors are responsible for keeping men and women in their present relationship pattern.

Cultural forces (controlled largely by males) have identified role expectations for men and women. Layton (1984) states that female and male roles are believed to be complimentary, women having the expressive-affectional role and men having the instrumental adaptive role. Layton (1984) states that "Mama takes care of the children, while Papa negotiates the outside world and supports the family with money and shelter. Women are typically accommodating, emotionally expressive and nurturing, while men

are competitive, rational and instrumentally striving" (p. 21). Hooks (1983) states that "to be female is synonymous with weakness, passivity and the will to nourish and affirm the lives of others" (p. 126). Men, on the other hand, are associated with strength, dominance, aggression and violence. (Hooks, 1983). So what's the problem? Men and women each have their role to perform. The problem appears to be not only how society appraises these roles (male role being more highly appraised) but that society, as a patriarchal system, has the input into role definition and evaluation of women. Due to society being a patriarchal system, male roles are going to be more valued than female roles, and more to the point, males are more valued than females. (For example, this is seen right from the time of the child's birth. A male child appears to get a 'warmer' reception to the world than does a female child.) Females take on a second class citizen status whose rights, or lack of rights, are controlled by men. The lack of rights and status is seen as contributing to the oppression of the female gender.

Female oppression and male supremacy appear to summarize the stereotype of both sexes (Walker, in Lystad, 1986). Rigby-Weinberg (1986) believes that "the goal of superiority over men and women prevents men from developing the social interest and cooperation which would yield a secure sense of connectedness with others" (p. 199). This statement is significant as it identifies that men not only try to be dominant or superior only over women but that they also try to exert this authority over other men. Therefore the lack of connectedness in male relationships, as identified by Rigby-Weinberg (1986) extends to the entire human race. Walker (in Lystad, 1986) states that men try to turn all unpleasant feelings into anger (an expression of feeling that is more appropriate to the male gender). Men do not allow themselves

to cry or to feel pain or hurt in ways other than what they have been 'programmed' or socialized to feel. "Emotional repression of masculinity exasperates men's attempts to satisfy their enormous emotional needs" (McGrath, 1979, p. 22).

Dalton (1986) believes that both sexes have masculine and feminine characteristics or 'sides' to them. Men are said to have 'cut themselves off' from their feminine side in order to 'win' over their father's attention and respect. However, in doing so, men limit themselves (as women do) in experiencing both sides of their sexual being. Dalton (1986) states that fathers are important to their daughters, for it is the fathers who inform the daughters what it means to be of the male gender and also teaches their daughters their role as women and and their role in relationships with men. Dalton (1986) believes that in order for fathers to be healthy role models for their daughters they have to acknowledge, recognize and allow their feminine side to be expressed. In turn this will allow daughters to develop their feminine and masculine sides.

There are some major differences in interpersonal relationships between the sexes. Schultz and Anderson (1986) state that stereotyped masculinity can express sorrow for inappropriate behavior, yet will blame the female or external sources for the difficulties they are having. Men do not appear to be able to accept responsibility for their actions (a behavior encouraged through the socialization process). Schultz and Anderson (1986) believe that women are more willing to see themselves as emeshed in a relationship and therefore experience a decrease in feelings of independence and autonomy. Men on the other hand are believed to "view people [in a relationship] as

separate ... [and see women as] individuals ... connected to them" (Schultz and Anderson, 1986, p. 369).

The socialization process has appeared to leave the female child with an inferior role to that of the male child. However, Brickman (1984) states that "there are serious limitations in the male sex role: the emphasis on sexual access of women as a need rather than a privilege; the failures of empathy, ... the moral shortcomings in the area of relationships; the inability to have or 'access' feelings in situations where one would expect them to occur; the substitution of anger and sexuality for other, richer feelings; the ability to objectify the world, including other people; the view of wife and children as possessions or property designed to fill one's needs or to express one's image; the idea that independence and separateness is a final developmental goal rather than interrelatedness and psychic unity" (p. 62). It appears that both sex roles have serious limitations in their role function. From reviewing the feminist literature on sex role, there appears to be a need for both sexes to consciously look at their prescribed sex role to consider the effects it had on their socialization, communication, and personal skill development and to have the freedom to change what each feels that prevents self actualization and the development of healthy relationships. Rance-Wentworth (1982) supports this belief as she feels that sexism and competition need to be confronted (not taken for granted) in order for men and women to be liberated and to live in a safe and nurturing environment. Liberation requires the 'status quo' to challenged. In this case the status quo would be the stereotypes of both sexes, which have been previously identified.

Power Structures

It is a given that due to the male role being the preferred role, the male inheritently has the power in the home. After all they are the ones that usually bring the paycheck home and monetarily provide for the family. Money is power. Bograd (1986) believes that symptoms of problems seen in women are due to the "inequal hierarchical relationship between husband and wife" (p. 102). Bograd (1986) states that one must look at the issues of domination and power . If this is not done, the least powerful (usually the women) are victimized. Gerber (1986) deals with the issue of relationship balance. She looks for balance in the relationship in three areas: 1) Positivity balance -which is the extent to which husband and wife's personality characteristics are seen as equally desirable. (This would directly relate to the value the culture places on the personality characteristics). Gerber (1986) believes that the more positive feminine and masculine traits one has , the more equally desirable the husband and wife will be. 2) Satisfaction balance- considers the level of satisfaction the couple have in their marital relationship. Gerber (1986) believes that the more feminine traits that characterize the relationship, the higher the level of satisfaction. The more masculine traits, the lower the level of satisfaction. 3) Leadership balance - looks at who the leader is in the marriage. Leadership "reflects the relative power which is exercised by the husband and wife in the marriage" (Gerber, 1986, p. 21). When the relationship exhibits more sex stereotypical traits, the male is said to be in power. The woman is said to be in power when there are more nonstereotypical traits. Gerber believes that using this framework helps one to conceptualize the "impact that changes in one marital partner will have on the other partner and on the relationship as

a whole" (1986, p. 26). McGrath (1979) states that there is a transition occurring between the two types of family models; traditional (dominant) family form to a new (equal) family form.

However, there is still a need to look at the existing family form and its power structure. Bagley (1984) states that there is a "deep-rooted value climate which allows males to regard females, and especially powerless females, as suitable objects for all kinds of exploitation" (p. 17), exploitation such as "rendering the experiences of women invisible and unrecorded" (Bograd, 1986, p. 97) and to reinforce the woman's position of insubordination (Mitra, 1987). Bograd (1986) believes that there is a lack of women defined standards of family relationships, which highlights the inequality of power between the sexes. As in other areas under feminist review, there is need to look at the wider social context which is supporting this position of inequality. Mitra (1987) did research on father-daughter incest appeal cases and found that the courts did not consider the degree of violence when sentencing the abuser but did consider the degree of 'provocation' by the victim. The judicial attitude was seen to "exonerate the father ... [and] ... to control female sexuality" (p. 145). The judicial system of the land is a good indication of how far a society has come in considering social issues such as power. Mitra's (1987) results do not provide support that society is changing the sex role stereotypes that influence the moral fibre of society. In this study, the judicial system supports and encourages the status quo: the domination of women by men, the oppression of women and the power imbalance between the sexes.

The Personal is Political

Eisenstein (1983), in chapter four of her book entitled 'Contemporary Feminist Thought', describes the concept of 'personal is political'. She describes how this concept developed out of the exercise of consciousness raising, a technique used by feminist to raise one's consciousness and to "become aware of knowledge one would have preferred to keep hidden or unconscious, of one's own subordination or oppression as a woman, and the impact that this had on one's life" (p. 36). Through this process, which is virtually the exchange of information from one woman to another, women began seeing their reality in a different light. Women were given the validation to express their feelings and encouraged not to be tied to the feelings that they thought they should be expressing. When together in a group, women shared personal feelings about their lives and found that their experience was not an isolated one. Due to other women having similar experiences, it was believed that the women's problems were the "symptoms of a society-wide structure of power and powerlessness, in which the victimization of women by the men holding the power of official authority, whether husband or public official, was hidden from public view by the mechanism of privatization" (Eisenstein, 1983, p. 37-38). The personal testimony of women became a collective phenomena, which became the elements of political advocation. Therefore, what was once personal, is now in the public eye and more readily available to all women in society. The process of the personal becoming the political highlights the feminist philosophy that the wider social context needs to be understood and addressed prior to the establishment of lasting meaningful change in all relationships between males and females.

Pornography

Pornography is said to be male violence toward females (Eckersley, 1987) It is seen as a way for men to gain power over women and as an avenue for sanctioned violent expression. (Eckersley, 1987). Women are seen as universal victims of men and are seen as creating their own oppression due to compliance. (Eckersley, 1987). D'Amico (1984) believes that violence and sexuality is used to perpetuate the patriarchal social relations between men and women. Pornography in this light appears to be a means to ensure that men and women maintain their proper role function. Although the men in pornography are seen as 'normal', acting in a normal way to express their normal sexual drives, the women are seen as weak, shameful, degrading, seductive and natural targets of the male's natural sex drive (Eckersley, 1987, Hartsock, 1984 and D'Amico, 1984). Hartsock (1984) discusses how males relate hostility and anger to sexual excitement and that excitement is due to performing a shameful or forbidden act. Eckersley (1987) states that pornography "enables women to see themselves in men's eyes, ie. as available and compliant objects of men's sexual demands with no personal autonomy or mode of sexual being of their own" (p. 174). Therefore, in some ways, pornography is seen as a tangible reflection of the male view of sex which is characterized by dominance, violence and conquest (Eckersley, 1987). Pornography may be seen as a larger social reflection of sexuality as sexuality is "culturally and historically defined and constructed" (Hartsock, 1984, p. 21).

Feminists make a distinction between erotica, good clean fun (Eckersley, 1987), and pornography that promotes degradation of or violence towards

women (Hartsock, 1984). Eckersley (1987) states that women engage in erotica when they read romance novels. However, how does one determine what is erotica and what is pornography or other literature that might be oppressive and degrading to women. (Romance novels also tend to use sex role stereotypes in their characters which promote male dominance.) Hartsock (1984) states that it is difficult to differentiate between erotica and pornography as society has a difficult time separating sex and violence. Sex and violence tend to one of the same. Hooks (1984) reinforces this point when she states that "love and violence have become so intertwined in this society that many people, especially women, fear that eliminating violence will lead to the loss of love" (p. 124).

Feminist Perspective on Intrafamilial Child Sexual Abuse

Bagley (1984) suggests that intrafamilial child sexual abuse be defined within the socio-biological framework (where incest occurs when there are sexual relationships between the child and blood relatives or those people in the position of a surrogate caregiver). The biological framework (where incest is only said to occur between blood related people) does not take into consideration the sexual relationships between the child and a step-parent or step-relative.

Brickman (1984) states that the "epidemic of incest is not puzzling or accidental, but a direct consequence of the growing independence of women from the protective control of men and the lack of concomitant growth and development in men" (p. 62). Brickman (1984) believes that "men who cannot deal with independent and equal sexual partners find themselves looking for younger sexual partners or using increasingly coercive

techniques or both" (p. 62). These dynamics result in incest. Incest is said to represent "the final way of teaching sexual submissiveness" (p. 62). McGrath (1979) echoes Brickman's belief by stating that the degree of male dominance is changing due to the changes in sex role. Males are seen as doing all they can to reinforce their sense of control, thus threats of the past become actions of the present and future. Males now have to resort to action and not just words if they wish to maintain their degree of control over females. McGrath (1979) goes on to say that "domestic violence is an indication of failures in other methods of social control and legitimation, a weapon of last resort" (p. 17) as "battering and rape have always been the instrumental foundation of men's power, and are based in some combination of male physical 'superiority' and propensity for aggressive behavior" (p. 18).

Brickman (1984) describes incest as an exchange of commodities between the powerful and the powerless. In intrafamilial sexual abuse, the offender is seen as having his power and sexual needs satisfied by the victim and in exchange, the victim receives some special status or reward and carries with her a life time of trauma. This unbalanced exchange is seen in different degrees in relationships where the power imbalance maintains the relationship.

Bograd (1986) describes the incest between father and daughter. "It is the father who has failed as parent and husband. He has not simply discharged sexual tension in deviant ways, but has abused his power. The mother takes no action, not because she supports the incest, but because she is immobilized and lacks power in and out of the family. The daughter

complies with father because she has little choice by virtue of being a female child" (p. 98). Further to this, Bagley (1984) states that the seeds of child 'approval' in the sexual assault of female children is 'nurtured' through their socialization process when female children are taught passivity and subordination (which is sometimes viewed as 'approval' or permission). Finkelhor (1979) agrees, when he emphasizes the power imbalance between the child and the abuser. It is therefore important to analyze family roles and patterns in the context of societal and sex role norms (Courtois, 1988).

From a feminist perspective, incest is "more related to sex-role development than to pathological processes" (Brickman, 1984, p. 66). It is sex role behavior that gives the offender the 'privilege' to express his feelings in an abusive manner (Schechter, 1982). Schechter (1982) believes that stress does not cause the abuse, as it is the offender's choice on how he will express himself. (This is noted when the offender can handle himself appropriately in front of his colleagues at the work place when under stress, however does not give his family members the same respect when feeling stressed while in the home environment. The offender has obviously made a choice as to which behavior will be emitted in which environment). The abusive expression, as part of the male sex role, enforces the male's authority and power position in the family. Society can therefore not rid itself of incestuous relationships without "eradicating the traditional dominant-submissive sexual power struggle" (Brickman (1984, p. 62). Incest is not a matter of sex, it is an issue of domination and power (Swink and Leveille, 1986, and Bagley, 1984).

Feminist Treatment Approach to Intrafamilial Child Sexual Abuse

The initial approach to treatment does not appear to be focused on the family or the individuals within. There is a focus on the therapists who will be working with the family members. Workers need to deal with their own sexuality and feelings about the sexual abuse of children (Bagley, 1984) and need to be aware of their own sexual bias and the impact this will have on the therapeutic intervention.

Brickman (1984) believes that the victims, the mothers, the nonabused siblings and lastly, the abuser, should receive treatment, in order of priority. However, it appears that the abuser is often the one who receives the help or 'attention' first. Gordon (1986) discusses the difficulty in determining who is the victim in the family where abuse has occurred. The abused child is the obvious victim, however the mother is also a victim of oppression and isolation. Swink and Leveille (1986) believe that the mother, victim and others in the home are all victims of the father's violence. (To some extent, all family members are victims.) Women (mothers) are said to play a dual role in abusive family environments. They are "simultaneously victims and victimizers, dependent and depended on, weak and powerful" (p. 458). Individual work is advocated initially in order to meet the needs of the individual family members. (Bagley, 1984). In this section, the word 'victim' will include the child victim, the mother and the other nonoffending people in the home, unless the information clearly states that it is referring to one member of the family.

Individual treatment for the victim includes 1) validating and normalizing the child's experiences and feelings, 2) alleviating the child's guilt feelings

around taking responsibility for the abusive event, 3) exploration of the child's feelings towards individual family members and 4) increasing the child's self-awareness and self-esteem (Bagley, 1984). The victim needs to be empowered as the offender abused the power within their relationship (Swink and Leveille, 1986). Individual treatment may also include helping the child clarify their role as a member of the female gender and increasing the child's awareness of how this gender role is played out in their own family.

Individual sessions for mother include 1) allowing her to vent and explore her feelings about the abuse, 2) empower her to leave the abusive relationship, 3) develop potential for social and economic independence (Gordon, 1986), 4) to confront the "competitive and sexist contaminations" in her own thinking (Rance-Wentworth, 1982) and 5) to explore childhood feelings and her own sexual history. The mother must deal with her history (which may include sexual abuse) before she is able to play an active role in the treatment of herself or her children (Bagley, 1984).

Individual sessions for the father focus on one main issue; taking legal, moral and emotional responsibility for the abuse (Bagley, 1984). In addition the treatment focus may be in helping men to redefine and expand their sex role characteristics and to acknowledge how their present sex role affects their life and the lives of their families and significant others. Education is a large component of the intervention. Men need to become more independent and acknowledge their dependency on women. Men and women need to understand the advantages of egalitarian thinking. They need education regarding both sex roles that emphasize the nature of mutual respect and

equality. Men also need to learn how to express feelings and thoughts in an appropriate manner. Due to the focus on learning, the men have to unlearn years of reinforced behavior. This will be an enormous task. Essentially, men are assisted to develop a new self-image.

Swink and Leveille (1986) identify a number of issues that need to be addressed by the victim, whether that be in the context of individual, dyadic or family work. The issues include: 1) victim to acknowledge that the abuse has happened, 2) "myths and facts of incest need to be clarified" (p. 122), 3) decreasing social isolation, 4) dealing with "dreams, nightmares and/or flashbacks of the abuse" (p. 123), 5) deal with fears and phobias, 6) look at family dynamics, ie) role reversals, 7) work through issues of guilt, depression and damaged physical image, 8) look at pyschosomatic responses to the abuse, 9) work toward preventing self destructive behavior ie. abuse of alcohol and drugs, eating excessively and becoming involved in another abusive relationship, 10) deal with the feelings of lack of trust in relationships, 11) look at the tendency to overvalue the male gender, 12) the victim will need to feel more in control during sexual relationships, 13) deal with the fear of intimacy and the expression of feelings, particularly anger and rage. Once anger is released, the victim is said to gain power. "Once they come into their own power and realize that they can use it appropriately, they are free to be survivors and no longer victims" (p. 128), 14) deal with the issue of control. Victims feel that there are two states of control: having no control or being in control of everyone and everything, 15) there is a need to increase decision making, communication, assertiveness and parenting skills and to learn relaxation and self defense

techniques, and finally, 16) the victim needs to confront the abuser with the abuse.

Bagley (1984) describes five general aspects of work that needs to be completed when involved in the treatment of intrafamilial sexual abuse which include: 1) understanding and changing values of the community, individuals and the professional networks concerning their attitude towards the sexual abuse of children, 2) develop an integrated response to sexual abuse through community involvement and co-ordination, 3) treatment programs for each family member will be lengthy and intensive and should be associated with self-help groups. All treatment should be geared to enabling the victim to recover her sense of dignity, self-respect and self-esteem, 4) treatment of the adult sexual abuse victim is crucial, and 5) the victim must learn how to prevent further abuse.

Family treatment is seen as the last step in intervention, preceded by individual and group work. When doing family work, the pattern of authority is to be changed and the victim is to be empowered to direct the changes in the authority pattern in a way that will make her feel safe (Brickman, 1984). An equal power balance is seen as the factor that decreases the risk of the family and reduces the chance of re-victimization. Implicit in this redistribution of power is giving one the power to make choices that will promote a safe environment (Brickman, 1984).

In the next part of this paper, the feminist approach to treatment will be addressed. The treatment approaches identified in this section can be applied to the treatment of intrafamilial child sexual abuse.

Feminist Approach to Treatment

Therapy looks at the "effect of the passive, noninstrumental, traditional feminine role in undermining women's abilities to exercise authority effectively and function as competent, self-affirming people" (Libow, Raskin and Caust, 1984 in Olson and Miller, 1984, p. 607). The goal of the feminist approach appears to be to empower the victim (Swink and Leveille, 1986 and Rance-Wentworth, 1982). Empowerment can be done in many ways, such as in consciousness raising groups (Thorman, 1983, Libow et al in Olson and Miller, 1984 and Rance-Wentworth, 1982), assertiveness training (Thorman, 1983, and Libow et al in Olson and Miller, 1984), political action (Thorman, 1983 and Eisenstein, 1983) and women networking with each other (Thorman, 1983 and Rance-Wentworth, 1982). Due to the belief in social learning theory, treatment often includes an educational component with all members of the family.

Reilly and Gruszski (1984) identify a program called "Structured Didactic Model" which is used to help men control their level of violence in the home. Each session within the program has goals for the men who participate. For example, some of the goals in session one are 1) to help the male break down the feelings of isolation and dependency on one female by getting support from others, 2) help men to deal with their feelings and to understand the use of their anger, and 3) "to feel better about self [and] to feel control over self and actions" (Reilly and Gruszski, 1984, p. 228). Other sessions help the men to identify physical and emotional cues that inform them that the level of violence will escalate, to help them look at how violence affects all family members and to gain insight into family of origin

issues regarding the sexes and sex roles. In regards to women, women learn how to define "their own reality and create images of who they are and how they want to be" (Rance-Wentworth, 1982, p. 91). They learn how to differentiate between themselves and the projections of others on to them. Rance-Wentworth (1982) calls this "freeing themselves from the projections' power" (p. 91). Women also learn to 'heal thyself' due to their involvement and cooperation with other women and by recognizing the 'power' of the validation they give to each other (Rance-Wentworth, 1982).

Bergh and Cooper (1986) state that the important components of feminist therapy are "1) informing clients of the nature of therapy, 2) not taking the position of the expert [as there are no experts on the female perspective], 3) enhancing the autonomy of clients in therapy, 4) serving as a positive role model and 5) facilitating the expression of anger" (p. 118). The therapist is to help the client to find personal power and to encourage the client to use "her skills in nurturance to foster her own growth" (Chambless and Wenk, 1982, p. 57). Goodrich, Rampage, Ellman and Halstead (1988) state that feminist family therapy "examines how gender roles and stereotyping affect 1) each individual in the family, 2) relationships between individuals in the family, 3) relationships between the family and society, and 4) relationships between the family and the therapist" (p. 12). It is suggested that by making gender role and stereotyping effects explicit, family members are freed from the restrictions that causes them to look at themselves, the family and society in a rigid way that maintains the status quo. Both sexes need to learn that there are choices to be made and that the status quo can and should be challenged. Goodrich et al (1988) believe that 1) gender roles, 2) the traditional family model, 3) theory and 4) practice of family therapy

are oppressive to women. They believe that gender role in families is accepted without question by family therapists. "Gender roles are key determinants of the structure and functioning of the family" (Goodrich et al, 1988, p. 13) and it is the dilemmas around gender roles that are the basis to problems brought to therapy. The therapist needs to challenge the gender role 'status quo' by questioning how the sexes acquired their role and how it is maintained in their family. The traditional family model is said to support and maintain gender based division of labor even though the roles of women have changed. Men are still viewed as dominant and women subordinate which prevents the equal distribution of power. Theory of family therapy is dominated by systems theory which is considered patriarchal. There will be more discussion about this issue later. Finally, practice in the feminist mode first looks at the therapist in terms of his/her own values regarding gender roles and the family. The therapist must evaluate these values and determine what part of his/her value base is entrenched in sexist stereotypes. The therapist can then "address gender issues and make them explicit to the family precisely because the family cannot see its problems as gender related" (Goodrich et al, 1988, p. 21). Practitioners must not "confuse biological sex with socially perscribed gender roles" (Goodrich et al, 1988, p. 22). In addition to this, practitioners must ensure that the male and female family members accept their share of the responsibility for family life. It is mentioned by Goodrich et al (1988) that the wife usually brings the family into family therapy and is focused on most of the time as the husband may be resistant and believe that his attendance is sufficient investment in the therapeutic process.

Feminist Critique of Systemic Theory

There is much criticism from feminists about systemic theory. Generally speaking, systemic theory is said to be patriarchal, thereby condoning the oppression of women. Systemic formulations "perpetuate culturally dominant notions of the proper place of men and women" (Bograd, 1986, p. 99). It is important to look at the family situation as it presents and not through male ideology (McGrath, 1979, p. 19). The strongest complaint of the feminists regarding systemic theory appears to be that the victim (child or woman) is blamed for the family dysfunction (Walker, in Lystad, 1986).

Systemic thinking does not consider gender based issues and the limitations inherent in these issues, such as males being dominant and females being oppressed (Bograd, 1984 and Layton, 1984). Women and men are defined stereotypically (Bograd, 1984, Brickman, 1984 and Layton, 1984) which reinforce the power imbalance between the sexes. Systemic semantics actually hide gender issues such as when the phrases 'battering couple/system' and 'violent couple' are used (Bograd, 1984). Systemic theory does not "address role of women in the family nor the position of women as a class" (Bograd, 1986, p. 96).

According to systemic thinking, violence may serve a function within the family (Bograd, 1984) and therefore somehow be sanctioned (Bograd, 1984 and Brickman, 1984) as part of the family functioning. Abuse is said to be due to the interaction of the couple and not due to (even on occasion) the male's personality characteristics (Bograd, 1984). Both men and women are to accept responsibility for the abuse which usually results in the women being blamed for the violence (Bograd, 1984). Schechter (1982) states that

systemic "therapists incorrectly place the source of the problem within the family system, not within the person who beats, the traditions that maintain the abuse or the institutions that support male domination" (p. 212).

Critique of the Feminist Theory

Information on the feminist critique is not readily available, other than statements from authors (Dell, 1986 and Erickson, 1988) stating that feminist theory is THE approach to use when dealing with issues of violence. This statement is somewhat correct. As mentioned previously, the feminist theory confronts the status quo; whether that be in terms of sex role behavior or a social system (patriarchal in nature) that condones oppression and violence towards women and all people. The status quo needs to be challenged to broaden one's perspective of any situation. To some extent the feminist approach in dealing with violence has become the status quo. In keeping with feminist principles, the theory needs to be challenged.

Although feminist theory clearly identifies social issues that impact on the behavior of people, issues that have not previously been taken seriously and acted upon as the feminists have done, the feminist theory falls short in dealing with the aftermath of the violence. Their theory is useful in the initial stages of work, however there is little direction on how to work with the family, whether that includes or excludes the father or offender. The feminist theory does not provide a framework on how to deal with family issues. Gender roles and power imbalances, for example, are dealt with within the context of the family. However, the feminist rely on the systemic framework in working with the family, such as when they recommend that

family dynamics and role reversals be discussed within the context of the family. There is limited information that states how to look at family dynamics (other than via sex role behavior and power imbalances) or how to address the issue of role reversals if not from a systemic perspective. It is confusing to hear feminists state that systemic theory is inappropriate to use in the area of family violence as feminists appear to rely on systemic principles in their treatment approach. Is it the theory or is it the therapist's personal 'additions' in implementing the theory that is in question? There is more to family functioning than sex roles and power imbalances, although these themes are important factors in family functioning.

Systemic theory promotes thinking of the family in a fairly mechanistic way. It is believed that there are predictable patterns that occur within a family and that these patterns, when changed, can help the family regain healthy functioning. Feminist theory has added a humanistic side to family intervention. The family is not just a few predictable patterns, but individuals who have needs of their own and who relate to others.

Due to a more linear approach to treatment, the strength of feminist theory appears to be in the area of dealing with victims and nonoffending parents in individual and group work. However, while family members are in individual or group work there is no attention given to helping the family members who reside in the home to re-unite after the explosion of the disclosure. (As a result of the disclosure it may be that the father, or offender, does not reside in the home.) In simplistic terms, the feminist approach appears to isolate family members, even those who reside in the same residence (nonoffending parent and children). Finally, although the

feminist theory state that there are no experts in the experience of women, the feminist approach does present as the 'expert' way in dealing with family violence, violence that includes the experience of women.

A systemic approach to family issues focuses on " a set of rules, interactions and interrelationships within the family systems" (Libow et al in Olson and Miller, 1984, p. 606). Key concepts of the systemic approach are listed below.

1) "The parts of the family are interrelated. One part of the family cannot be understood in isolation from the rest of the system. Family functioning cannot be fully understood by simply understanding each of the parts" (Epstein and Bishop, 1981, p. 447.). The entire system is said to be greater than the sum of all the subsystems (L'Abate, Ganahl and Hansen, 1986). The family is considered a system, as all parts of the family are necessary in order for the family to function.

2) "A family's structure and organization are important factors determining the behavior of family members. Transactional patterns of the family system shape the behavior of family members" (Epstein and Bishop, 1981, p. 447). Although the structure is believed to remain stable, "individuals within it are continually changing according to the process defined by the family rules" (L'Abate et al, 1986, p. 11).

3) Within the system there are smaller groups known as subsystems (Skynner, 1981). Boundaries between these subsystems and communication across the boundaries provide the subsystems with structure and autonomy (Skynner, 1981) from the larger family system. "The boundary separates the system from the other elements of the environment making it a 'distinguishable entity'" (L'Abate et al, 1986, p. 12). The separation noted is

between the system and subsystems within it and between the system and the environment. Boundaries can differ in degrees of flexibility and openness. In order to understand what is a good degree of openness and flexibility, one must be aware of the issue of hierarchy within the family in systemic theory. Each of the four major subsystems within the family (the individual, husband-wife, sibling and parent-child) have their own roles, norms and values. (L'Abate et al, 1986). It is "the larger system [that] interconnects and influences each of the subsystems" (L'Abate et al, 1986, p. 11). Being goal directed, the family system has to organize itself in order to the complete necessary tasks. Roles and rules are designed by the family to assist in this organization. Therefore each subsystem has responsibility for task completion. Organization of the family system is seen in terms of a hierarchy, with the marital subystem given the most power, followed by the parent-child, sibling and individual subsystems. Each subsystem needs to identify and preserve an identity. Boundaries are set up in order to maintain the identity of the subsystem and to clarify the roles and rules that govern each subsystem. For example, the marital subsystem is responsible for the overall functioning of the home. The quality of their relationship determines the quality of the home environment, due to the powerful and influential role this subsystem plays in the family system. If the marital subsystem involves others (like children) into the subsystem, the subsystem is rendered ineffective, as the marital subsystem, by definition, is only accessible to the husband and wife. There is much focus on this subsystem (at times to the exclusion of other subsystems) and therefore the boundaries between this subsystem and all others need to be clear and strong.

Part of the relationship in this subsystem is of a sexual nature. Sexuality is seen as a central ingredient to help bond the parental subsystem and facilitate separation and autonomy from other family members. (Skynner, 1981, in Gurman and Kniskern, 1981). Sexual relationships between any family members other than the husband and wife is not appropriate. Another part of the marital relationship is to deal with emotional and instrumental issues that are of an adult nature, such as both adults being emotionally supportive to each other, paying the bills and being responsible for child care. These tasks are also not appropriate for children in the family. The systemic theory identifies a hierarchy that is used in assessing the family and to work towards in clinical practice (ie. strengthen the marital subsystem).

In addition to boundaries between subsystems within the family, boundaries between the family and the general environment are also addressed. It is stated that it is important for the family system boundary with the environment to be open in order for the family to grow (L'Abate, 1986). Without the stimulus of external energies and influences, the family would stagnate and deteriorate.

4) Differentiation of family members from each other and from their family of origin is important. If differentiation of family members is not completed, the family projection process is noted. Kerr (1981 in Gurman and Kniskern, 1981) states that the family projection process occurs where family members project undifferentiated issues onto other family members. (This sometimes is referred to one dumping their unresolved issues on others who were not involved in the creation of the issues.) Kerr also identifies the

importance of noting the presence of multigenerational issues that are passed from one family of origin to the next. L'Abate et al (1986), discuss the importance of differentiation of self and identifies a continuum of differentiation: differentiated, reactive and undifferentiated. "The differentiated person has clear sense of self and is only minimally concerned with obtaining the approval of others. A reactive person functions in reaction to the demands and expectations of a significant other ... The undifferentiated individual does not function separate from the significant other" (L'Abate, 1986, p. 18). L'Abate et al (1986) state that when stress is apparent in a family system where the members are not differentiated, the family tends to deal with the stress through the use of triangulation. Triangulation prevents one from differentiating and maintains one in emotional mode of presentation. As undifferentiated people tend to response to stress predominantly with emotions, "there is a greater chance for distortion and fantasy to occur" (p. 18). However, with a differentiated person, there is a tendency to respond to stress in a thinking mode.

5) There is a belief in systems theory that the helper is to move the family to work toward an affiliation, rather than oppositional, attitude with other family members (Skynner, 1981 in Gurman and Kniskern, 1981).

6) Symptoms of family stress are seen as failures in adaptation and are usually not the 'real' reason for the system's dysfunction. Kerr (1981 in Gurman and Kniskern, 1981) states that "the type of symptom that develops is frequently a complication or exaggeration of the mechanism that has been used to preserve the system balance in the first place" (p. 235).

7) There are competing forces within a system that require an appropriate balance. These forces include: a) individuality vs togetherness, b) intellectual vs emotional and c) emotional dominance vs togetherness. (Kerr, 1981 in Gurman and Kniskern, 1981). Further to this Kerr states that the role of complementarity is important. For example, if one member or part of the system is in the intellectual sphere of functioning, in order to have a balance, other family members would have the complementary role in the emotional sphere. Therefore, all family members are said to play complementary roles to maintain the system's balance (Kerr, 1981 in Gurman and Kniskern, 1981). Further to this, systemic theory believes that the system can be self-regulating (Erickson, 1988), as it maintains itself over time. It is the complementary nature of the relationships within the system that assist in the system's process of self-regulation.

8) The family is considered an open system. The family system is not predetermined by it's initial state, "instead, the final state will be determined by the elements of the systems itself which is goal directed" (L'Abate et al, 1986, p. 14). The system is influenced by the environment in which it exists. In reference to the family system, the family would be influenced by all that come in contact with each family member. The assumption that the system is open, implies that the family will allow, acknowledge and consider the influences and feedback from the environment. Influences and feedback from the environment may come from subsystems within the family and the systems acting on the family that are not within the family system (ie. political and social influences). To safe guard the system against 'outside influence overload', there needs to be a mechanism that will be able to determine what influences the system can

and cannot endure. L'Abate et al (1986) identify this mechanism as the steady state. The "steady state represents the simultaneous operation of several internal processes that combine to allow the system to change and develop over time while maintaining a degree of internal identity" (L'Abate et al, 1986, p. 13). The two internal processes identified by L'Abate et al (1986) are homeostasis, where the system "maintains a stable balance" (p. 14) and morphogenesis, where the system aims toward "growth and development" (p. 14).

9) Circular causality is also an important issue in systemic thinking. This approach to thinking believes that finding the cause of a behavior pattern is impossible, and to some extent is not necessary, as the pattern is reinforced by all members within the family system. No one is to blame for the dysfunction within the family as everyone contributes to the pathology. Therefore there are many reasons or causes for an event happening. "It is not simply that A caused B, rather, A can be seen as if caused by previous events and/or systemic relationships" (de Shazer, 1989, p. 119). The person in the family "affects and is affected by the members of the system" (L'Abate, Ganahl and Hansen, 1986, p. 11).

The topic of circularity includes the issue of feedback. "The therapist [is] to conduct his investigation on the basis of feedback from the family in response to the information he solicits about relationships and, therefore, about difference and change" (Selvini, Boiscolo, Cecchin and Prata, 1980, p. 8). Selvini et al (1980) gives examples of this type of feedback. They discuss how the therapist should get members of the family to comment on relationships between other members in the family. For example, the son

would comment on the relationship between his father and mother. The therapist would use this information from the son as a means to help the father and mother look at their issues. Selvini et al (1980) believe that "regardless of the limitations imposed upon us by language and cultural conditioning" (p. 9), we, as therapists, can gain great insight into family dynamics by allowing the family members to identify and describe the various relationships in the family. Each family member will have their own perception of the family or specific relationships within it. These different views adds to the wealth of information on the family. Allowing the exchange of information between family members promotes change within the family system. The information allows the system to correct itself in terms of the system's "course of action" (L'Abate et al, 1986, p. 12). Also the therapist acts as a change agent by investigating the various patterns of feedback between family members that affect the family's patterns of interaction. The circularity of feedback becomes evident when the feedback identifies a chain of events that occurs to help maintain the pattern of behavior. For example: son yells at mother, mother yells at son, sister becomes involved and yells at son, mother and son yell at sister, sister leaves, mother and son relate in a positive manner, son yells at mother, etc.

10) Neutrality tends to be highly respected among systemic therapists. There is a belief that one should and could be neutral when working with families. Therapy is not the place for the therapist's values. The therapist is to work for the family in helping them to get to where they want to go in the way they want to 'travel'. Selvini et al (1980) consider neutrality in terms of the therapist not 'siding' with any particular family member. They state that if the family was asked to provide feedback about the therapist, they could

in terms of how effective the therapist was. However, if the family was asked to "state whom he [therapist] had supported or sided with or what judgment he had made concerning one or another individual, or his [therapist] respective behavior or of the entire family, they should remain puzzled and uncertain" (Selvini et al, 1980, p. 11). Selvini et al (1980) discuss the issue of the therapist shifting alliances from one family member to another with the end result of the therapist "allied with everyone and no one at the same time" (p. 11). It is the good therapist who is more interested in encouraging feedback between the family and collecting information and who is therefore "less apt to make moral judgements of any kind" (Selvini et al, 1980, p. 11).

11) There is a focus on the present functioning of the family (present context emphasized). There is little focus on what is said, however there is much interest on how interactions affect others (process) and what role that process plays in maintaining the family's stable state.

"A major contribution of general systems theory to family therapy has been the idea of understanding the individual in relation to his family system and to understand the family in relation to the community." (L'Abate et al, 1986, p. 11). This philosophy or framework has been an influential factor in working with families. However the systemic theory has come under attack, which has led systemic followers to question the general use of the theory in all situations. In addition to it's utility there has been confusion about what constitutes systems theory. "In many ways, the problem is not that systems theory is bad, but that what most family therapists know and use and love or hate as systems theory is just bad systems theory" (Constantine, 1989, p.

111). People like Minuchin (1982) and Kantor and White (1975 cited in White, 1978) have used systemic theory to create their own approach to working with people. Although their theoretical basis is systemic, they have added to the theory. Systemic theory as proposed by Bateson (1979) will follow.

Bateson is said to be the father of the systemic theory (Morris, 1989 and Erickson, 1988) and therefore appears to have the "pure" or untainted theory about systems. In his book entitled Mind and Nature: A Necessary Unity, Bateson (1979) was interested in how the world 'fit together'. Bateson noted the importance of the mind in determining the status of a situation. It was not the nature of the situation itself, rather the meaning of the situation given by the mind (the system). Bateson (1979) states that "it is the context that fixes the meaning to the action" (p. 15). One can note a relationship between the environment and the system's perception. It is this relationship that is believed to be the most important factor (Bateson, 1979) in assessing the system.

A "relationship is always a product of double description" (Bateson, 1979, p. 132). Here Bateson refers to the belief that there is a need for at least two people in order to have a relationship. Anything that occurs in that relationship is seen as a product of that relationship, in other words, a product of the people in the relationship. Bateson is firm on his belief in the importance of the relationship. He states that one cannot explain aggressiveness and pride on an intrapsychic level as "such an explanation, which shifts attention from the interpersonal field to a factitious inner tendency, principle, instinct or whatnot, is ... very great nonsense which only

hides the real questions" (Bateson, 1979, p. 133). Bateson describes how pride for example, relies on one being admired by another and one accepting the admiration. There is a process or sequence that is necessary for one to feel proud. "All characterological adjectives ... derive their definitions from patterns of the interchange" (Bateson, 1979, p. 133). One can only understand behavior within a relationship framework, therefore the only information one needs is information regarding the relationship. Within this framework, individual behavior is not recognized as meaningful in understanding behavior. It is therefore appropriate and consistent with the theory that Bateson dismisses the relevance of linear thinking and advocates for circular causality, also known as 'cybernetic circuits of interaction' (Bateson, 1979).

Bateson looks for the "pattern which connects" (1979, p. 8). The pattern is a way to see how each part of the organism (family) is related or connected with each other. A pattern contains three components which is necessary for the development and maintenance of the pattern. These three components are the stimulus, the response and the reinforcement. (Bateson, 1979). These components rely on the interplay of factors. For example, the stimulus may be burned toast (factor one), the response may be one where the intended eater demands that the person who made the burned toast make him some other toast (factor two) and the reinforcement for the demand for new toast is noted when the person makes more toast (factor three). All factors need to be present before any of them were noted.

Patterns, or ways of acting, are divided in two categories: those patterns that are complementary (where one elicits a response and the other

complements or completes it) and symmetrical (where one elicits a response and the other provides the same response) (Brundage, 1985). An example of a complementary relationship would be where one person is dominant and the other person is subordinate. In order for one to be dominant, someone has to be subordinate. The subordinate complements the dominant. An example of a symmetrical relationship would be where both people in the relationship can nurture each other and there is no need to have one identified as the nurturer and the other identified as the dependent one. The complementary and symmetrical nature of relationships can only be understood by looking at the relationship issues.

Individuality or personal autonomy were not part of Bateson's theory. Individuality "is the fallacy of mentalism" (mental processes) (Brundage, 1985, p. 44) as all people are connected to a higher and more powerful system. Under the systemic perspective, the individual "perceives himself to be part of a greater and saving whole and, consequently, accepts a complementary relationship to a Higher Power or God ... the self- the pseudo-individual bounded by his skin - accepts his nullity and impotence to choose and, in so doing, achieves a new epistemology that is a new sanity" (Brundage, 1985, p. 44). According to Brundage, Bateson sees this switch from individuality to being part of the whole, as "a change from an incorrect to a more correct epistemology" (1985, p. 44). There is no sense of self. "Rather, the so-called self is an element of a system" (Brundage, 1985, p. 44) and it is the system that determines behavior. "It is not the self that is morally responsible, because it is the larger system that thinks, acts, and decides ... Even at the highest level there is no moral responsibility, for even God is bound by systemic determinism" (Bateson, 1971 cited in Brundage,

1985, p. 44). "The unit of survival ... is not the organism or the species but the largest system or 'power' within which the creatures lives" (Bateson, 1971, p. 332, cited in Brundage, 1985, p. 49). "The ultimate good is to be in harmony with Providence (which is Nature) and necessity" (Brundage, 1985, p. 49). It is an assumption of this theory that nature knows how to identify harmony and to determine what is necessity. Nature knows best.

It appears that 'pure' systemic thought focuses on the need to consider all behavior in terms of its relationship with the environment. No behavior occurs in isolation and all behavior influences or affects subsequent behavior. Bateson's view of systems helps to provide a framework to assess patterns in the family and to also account for the influence the family experiences from larger systems, such as society. Bateson's view of behavior appears similar to that of the 'food chain' we all learned in biology. When one part of the food chain is broken, the entire population within that food chain is affected.

Systemic Perspective on Intrafamilial Child Sexual Abuse

The systemic perspective highlights the patterns that are believed to occur in families where intrafamilial child sexual abuse has occurred. In keeping with the belief in patterns, systemic theory looks at intergenerational themes or patterns in the family's family of origin. A genogram, which identifies issues and patterns throughout the generations, would be a good tool to use to identify intergenerational patterns of sexual abuse. Eist and Mandel (1968) state that if there are not patterns of incest that are noted in intergenerational patterns, then there will be dynamics that are believed to promote sexual abuse of children.

Alexander (1985) states that one must consider the characteristics of the family system and the environment that appear to maintain the incestuous abuse and that there are certain predictable changes in the family structure that must occur between the family and the environment in order for the incest to stop. Predictable changes such as strengthening generational boundaries, in order to prevent role reversal between the mother and daughter. Alexander (1985) states that within a systemic perspective, incest is viewed as "a behavior symptomatic of a family that is isolated from the environment; that is, avoidant of the differentiation of roles, functions and individual members and that uses the incest behavior as just one more means to avoid the growth and change" (p. 82) necessary for healthy family functioning. Giaretto (1982d) states that "incest can be regarded as a symptom of a dysfunctional family: a family headed by parents who are unable to develop a satisfying marital relationship and who cannot cooperate effectively as parents" (p. 4). Incestuous families are considered to be closed systems, enmeshed and to have an undifferentiated family structure (Alexander, 1985).

Rist (1979) discusses the need to consider family patterns in terms of triangles. She states that triangulation occurs when one of the two people from one generation (parents) develops a coalition with another member of the family from another generation (child victim) against the other. What is usually seen is a father developing a coalition with his daughter against the mother. (The coalition noted in the nuclear family is often seen between the mother and her parents.) The breaching of generational ties with the child is said to lead to the breaching of generational ties in the next generation. Rist

(1979) states that incest is an issue of rejection and abandonment and not an issue of sexual deviation.

Cited in Machotka et al (1967), Weiner (1964) describes how the mother is the cornerstone in the pathological family. The mother is said to be dependent, infantile and pushes her daughter into fulfilling adult responsibilities and expectations that she cannot meet. By doing this, the mother is said to be rejecting the daughter. In addition, Weiner (1964) states that the daughter's incestual relationship with the family is due to the daughter's revenge against her mother for rejecting her. Weiner states that if the daughter is in the pre-genital stage of development (pre adolescent), the daughter is looking for some sort of parental attention from the father due to the rejection she is receiving from the mother. Weiner does not state what the daughter's intentions are if she is in the genital stage of development.

Swan (1985) states that the child victim protects the family by diverting family pressures away from marital and family problems by being sexually abused. The child obtains power due to the sexual abuse and takes a superior position in the family, a position that the child uses to blackmail others in the family. The child seeks out power and is encouraged by the family to take the responsibility of family problems off the family. "Rather than the parent misusing power over a child, the parent gives up power in an incestuous relationship" (Swan, 1985, p. 69).

Machotka et al (1967) discuss the patterns and roles of the non-participant and the participant in intrafamilial child sexual abuse. According to the systemic theory, everyone plays a role in the incestuous relationship. For

example, the non-participant family members are said to deny that the incest is occurring and therefore maintains the secret and incestuous relationship. By doing this, the non-participant colludes with the participants and condones the incestuous relationship. The participants also engage in denial which is said to keep them unaware of their own role in the abuse and which creates the family secret. By keeping the secret, the participants cement the pathological family relations and make the family system more resistant to change. The child victim is seen as having the power to blackmail family members by threatening disclosure of the secret. Machotka et al (1967) support their belief that intrafamilial sexual abuse is a systems problem as they believe that if the child is removed from the abusive environment, the symptom will be substituted. In other words, another child would take the place of a previously removed sexually abused child.

It is clear from the above information that intrafamilial child sexual abuse within a systemic framework, is due to patterns within the family, patterns that all family members are responsible for and that there are predictable ways in which to assist families dealing with the intrafamilial sexual abuse. There is much faith that these predictable ways will bring about the necessary changes that will promote healthy family functioning.

Other dynamics of the incestuous relationship that are formulated from a systemic perspective will be identified later in this paper when general dynamics of the incestuous family are discussed.

Systemic Approach to the Treatment of Intrafamilial Child Sexual Abuse

Systemic theory appears to allow for the treatment of family members outside of the entire family context (Rist, 1979). However much of the treatment focus appears to be on the family unit. "Treating the family as a whole would help distribute responsibility appropriately, place individual guilt in perspective and prevent recurrence" (Machotka et al, 1967, p. 113). Treatment that emphasizes and deals with the family system and environmental interplay could decrease or eliminate the family's need for such symptomology. "This orientation would ... help to mitigate some of the righteous indignation with which incest is frequently viewed and which serves only to further isolate the family from community resources" (Alexander, 1985, p. 82). Blaming the abuser as the major part of therapy only serves to weaken family ties and solidifies the negative experience and therefore does not promote positive family functioning. If blame of the abuser is the major part of therapy, it is believed that there will be long term negative affects for the family (Swan, 1985).

Boundaries within the family system and subsystem are of major importance. In intrafamilial sexual abuse families there is no regard for "personal territorial rights" (Eist and Mandel, 1968, p. 219). As alluded to above, generational boundaries need to be strengthen. This would result in the marital, parental and sibling subsystems becoming clearly defined and strengthened in order to prevent a breach of territorial space. Eist and Mandel (1968) give examples of work needed to be done regarding boundaries; such as developing new and appropriate coalitions, developing better methods of communication and helping the child give the responsibility for parenting back to the parents. Boundaries between the family and the environment need to be restructured. The therapist helps to

provide the family with "positive, growth producing extrafamilial relationships" (Eist and Mandel, 1968, p. 223).

Machotka et al (1967) advocates for the therapist to focus on the denial, the incestuous behavior and the disordered relations. Each member needs to realize the role they played in maintaining the secrecy and environment that was conducive to the abuse occurring. Alexander (1985) believes that the treatment of sexual abuse should be a short term crisis orientated intervention rather than a prolonged intervention.

In dealing with the issue of family violence in general, Shapiro (1986) believes that a systems approach can work "if the resistance and fears of both the therapist and the family are addressed" (p. 48). Shapiro recommends that a nonviolence contract be set up to prevent further abuse and further states that a systemic approach can be effective as "both partners have a personal investment in maintaining the violent relationship" (1986, p. 46).

Much of the general approach to treatment, which will be discussed later, includes systemic principles. It would be repetitive to identify this information at this time.

Critique of the Systemic Approach to Family Violence

Intervention in family violence based on systemic theory has not been well received in the professional community (Willbach, 1989, Dell, 1986 and Erickson, 1988). Dell (1986) states that "the systemic perspective is simply incapable of addressing violence, power, and control ... these phenomena ...

can be neither distinguished nor even spoken of from within the world of systemic epistemology" (p. 528). Willbach (1989) criticizes systemic theory for its neutrality stance, stating that a therapists' "moral sense should inform their practice" (p. 49) and that one's inability to "utilize their moral judgment results in personal confusion for ... therapists, which translates into therapeutic confusion" (p. 49). Willbach (1989) also questions the systemic belief in circular causality. He argues that if everyone influences the behavior of others, there is some implication of reciprocity. However, reciprocity implies that all participants have an equal power base which is not true in violent families.

Although there are concerns about the systemic theory, one must not discard the theory completely. Systemic theory can provide direction when assessing family dynamics, however the theory does not have the framework to consider issues of an individual nature, such as an individual's safety. Chapter Five will discuss more about the use of these two theories. Chapter Three, to follow, will identify family dynamics.

FAMILY DYNAMICS OF INTRAFAMILIAL CHILD SEXUAL ABUSE

Incest is seen as originating as a strained sexual relationship between husband and wife. (Weiner, 1967 in Machotka, Pittman and Flomenhaft, 1967 and Rist, 1979). Parents lack emotional energy to nurture each other and design their social and work schedules in such a way as to avoid each other (Courtois, 1980). Role reversal between the mother and child is seen as a result of the estranged parental relationship (Machotka et al, 1967, and Finkelhor, 1978). Roles and boundaries between the generations and family members become blurred (Everstine and Everstine, 1983), leaving the child the responsibilities of the wife and parent role (Courtois, 1980). One of these responsibilities for the surrogate wife is sexual satisfaction of the husband. The mother is said to sacrifice her child for her own self-serving reasons (Finkelhor, 1978) and that the mother consciously or unconsciously sanctions the sexual relationship between her child and her husband (Rist, 1979). Role reversal is also noted when the father looks for parenting from the child. Failure of the child to meet the father's expectations and needs leads to the abuse (Bolton and Bolton, 1987).

Social isolation of the family is also said to promote sexual abuse (Finkelhor, 1979). The affects of social isolation are loneliness, an exaggerated sense of how important the family is (Bolton and Bolton, 1987) and the prevention of the family being scrutinized by the public (Finkelhor, 1978). As a result of the social isolation, the family environment "offers the opportunity for uncontrolled experimentation and lapses in judgement" (Bolton and Bolton, 1987, p. 47-48). The family relies on its members for need satisfaction, becomes enmeshed and develops rigid boundaries to 'outsiders' (Courtois, 1988) for protection.

Incestuous families live in a milieu of abandonment (Finkelhor, 1979). These families are said to have a history of abandonment, with family members changing frequently. Finkelhor (1978 and 1979) stated that a sexual relationship between an adult and child is seen as a way to keep the family system together. "It is a desperate way to give some substance to tenuous family ties that cannot seem to be sustain in any other way" (Finkelhor, 1978, p. 46). This dynamic is said to support the belief that all family members collude in maintaining the environment for the incestuous relationship to continue.

Sexualization of family relationships (Finkelhor, 1978) is another commonly found dynamic of the incestuous family. The child is also said to be exposed to sexually stimulating talk or unusual sexual acts (Finkelhor, 1979) and that the family fails to protect and respect each other's need for privacy and personal boundaries (Finkelhor, 1978). Feelings of closeness are intolerable and frightening. It is common for these families to have a low level of appropriate touch as affection is physically expressed in a sexual manner (Courtois, 1988). Williams (1983) believes that the combination of sexualized dysfunctional family relationships and the child's insecurity and unmet needs for attention and affection, predispose the child to sexual abuse. Inadequate parenting (Courtois, 1988), poor supervision of the children (Finkelhor, 1979, and Swan, 1985), opportunity or access to child (Finkelhor, 1978), and a collective denial of the incestuous relationship (Machotka et al, 1967) are also said to be dynamics of the incestuous family. Other dynamics would include unpredictability and instability of the family environment, poor tolerance for differences in the family (Courtois, 1988), expression of

feelings are not allowed (Eist and Mandel, 1968), poor interpersonal skills of family members (Ingram, 1985), alcoholism in the family (Swan, 1985), and intergenerational victimization (Courtois, 1988).

A basic lack of trust between family members and a conspiracy of fear help to protect the secret of sexual abuse (Finkelhor, 1978). Bolton and Bolton (1987) stated that "as sources of gratification [in the family] are choked off by jealousy, embarrassment or fear of disclosure of the family secret, reinforcement, recognition and support disappear" (p. 75). Feelings of helplessness, being trapped, having no control and being depressed is felt by all family members (Bolton and Bolton, 1987).

Courtois (1988) believes that the family develops rules to maintain the incestuous environment. These rules include: 1) double binds, where the child learns to dissociate as a response to the paradox, 2) family members are not to feel or express feelings, 3) family members are told to be in control at all times and if they ask for help they are seen as being weak, 4) to deny what is happening by not trusting their own perception of the event, 5) secrets are to be kept and even if disclosed, other family members will not believe the information in the disclosure and 6) the victim is to be ashamed of herself for she is to blame for everything that goes wrong in the family.

Finkelhor (1984) has identified eight factors "which made the strongest independent contribution to the explanation of sexual victimization" (p. 28). These factors are: i) the paternal parent is a step-father, ii) the children have lived in a home without their mother, iii) children not emotionally close to the mother, iv) the mother never finished high school, v) sex-

punitive mother, vi) children receive no physical affection from the father, vii) the annual family income is under $10,000 and viii) the children have two friends or less in childhood. If a child has none of these factors in his/her family, then sexual abuse is said to be virtually absent. If a child has five of these factors, then the child has a sixty-six percent chance of being sexually abused. Finally, if the child has six or more of these factors, the possibility of being sexually abused increases by ten to twenty percent with each additional factor.

Characteristics of the Victim, Nonoffending and Offending Persons

The following is a sketch of the characteristics of the sexually abused victim, the nonoffending person (usually the mother) and the offending person (usually the father). It should be noted that all of the members of these three groups (victim, offending and nonoffending persons) have some similarities with other members of their group, such as most child victims experience role reversal with the nonoffending person. However, each member within a group is not identical to other members. Each nonoffending and offending person and victim have their own unique characteristics. It is this fact that supports identifying each group as heterogeneous and identifying only those characteristics that are seen most often.

Charactertistics of the Sexually Abused Child

There is much literature on describing the sexually abused child. These characteristics include:

1) the child being responsible for their own emotional and physical care (Eist and Mandel, 1968),

2) the child is not allowed to be dependent on adults (a normal developmental phase) as the child becomes responsible for meeting adult needs (Bolton and Bolton, 1987),

3) the child is extremely needy (Machotka et al, 1967) as she and her needs have been neglected,

4) the child feels abandoned by the mother and as a result, turns to the father for affection (Rist, 1979),

5) the child feels that the basic trust bond in the family has been violated and therefore does not feel protected (Everstine and Everstine, 1983),

6) the child has a poor relationship with the mother (Finkelhor, 1984),

7) the child experiences role reversal with the mother (Finkelhor, 1978),

8) the child who is victimized is usually the eldest daughter (Meiselman, 1978),

9) the child experiences feelings of guilt, worthlessness, low self-esteem (Everstine and Everstine, 1983) and insecurity (Williams, 1983),

10) the child emits behavior such as intense fears, night terrors, clinging behavior, developmental regression, running behavior, a drop in school performance (Williams, 1983), atypical sexual behavior, lying, habitual stealing (Meiselman, 1978) and often the child cannot describe the abusive situation in a clear way that is understandable by adults (Everstine and Everstine, 1983). If the child discloses sexual abuse in a 'mumble jumble' way, there is a tendency by caretakers of the child not to take the disclosure seriously.

Characteristics of the Nonoffending or Maternal Person

The mother of sexually abused children is described in following manner:

1) she may have been a victim of abuse previously or was an incest victim in her family of origin (Bolton and Bolton, 1987),
2) she was deprived of a normal family life as she had unhealthy childhood experiences and inappropriate role models (Bolton and Bolton, 1987),
3) she was rejected by her own mother (Eist and Mandel, 1968, Machotka et al, 1967),
4) she needs to deal with her own issues regarding her childhood (Swan, 1985),
5) she is said to be fearful of sex, inhibited sexually (Everstine and Everstine, 1983) and not available to her partner for sexual relations (Meiselman, 1978),
6) she has unrealistic expectations of her marriage (Everstine and Everstine, 1983),
7) she has difficulty parenting, she maintains an emotional and physical distance from her children (Browne and Finkelhor, 1986), has problems relating to her victim daughter (Finkelhor, 1978) and is often absent from family life or incapacitated (Meiselman, 1978),
8) the mother has a lack of ability or willingness to protect her children (Finkelhor, 1978) and is ineffective in her general role performance (Machotka et al, 1967),
9) she often denies that the incest is occurring (Machotka et al, 1967),

10) she is dependent, infantile (Rist, 1979), passive and one who has a sense of inferiority (Meiselman, 1978) which may lead to depression or suicide (Bolton and Bolton, 1987).

Characteristics of the Offending or Paternal Person

There is a lot of information on the offending person, who is usually the father. His characteristics will be divided into subheadings.

i) Family of Origin Issues

Meiselman (1978) describes the offending parent as one who left home early, lived by himself or with nonfamily until he was married. He may have a history of frequent job changes and periods of unemployment. The offending parent's father was said to be absent or a harsh disciplinarian and who was an incest offender. Therefore the offending parent did not have an opportunity to learn about socially appropriate behavior. The offender is said to have preferred his mother over his father, yet the relationship with his mother was poor in quality. In general, child-parent relationships in his family of origin was de-emphasized in importance. It is not surprising that Meiselman (1978) also found offenders to have psychopathology and were personally maladjusted.

ii) Relationship Issues

The offender is said to be a powerful influence in the family. He is controlling and dominant (Finkelhor, 1978 and 1979, and Meiselman, 1978) and is an authoritarian (Finkelhor, 1978). He is often the emotionally essential person in the child victim's life (Finkelhor, 1978) yet cannot control

his involvement with the child (Meislman, 1978) and does not know how to deal with the child's developing sexuality (Swan, 1985). The offender is more likely to be step-father than a biological father (Finkelhor, 1984), who may want to be dependent on his wife or who may want his family to be dependent on him (Bolton and Bolton, 1987). The offender is noted as blaming the victim, discounting and rationalizing his behavior and may even believe that the sexual abuse served as sex education (Faller, 1988). The offender is seen as socially inept (Bolton and Bolton, 1987, Everstine and Everstine, 1983) and shy (Finkelhor, 1978). Bolton and Bolton (1987) discuss the issue of role preparation of the male offender. "First, this individual finds it difficult to discriminate between sexual and nonsexual affection. Second, .. [his] identity is closely tied to success at sexual conquest. Third, ... sexual activity may be thought of as independent of the relationship status. Fourth, ... [he] has been taught to seek younger and smaller persons as sexual partners. Finally, ... [he] has been socialized to be the aggressor, seducer and initiator in sexual activity. If [he] reverses [the parental] roles with the child and seeks nurturance ... from them; the nurturance may be sought through sexual activity" (p. 123).

iii) Other Characteristics

The offender is noted as abusing alcohol (Finkelhor, 1978 and Meiselman, 1978), obsessed with sexual concerns (Everstine and Everstine, 1983), sexually fixated (Finkelhor, 1979), insecure about his masculinity (Bolton and Bolton, 1987 and Meiselman, 1978) and is insensitive and paranoid (Everstine and Everstine, 1983). The offender is said to set himself up to fail (by sexually abusing a child) which reinforces his low self-esteem. He feels out

of control and is impulsive regarding his expression of fear or rage (Bolton and Bolton, 1987). Depression and suicide are also noted in this client population (Bolton and Bolton, 1987).

Siblings as Perpetrators

The literature confidently states that sibling incest is the most common type of incest (Santiago, 1973, Arens, 1986, and Mrazek and Kempe, 1981). It is said to be five times more common than father-daughter incest (Cole, 1982). However, there is a need for more information and research on sibling incest (Finkelhor, 1986) as "neither the seriousness of sibling incest nor its complexity have been adequately appreciated" (Cole, 1982, p. 80). The literature tries to separate the issue of incest and 'normal' sexual experimentation (Cole, 1982), however this is a difficult task as there is risk of minimizing the effect of the incestuous relationship. Age of the victim and perpetrator has been used as an indicator in helping one determine whether the sexual activity between the victim and perpetrator is incest or 'normal' (Finkelhor, 1981). If there is a five year or greater age difference between the perpetrator and the victim, the sexual behavior is usually identified as incest (Russell, 1986). However, Russell (1986) states that this approach to differentiate incest from 'normal' is inappropriate as there is an issue of mutual consent that needs to be addressed. Russell (1986) further advocates that mutual consent cannot be present within sexual relationships between siblings as there is a power differential between the perpetrator (usually the brother) and the victim (usually the sister). Cole (1982) simply states that age difference is not important in determining whether incestuous activity has occurred, rather it is important to consider the dynamics of the

involvement. The most common form of sibling incest is between brother and sister, therefore this relationship will be addressed in this paper.

Social Factors Affecting Sibling Incest

Society appears to be tolerant of sexual contact between siblings if the contact is seen as experimental and if transitory in nature (Schlesinger, 1981). "Our society reserves a special emotive reaction to brother-sister incest which fails to involve public insult or horror" (Arens, 1986, p. 142). One may hear 'they're just kids, doing a little experimenting. There's nothing wrong with that. It's just the way they show their brotherly and sisterly love'. Arens (1986) takes exception to this and states that sex is not love.

There does not appear to be a clear definition of what behavior is incestuous and what behavior is just 'normal' experimentation. This confusion is also evident in the judicial system as the legalities of sibling incest is not clear (Porter, 1984). Bolton and Bolton (1987) state that "sibling abuse implies an aggressive or violent act directed from one sibling to another" (p. 154). Does this mean therefore that nonaggressive or violent acts are not considered to be incest? There is concern about this generalization, as not all incestuous relationships are initially seen by the victim to be aggressive or violent. Russell (1986) states that there is a pleasurable wanted side to the incest, however this is considered a rare occurrence. More specifically, there is a want of pleasurable attention that the child wishes to receive from the offending sibling. There is concern that society and, more specifically, professionals dealing with families where sibling sexual abuse or incest has occurred, will not take the reporting of abuse seriously and view the abuse

as 'just play' and believe that the consequences of sibling abuse is not detrimental (Cole, 1982). However, "sexual abuse between siblings ... is ...[a] genuine threat to normal childhood development" (Bolton and Bolton, 1987, p. 156).

Dynamics of the Brother-Sister Incestuous Relationship

Sibling sexual abuse is said to have started by sexual play in early childhood which progressed into sexual exploitation (Caprio, 1955 and Gebhard et al, 1965). The abuse is not 'benign'. Testimony from women abused by brothers identify that the abuse was coercive, forceful, violent and was accompanied by physical abuse (Cole, 1982). The offender engaged in behavior similar to other sexual abuse perpetrators, such as threatening the victim to maintain the secret and rationalizing the abuse (Santiago, 1973). In a study completed by Russell (1986), 44% of the sibling offenders used force as a primary strategy for female compliance and others used their good relationship to gain sexual access to their sisters. In this study, the average age of a brother offender was 17.9 years compared to the age of other sexual offenders which was 35.3 years. Interestingly, the average age of the victim at the time of the first incident of abuse by a brother is 10.7 years, while the average age of victims of abuse by other offenders is 11.1 years. The difference is not great. In a study done by Arndt (1981) more males than females admitted to entertaining some thought of becoming involved in sexual relationships with their sibling.

The victim experiences self-blame (Cole, 1982 and Santiago, 1973), dissociation (Santiago, 1973), and accepts responsibility for the abuse (Santiago, 1973). Victims may perceive incest as 'benign', yet experience

after effects that suggest that the abuse does effect their lives. After effects noted are depression, repeated victimization, lack of assertiveness, confusion between intimacy and sexuality and intense distrust of others (Cole, 1982, p. 87). Also, the victim is said to be more fearful of sexual assaults as children than other victims of incest and that 47% of sibling incest victims never marry (Russell, 1986). Santiago (1973) states that "any form of seduction between siblings ... may lead to serious emotional problems in childhood or later in adulthood" (p. 170). However, Finkelhor (1981) would disagree. "Incest with an older brother is usually not the root cause of later sexual problems in the sister. Of potentially more harm is the seduction of a young teen-age boy by an older sister" (p. 23). As a survival mechanism, the victim is said to rationalize to herself that she is getting something good out of this abusive relationship (Cole, 1982). In addition, when the offending sibling is a half-sibling or step-sibling, the victim is said to rationalize the incident by believing that since their is no blood tie, the incident is not incest (Russell, 1986). Even with these rationalizations, one would believe that the victim would undoubtedly feel intense isolation, abandonment and rejection from the brother as he was the only important family member to the victim.

Issues, such as those described in the feminist literature review on father-daughter incest are also raised here, such as the effects of the power differential and sex role stereotypes and that the female gender is taught to be submissive to the requests of males. (Cole, 1982).

Unlike father-daughter sexual abuse, sibling sexual abuse is said to occur for only a short period of time; not longer than a year. It is believed that the brothers may look elsewhere for their aggressive release and/or that sisters

may assert themselves due to the power differential not being as great as it is between a child and an adult (Russell, 1986). However, like father-daughter incest, the victim is blamed for the abuse. When the victim is 'caught' doing something 'bad', parental response is usually in terms of making the victim responsible for the abuse. Parental response is a key factor in sibling incest (Bolton and Bolton, 1987) as parents usually decide what action to take, if any. The parents determine whether this 'activity' is abuse or 'inappropriate' or appropriate sexual experimentation. Cole (1982) states that usually these cases are not reported and if reported by the victim, the family will not support the victim in her attempt to stop the abuse.

Interpersonal and Family Dynamics

As one will note, the following dynamics are very similar to the dynamics identified previously where the father or father figure is the perpetrator and the child is the victim.

The Child Victim

The child is usually the youngest female in the family (Mrazek in Mrazek and Kempe, 1981) and has one or more older brothers (Russell, 1986). The child idolizes the offending brother (Mrazek in Mrazek and Kempe, 1981) who is usually her only source of nurturing as she is not connected with other members of the family (Cole, 1982). Also, the child victim believes that she is the only resource for the perpetrator. These dynamics establish a relationship built on mutual dependency (Santiago, 1973). The child victim is also said to romanticize her relationship with her brother (Santiago, 1973).

The victim is believed to have been sexually abused previously by her father or peers (Mrazek in Mrazek and Kempe, 1981) and to have legal and educational problems (Porter, 1984).

The Child Offender

Child offenders may have been sexually abused by others (Caprio, 1955). There is some difference in the literature in terms of the relationship the offender has with his parents. Santiago (1973) and Caprio (1955) state that the child is favored by his parents while Bolton and Bolton (1987) state that the child is seen negatively by parents and does not receive parental attention. The offender is said to use pornography (Cole, 1982) and engages in sexual fantasies about family members (Caprio, 1955). Half-brothers or step-brothers who offend may not feel the restraint of the incest taboo (Russell, 1986).

Family Dynamics

The family environment is described as chaotic, disorganized (Bolton and Bolton, 1987), and is characterized as being isolated from the community (geographically and socially) (Randell, 1973). It is a violent family environment (Porter, 1984 and Caprio, 1955) where the crisis is centered around the mother (Bolton and Bolton, 1987). "Sibling abuse is more likely to occur in a home that already knows child abuse at the hands of the parent. Exposure to this aggressive parent and a general lack of positive affect can result in difficulty in controlling aggressive impulses" (Bolton and Bolton, 1987, p. 155). The home environment may be "excessively permissive about sex in the home with considerable discussion of sexual

matters, nudity and acceptance of their children watching parental intercourse" (Mrazek in Mrazek and Kempe, 1981, p. 104). Also, nurturing and caring between parent and child may be expressed in a sexual manner (Bolton and Bolton, 1987). Sibling sexual abuse is said to happen in large families where both parents are absent and neglectful of the children (Russell, 1986), and where the children receive very little supervision (Santiago, 1973 and Russell, 1986).

The father is said to play an absent role in the family (Santiago, 1973, Mrazek in Mrazek and Kempe, 1981, Russell, 1986). Santiago (1973) states that the female child is not able to work through her Oedipal issues with her father and therefore transfers these issues to the brother, who is unable to deal with them in an appropriate manner. Mrazek (in Mrazek and Kempe, 1981), states that the father may encourage the oldest son to engage in incest by not providing prohibiting inhibitions to his son and by allowing his son to take the father role in the family when absent. Russell (1986) states that the father permits the son to take on a "more dominant and sometimes abusive role unchecked" (p. 291) due to his absence from the home. "In some cases the brothers may even play a surrogate father role. Such cases are likely to share some of the same dynamics of father-daughter incest" (Russell, 1986, p. 292). The father is also said to be chronic alcoholic ((Santiago, 1973).

The mother is said to be a "nervous type but pleasant, considerate and martyr-like" (Santiago, 1973, p. 157). The mother (like the father) is seen as being unable to provide prohibiting inhibitions especially when the offender's behavior involves interaction with his young siblings. The mother is said to be "rigid and puritanical in her attitudes about sexuality" (Mrazek

in Mrazek and Kempe, 1981, p. 104). The mother is not satisfied with her marital relationship with the father and attempts to bring the son and daughter into the marital relationship and thus encouraging sexual relations. In addition, the son is said to identify with the mother who is unable to provide good parenting to him. Therefore, the brother becomes involved with the sister and transfers his "mother fixation" on to his sister (Caprio, 1955, p. 214). Caprio (1955) believed that due to the son's fixation on his mother there is a link between incest and homosexuality as the son should have been identifying with his father (who was most likely absent). Santiago (1973) supports the belief that offending brothers experience covert homosexual tendencies.

Treatment Issues

Santiago (1973) discusses many treatment issues in dealing with sibling sexual abuse. He advocates that the offending child should learn the difference between sex and intimacy and that "the child should understand that incestuous words, thoughts and feelings are not unusual at certain stages in life and are not tantamount to committing incest" (p. 171). In addition, the offender should take responsibility for the abuse and receive sex education that assists the child to understand "sex, sex differences and its expressions and prohibitions" (p. 172).

Santiago (1973) focuses a lot of the treatment on restructuring the family, such as helping the family develop clear boundaries around each person in the family. Santiago (1973) advocates that there should be separate sleeping arrangements for the sexes, parents are to take responsibility for supervision of the children, assist parents to help their children how to gain

self control and children are to have access to "outside" playmates. The issue of sexuality in the family needs to be addressed. Santiago (1973) states that if coercion or intercourse is part of the incestuous activity, a psychiatric assessment of the offender and victim needs to be completed, family and marital therapy should be implemented and the offender should be separated for a time from the home.

Cole (1982) believes that the victim should be told it is not her fault, and both offender and victim need to know that incest is not acceptable. The victim needs to be validated, is encouraged to tell someone should the abuse occur again and should have an opportunity to become involved in a group experience to help her deal with the effects of the abuse.

Short and Long Term Effects of Sexual Abuse

The literature discusses the effects of sexual abuse on the victim however does not address the short or long term effects of the abuse on other family members, the family as a whole, the non-offending parent or the offending parent. Therefore the discussion to follow identifies only those dynamics relating to the victim. The information presented specifically addresses the effects of sexual abuse on the child victim. In addition to this, there will be information presented on the effects of rape on the victim as this information is highly relevant to the issue of child sexual abuse and may be used to provide more insight into the dynamics of sexual abuse and direction in the treatment of child victims.

Browne and Finkelhor (1986) discuss the factors that influence the effects of sexual abuse on the victim. The authors discuss nine issues that are believed to be influential. 1) Duration and Frequency - There is no evidence to support any conclusions in this area. The authors state that it is usually believed that the longer the abusive relationship, the more trauma the victim will experience. However they also state that the opposite of this is true. Browne and Finkelhor (1986) believe that the 'jury is out' on this issue. 2) Relationship to the Offender - "It must be kept in mind that how closely related a victim is to the offender does not necessarily reflect how much betrayal is involved in the abuse" (p. 15). Browne and Finkelhor (1986) state that although the relationship of the offender to the perpetrator is important, it appears that the issue of betrayal is just as important, if not more important. To highlight the importance of the issue of betrayal, the authors make the point that abuse from a trusting neighbour is more devastating than abuse by a distant uncle. However, generally it is believed that there is significantly more trauma experienced by the victim if the offender is a family member (including step-parents), than if the offender is a non-family member (Finkelhor, 1979). 3) Type of Sexual Act - The authors believe that "molestation involving more intimate contact is more traumatic than less intimate contact" (Browne and Finkelhor, 1986, p. 16). Therefore, those victims who experienced sexual intercourse or anal penetration would be more traumatized than those who experienced fondling. 4) Force and Aggression - Although not conclusive, it is generally believed that the more force and aggression used in the sexual abuse, the more traumatized the victim will be. 5) Age at Onset of Abuse - This factor addresses developmental issues of the abused. There appear to be two conflicting views about this issue. On one hand, it is believed that the younger the

victim is, the more vulnerable and the more impressionable the victim is. Therefore the younger the child, the more traumatic the experience of sexual abuse will be. On the other hand, it is believed that the younger victim will be protected from some of the negative effects as they would be ignorant to the social taboo of incest. The implication appears to be that the younger child will experience less guilt and shame. Browne and Finkelhor (1986) state that the debate continues and that the variable of age may be influenced by other variables or factors identified. 6) Sex of the Offender - Male offenders are said to produce more trauma in victims than do female offenders. Part of this finding may be due to the fact that little is known about female offenders and that the techniques male offenders use to ensure access to their victims may be more forceful and aggressive. 7) Adolescent and Adult Perpetrators - Browne and Finkelhor (1986) cite Finkelhor (1979) and note that victims feel more traumatized when abused by older offenders and that the experience with an adolescent offender may be less traumatic. (There is more written on the issue of age difference between the victim and offender. See the section on Sibling Incest.) 8) Telling or Not Telling - There is no support to the belief that children who keep the secret of incest suffer greater psychic distress than those who disclose. 9) Parental Reaction - Parental response to the abuse is influential. When parents emit a negative and unsupportive response, the child's traumatic experience is aggravated. However, a positive and supporting response from parents is not believed to be related to a decrease in the child's experience of the trauma. This does not advocate for parents to be unsupportive, rather the issue of parental reaction emphasizes the independent level of stress the victim will feel regardless of the response by the parents.

Newberger and DeVos (1988) would disagree that positive and supporting parental reaction would not directly affect the trauma experienced by the child. They state that the family's response to the child affects the child's ability to cope and that one must increase parental sensitively to the child. In addition to this, Newberger and DeVos (1988) believe that an influential factor in the trauma experienced by the child is the child's cognitive appraisal of the abuse. It is important to look at what meaning the sexual abuse has for the child. The technique of cognitive appraisal is believed to help the child feel in control of the situation by assisting the child to view the sexual abuse from an objective point of view. Nelson (1986) furthers this discussion by stating that how the child views the abusive experience highly correlates with the child's view of exploitation. The more negative the child views the abusive relationship, the more the child will feel exploited and the more guilty the child will feel.

"It is important to be aware of ... [the short and long term effects of child sexual abuse] ... and to be able to reassure the victim that they have been resilient enough to survive to this point and that the damage can be overcome" (Bolton and Bolton, 1986, p. 107). Initial effects are considered to be those that occur within two years of the termination of the abuse (Browne and Finkelhor, 1986). These would include insomnia, "eating disturbances, fears and phobias, depression, guilt, shame and anger" (Anderson, Bach and Griffith, 1981, p. 3). Other initial effects are school problems, somatic compliants (Anderson, Bach and Griffith, 1981), marriage by adolescent victims (Browne and Finkelhor, 1986), "motor disturbances ranging from withdrawal to restlessness and hyperactivity" (Katz and Mazur (1979, p.

233), enuresis, regression, antisocial and delinquent behavior (Katz and Mazur, 1979).

The most common long term effect appears to be depression (Browne and Finkelhor, 1986). Other effects are "self destructive behavior, anxiety, feelings of isolation and stigma, poor self-esteem, a tendency toward revictimization and substance abuse" (Browne and Finkelhor, 1986, p. 12). Victims also experience problems in sexual dysfunction and trusting others. In general, a "history of childhood sexual abuse is associated with greater risk for mental health and adjustment problems in adulthood" (Browne and Finkelhor, 1986, p. 13). However "most empirical studies showing long-term effects of childhood sexual assault reported that the great majority of children recovered completely and that little long lasting damage occurred" (Katz and Mazur, 1979, p. 241). Katz and Mazur (1979) question the results of these studies as most did not have the use of control groups in which to make comparisons, however in the studies that had control groups comparisons it was found that only those "victims of force and brutality" suffered psychiatric illnesses while those victims who did not experience this did not present psychiatric symptoms (Katz and Mazur, 1979, p. 242).

The literature on the effects of rape shows many similarities to the literature on the effects of child sexual abuse. One similarity is that the literature focuses on the female victim. Doan and Levy (1983) states that there is not enough information on the effects of rape by a male rapist on a male victim. A homosexual rape presents different dynamics to the rape event, dynamics that are not well researched or documented. There are many other similarities that will become apparent. The literature presents two opposing

views regarding the conceptualization of the rape event. "There has been a growing trend to de-emphasize or ignore the sexual component of sexual assault yet a sexual assault is none other than an imposition of a sexual act on a woman without consent or on children who cannot give consent" (Becker, Skinner, Abel, Axelrod and Cichon, 1984, p. 5). Mezey (1985) disagrees and states that "by focusing on the sexual aspect rather than the violent nature of the assault, the rationalization can be made that both victim and offender are seeking mutual gratification and that the victim must in some way have welcomed or even provoked the attack" (p. 152). One view advocates for more focus on the sexual nature of the rape while the other view believes that the focus should be on the violent nature of the act.

Whatever one's theoretical or philosophical framework is regarding the act of rape, one thing is very clear; the rape victim suffers incredible loss (Becker et al, 1984, Mezey, 1985 and Rose, 1986). The female victim experiences "loss of trust in others, loss in her ability to protect herself, loss of her self-respect and sense of autonomy, her privacy, and occasionally her virginity (Mezey, 1985, p. 152). Losses may also be in the area of finances, as the victim requires time off of work and spends money on items (additional locks, gun, mace) to ensure her safety (Katz and Mazur, 1979). The victim may experience a loss of affective ties with her family, husband or sexual partner, her friends and other social support networks (Stuart and Greer, 1984), loses her trust in herself and experiences a sense of loss of "autonomy, control and mastery over ... [her] ... body" (Rose, 1986, p. 820). "Victims suffer a severe loss of sense of self and others as competent, confident, and predictable human beings, and ego functions are no longer felt to be reliable;

thus, both inner and outer worlds are filled with unpredictability and terror" (Rose, 1986, p. 820-821). The victim is said to depersonalize and dissociate in order to deal with the trauma of the rape and the loss of the 'old self' (Rose, 1986).

In addition to loss, the victim experiences the "threat of death and destruction of parts of the self" (Rose, 1986, p. 818). The victim experiences generalized anxiety (Santiago, McCall-Perez, Gorcey and Beigel, 1985), she does not feel safe in her own home, she fears men, sex, pregnancy (resulting from the rape) and fears contracting venereal disease (Katz and Mazur, 1979). In light of the AIDS epidemic, it is certain that the victim would also fear contracting AIDS, which is a direct threat to her life. Victims are said to have murderous rage which they fear to experience covertly (by acknowledging their rage to themselves) and overtly (by discussing their rage with others) as they become terrified and shameful that they will be just like the offender (Rose, 1986) should they become angry. This anger is sometimes paired with revenge (Katz and Mazur, 1979). Other effects of the rape include stuttering, changes in sleep patterns, the occurrence of nightmares, changes in eating habits, feeling worthless, being irritable, fatigued and suffering from exhaustion (Katz and Mazur, 1979). The victim may feel transparent (Rose, 1986), where she believes that everyone knows she has been raped and will react to her according to how she views herself. Greer (1975) identifies other effects such as vomiting, victims washing themselves compulsively, experience terror of darkness and being unable to leave the home. The victim is said to attempt to "play down and deprive herself of sexuality, ranging from dressing less attractively to developing anorexia, from avoidance of sexual relationships to involvement in

masochistic, promiscuous or homosexual relationships" (Rose, 1986, p. 822). The rape victim is said to experience disruption in all relationships which "add substantially to the intrapsychic losses" (Rose, 1986, p. 822).

Rose (1986) has also considered the impact of the rapist on the victim, stating that "the style and the psychodynamics of the assailant must be included in any formulation of the psychodynamics of the trauma of sexual assault" (p. 822). She also discusses the process where the rapist's defenses contribute to the victim's psychodynamics. "Projective identification, identification with the aggressor, and reenactment are central defenses used by rapists; the victim becomes both the recipient of projections of the rapist's helplessness, humiliation, pain, rage, guilt, and terror and the participant in her assault. The rape victim introjects these projections and may act upon them. Thus the rapist's defenses become contributors to the victim's psychodynamics" (p. 823).

Amanat (1984) identifies two phases rape victims experience. The first phase is the Immediate Response, also known as the Alarm Phase. The symptoms in this phase are experienced by the victim anywhere from a few hours to several weeks after the rape. The symptoms include "hyperawareness, revival of other crisis emotions, hyperemotionalism, specific physical symptoms, sleep disorders, blocking of thoughts, poor concentration, multiple fears of injury or death and sexual behavior changes" (p. 41). The second phase is the Reorganization Phase where delayed reactions from the rape are sorted out. This phase can last from three to four weeks to several years. Amanat (1984) states that the duration of this phase relies on the "personality structure and psychological development of

victims prior to the incident of rape" (p. 42). Those victims with "less intense temperament and adequate emotional support" (p. 42), require a shorter time period to reorganize themselves and their lives than those with other characteristics.

Sales, Baum and Shore (1984) examined three variables of the rape event; they are 1) the pre-assault factors, 2) the characteristics of the assault and 3) the post assault experiences. Their study presented the following significant findings. 1) Pre-Assault Factors - Younger women (age not identified) tended to experience "more acute symptoms while older women [age not identified] had fewer acute symptoms" (p. 122). However, symptoms in the younger women were of short duration while symptoms in the older women were of a longer duration. Those lacking in social supports took longer to recover and showed symptoms for a longer period of time. 2) Characteristics of the Assault - Penetration was the "strongest predictor of reaction ... [as it] ... represents the extreme of both physical domination and psychological violation" (p. 125). The authors found that "the actual violence of an attack [was] less critical to victim reaction than the felt threat" (p. 125) of impending death. Multiple assailants and threats of injury were indications that the victims would experience more trauma. However there was "no relationship between victim-assailant relationship and recovery ... [as the] acquaintance with the assailant was unrelated to symptoms" (p. 125). 3) Post Assault Experiences - The findings revealed that those victims who brought "charges against their assailant, and whose charges [held], show[ed] somewhat fewer symptoms" (p. 127). The authors suggested that having the charges hold for the assailant might have legitimized her victimization and, the writer suggests, validated her

experience. Sales et al (1984) found that those victims who were emotionally close to their family members had fewer symptoms. Family members initial reactions to the rape and the victim and the presence of a quality relationship between the victim and a male, had no impact on the rate or quality of recovery. In conclusion, the authors stress the importance of the victim's pre-rape level of functioning in the process of recovery and that their findings, although significant, does not assume causality. They state that more work is needed in order to identify causal links between the variables identified above.

TREATMENT ISSUES

To some extent, treatment issues have already been discussed according to the feminist and systemic perspectives. From reading these sections, one will note that each perspective uses a very different treatment approach from the other. Treatment issues evolve from one's perspective of a problem. How the problem is defined, determines the treatment approach. This provides the clinician with flexibility, as it is the clinician's perspective on problem etiology that will determine the treatment approach. However, this flexibility can also be a source of confusion and frustration. "Where do I go, when do I go there and what do I need to do to get there?" The following is a discussion of the treatment issues that are found in the literature. The treatment issues identified are guides to treatment and do not have 'etched in stone' status. After all, the issues identified are from the authors' perspectives of sexual abuse and are identified in this chapter to be modified by the clinician who has to make decisions about what he or she believes will be beneficial to help families. This is important to consider throughout the reading of this next section, as it will keep the clinician humble and readily available to consider a new perspective or a approach to treatment. This section will be divided into two parts. One part will discuss basic treatment issues while the second part will identify a more specific treatment approach.

Basic Treatment Issues

Basic treatment issues are those issues that the clinician has to be aware of at all times during treatment. These issues are listed below.

1) Haugaard and Reppucci, (1988) discuss the importance and influence of transference and countertransference in the therapeutic relationship. Transference is where the client becomes dependent on the therapist, as part of the therapeutic process, and works on unresolved issues through the therapist (Rioch, Coulter and Weinberger, 1976). The issue of dependency is central to the concepts of transference and countertransference, whether it be the client dependent on the therapist (transference) or the therapist dependent on the client (countertransference). Countertransference reactions are on the part of the clinician. These reactions are "evoked by the interplay of the client's behaviors and the beliefs and emotions of the clinician. This process is often out of the consciousness of the clinician and consequently may result in behaviors by the clinician that are later evaluated as having been countertherapeutic" (Haugaard and Reppucci, 1988, p. 188). Haugaard and Reppucci (1988) give an example where the clinician in dealing with the sexually abused victim either is overly protective of the child or withdraws from the child due to the child's sexualized behavior. They identify that countertransference can be beneficial to the therapeutic relationship if the clinician becomes conscious of the feelings he/she has and uses this information as an indication that others may feel this way also. Meyer (1987) states that sexually abused children now in adulthood, "strive to make you feel and react as though you are either the violent parent or the terrified, helpless child - and in some measure they always succeed" (p. 145). Ingram (1985) believes that male therapists must be very sensitive to transference and countertransference issues as most perpetrators are male.

2) The clinician must develop his/her own perspective on the issue of responsibility of the child victim, non-participants and offender for the

abuse (Haugaard and Reppucci, 1988). It is important for the clinician to deal with this crucial issue of responsibility. Is the child, non-participants and/or offender responsible for the abuse? What role does the child and non-participants play in the abuse? Both of these questions can be answered only when the clinician commits him/herself to a philosophy that 'fits' for him/her. The personal philosophy will 'dictate' the answers to these questions. (One has already noticed the great difference between the systemic and feminist perspectives about who is take responsibility for the abuse.) Regardless of one's perspective, it appears that the consensus among professionals who work in the area of sexual abuse believe that the child must know at all times that the adult is legally, morally and socially responsible for the abuse (Haugaard and Reppucci, 1988). The issue of who is responsible does not prevent others who are not responsible for the abuse to express their feelings of responsibility and to work them through.

Related to this issue of responsibility for the abuse is the issue of responsibility for maintaining an environment that is conducive to the occurrence of the abuse. Sgroi and Dana (1982, p. 199, cited in Haugaard and Reppucci 1988, p. 196) discuss this issue regarding the role of the nonoffending mother. "Women must acknowledge their own failure to prevent the incestuous behavior by contributing to and permitting the blurring of role boundaries among family members. It is difficult for most women to be held accountable in this fashion. For the mother, it is far more palatable to blame the husband entirely for the incestuous behavior and to perceive herself totally as an additional victim". Haugaard and Reppucci (1988) find this statement confusing. "The mother is not to be required to accept any responsibility for the incest but she must accept her share of

responsibility for not preventing it" (p. 197). The authors caution that this type of semantic gymnastics may leave the offender and nonoffender believing that if abuse is to occur again, it will be the other's fault. This is likely to occur if the parents have not addressed their own issues of responsibility. Haugaard and Reppucci (1988) advocate for "approaching each case without preconceived notions about the roles played by the victim, perpetrator, and family, or about the responsibility that the child and adults perceive they have ... This should increase the chance that the clinician will be able to understand the dynamics of each case and consequently provide the most effective treatment to each client" (p. 197).

3) The effects of the disruption on family patterns need to be addressed. Faller (1988) discusses the need to be sensitive to what happens to the role of the offender in the family. He looked at issues such as how the missing role is managed, if someone took the place of the offender, to determine what purpose the role served in family functioning and how the family regained homeostasis after the abusing role was withdrawn. In addition to being sensitive to the changing role of the offender, it would also be important to be sensitive to the changing roles of the entire family and to be aware of how these changing roles are accepted (with resistance or with 'open arms') by each family member.

4) Finkelhor (1984) addresses four questions when working with intrafamilial child sexual abuse. These questions are: i) "Why does a person find relating sexually to a child emotionally gratifying and congruent? ii) Why is a person capable of being sexually aroused by a child? iii) Why is a person blocked in efforts to obtain sexual and emotional gratification from

more normatively approved sources? and iv) Why is a person not deterred by conventional social inhibitions from having sexual relationships with a child? (p. 37). Finkelhor (1984) states that questions i) through iii) address how one develops an interest in the child while question iv) looks at how that interest is transmitted into action.

5) Crisis intervention principles will be used throughout the work with these families. "The general goal of crisis intervention is to return the person or family to their level of functioning before the crisis developed" (Haugaard and Reppucci, 1988, p. 217). However in child sexual abuse, the family's 'level of functioning before the crisis developed' is not an appropriate state to which to return. There needs to be some work done with the family to help them deal with the many emotions and various responses to the crisis, and it is hoped that the family would return to a more healthy level of functioning. Sesan, Freeark and Murphy (1986, cited in Haugaard and Reppucci, 1988) provide goals for crisis intervention with families who are dealing with child sexual abuse. Their crisis goals include, "giving permission for the family to discuss the abuse, exposing previously unexpressed fears, allowing ventilation of feelings, putting the abuse and the effects of the abuse into proper perspective, exploring the reasons for the child's vulnerability to sexual abuse and beginning to lessen the vulnerability, and planning future therapeutic work" (p. 218). Putting the abuse into proper perspective would be influenced by the clinician's perspective on abuse. The 'proper perspective' for a systemic and feminist clinician would be very different. (This provides further evidence that one needs to develop their own perspective on child sexual abuse in order to interpret vague directives in the literature like 'putting the abuse into

proper perspective.) "Indications that the crisis intervention has been successful include: the family has an accurate perception of what occurred and of the possible effects on the child and family, the affect is being properly managed in that individuals are aware of their feelings and these feelings are being discharged appropriately; and the family is seeking and using the help that is available" (Simrel, Berg, and Thomas, 1979, p. 218).

Bolton and Bolton (1987) discuss the need for the clinician to provide concrete crisis services. The authors refer to assisting the family to secure financial support (should the breadwinner be removed from the family and have total control over the finances), to be available to the family twenty-four hours a day, to do things for the family that may not be considered 'purely' counselling services and to advocate for the family and its members, in order that they receive the necessary community services. In general, Bolton and Bolton (1987) believe that the clinician's crisis response should be to help the family deal with issues that are needed for their survival, whether those issues be of a psychological (intangible needs) or material (tangible needs) nature.

Moos and Schaefer (1986) identify five adaptive tasks that an individual should complete when faced with life transitions and crises. These tasks are to be completed in the order in which they are identified. 1) "Establish the meaning and understand the personal significance of the situation" (p. 10). 2) One must confront reality and respond "to the requirements of the external situation" (p. 11). 3) "Sustain relationships with family members and friends as well as other individuals who may be helpful in resolving the crisis and its aftermath" (p. 11). 4) Preserve "a reasonable emotional

balance by managing upsetting feelings aroused by the situation" (p. 12). 5) Preserve "a satisfactory self-image and ... [maintain] ... a sense of competence and mastery". (p. 12). Moos and Schaefer (1986) state that task completion depends on one's personal characteristics, the nature of the stressor and the unique set of circumstances that surround the stressful event.

6) Sexuality is another basic treatment issue due to it being the central theme in working with intrafamilial child sexual abuse. Ficher (1976 in Oaks, Melchiode and Ficher, 1976) states that "sexual problems are frequently the presenting symptom in a discordant marriage and the symptoms have different meanings for each individual" (p. 81). It is important to look at each partner's fears, needs, expectations, conflicts from past sexual experiences and the "influence of cultural norms of the society in which he lives" (p. 81). Ficher (1976) suggests several causes for sexual dysfunction, such as anxiety, fear of failure, guilt and shame, sexual ignorance, religious restrictions, poor self-esteem, unrealistic expectations, intrapersonal conflict, poor communication and "excessive need to please the partner" (p. 82).

Treatment Approaches

In review of the literature, it appears that treatment of intrafamilial child sexual abuse follows the order of individual, dyadic and family work. Individual and dyadic work are seen as being important to the success of future treatment (Haugaard and Reppucci, 1988). Due to the high level of need of the victim, nonoffending and offending persons, individual and dyadic work are seen as the best avenue to discuss issues that relate specifically to the individual or dyad. In all work with individuals, dyads

and families, the clinician needs to build a trusting relationship with the client. "A primary task for the therapist is the creation of a safe, secure therapeutic environment so that an intimate, trusting relationship can develop" (Ingram, 1985, p. 177).

Individual Treatment with the Victim

Individual work with the victim would initially focus on the beliefs the child has in regards to the reason the child is in therapy. Any misconceptions and faulty thinking needs to clarified at this time. The child also needs to know how the experience with the clinician 'fits' into the whole picture of community services involvement. The clinician needs to identify his/her role for the child, as some things the clinician may say to the child may impact on the child as other workers in different capacities or the offender may have said the same thing (Haugaard and Reppucci, 1988). Clarifying the role of the clinician helps the child to build a framework in which to interpret the responses of the clinician. It is also important to be aware that otherwise neutral behavior and objects may have special meaning for the child. "An initial task of the therapist is to have the client focus on the present experience as it relates to the sexual abuse ... the client's perceptions surrounding the abuse are more important to process than the attempt to achieve historical accuracy" (Ingram, 1985, p. 178). Ingram (1985) states that the clinician needs to consider the following issues when discussing the abuse with the child: "[the] duration; age of onset, frequency; covert or overt, did the family know about the incest; identity of perpetrator; victim's consent or coercion in the abuse process and [the] use of force" (p. 178). The

abuse needs to be explored and not ignored. The child needs to know that she can say no to undesirable approaches.

It is important to investigate with the child their beliefs about him/herself, others and the abusive situation (Newberger and De Vos, 1988). Newberger and DeVos (1988) discuss how one can investigate the child's cognitive process. They identified four areas in which to direct clinical attention. These areas are: i) locus of control - This is where the child assesses whether "the causes of successes or failures ... [are] within or outside his or her control" (Newberger and DeVos, 1988, p. 509). ii) perceived confidence - The clinician is to assess whether the "child's expectation of being capable of achieving desired outcomes in areas appropriate to his or her control" (Newberger and De Vos, 1988, p. 509), iii) interpersonal problem solving - The clinician is to assess the "child's ability to generate solutions or strategies for action for use in achieving desired outcomes to interpersonal problems" (Newberger and DeVos, 1988, p. 509), and iv) interpersonal perspective-taking - The clinician is to determine the "child's capacity to consider the perspectives and intentions of others, as well as other's perspectives on the self" (Newberger and DeVos, 1988, p. 509).

The child will need to have an opportunity to become aware of, express and discharge feelings of distress, whether that be in form of anger, anxiety, depression, fear, guilt or aggressions (Newberger and De Vos, 1988 and Haugaard and Reppucci, 1988) that are directed toward themselves, their parents and/or the offender. The expression of these and other feelings need to be explored through action. Sitting down with a child to discuss the issue of sexual abuse, as one would an adult, is ineffective. The child

appears to need the security of an activity to assist him/her in expressing feelings. Other issues to explore with the child during individual sessions are those identified previously in the characteristics of the sexually abused child; issues such as feelings of rejection, worthlessness, insecurity and low self-esteem. Attention will need to be given on how to manage the child feelings and behavior at home, at school and in the community. The child will also need an opportunity to question why she was chosen as a victim (Haugaard and Reppucci, 1988). This may have some link to the child feeling responsible for the abuse.

Damon, Todd and MacFarlane (1987) discuss the issues of treating a young child who has been sexually abused. They focus their interest on age three to six year olds. Although the information is age specific, it is important to keep in mind the developmental issues that influence the treatment of children. Damon et al (1987) state that the difficulty working with this age group (three to six year olds) is that they are not cognitively advanced and have difficulty understanding the motives of the adults trying to help them. Verbal limitation, due to their age and the affects of the abuse, reinforces secrecy and avoidance. Structured and a direct therapeutic approach is said to work best. Damon et al (1987) discuss the issues of denial, repression and retraction, which all hinder the disclosure and treatment of the child. The child is said to need the safety of distance from the event and therefore indirect measures such as play and metaphor work (TAT drawings) are effective. The child's phase of cognitive development is another difficulty encountered by the clinician. For example, children at this age are ego - centric, the world revolves around them and they magically control the environment. Discussing the issue of responsibility, where one tries to clear

the child from feeling responsible, is very difficult. In addition to being ego -centric, children at this age have many fantasies. Their fantasies involve the offender being angry with them and they worry about perpetrator retaliation. Damon et al (1987) advocate for parental involvement when dealing with children at this age. Parents need to be brought into therapy to be nurtured so they can learn how to nurture the child. Also parental involvement is needed when the therapist wishes to address issues with the child that may ethically require parental knowledge or consent; issues such as sex education and self assertion. As a final note, Damon et al (1987) state that children at this age, and at any age, are easily swayed by suggestive questioning. The clinician has to be careful not to 'put words in their mouths' in terms of how they are feeling and the incidents that occurred.

Sink (1988) has developed a hierarchical model for the evaluation of child sexual abuse. Sink believes that there are four levels in which intervention could occur. The levels are on a continuum and go from level one (most certain abuse has occurred) to level four (least certain abuse has occurred). If the child presents at a level one, direct communication and involvement by the clinician is required, that is, the sexual abuse is discussed directly. Level two requires indirect communication such as through the use of play therapy, where a supportive, safe environment can be structured in order to help the child disclose the abuse. The third level is referred to as "Acute Traumatic Symptomatology". Sink (1988) states that "often the implications of the trauma in the child's mind are revealed well before specific abuse is disclosed" (p. 134) and their is a need to spend time with the child to work symbolically through the abuse via play therapy. The child at this level needs time and a safe environment to remember the incidents of the abuse.

Level three is different from level two as in level two the child has the information or details about the abuse but does not feel safe to disclose them, while a level three child does not have memories of the abuse immediately available for recall. A child at level four is one who has dissociated him/herself from the abuse and its affects. Questioning the child about the abuse is said to ineffective. Sink (1988) recommends that therapeutic intervention focus on building a trusting supportive relationship with the child and to make statements to the child that abuse can and does occur and that abuse can be talked about. These children are said to require long term work before they are able to disclose the abuse and begin to deal with the issues.

Individual Treatment with the Nonoffending Person

"The amount and type of individual treatment for the mother will be influenced by a) her current emotional state, b) the assessment that the clinician makes about the mother's role in the family and in the incest, c) the current structure of and future plans for the family, and d) the mother's inclination and ability to be a source of support for the victim" (Haugaard and Reppucci, 1988, p. 247). The nonoffending person (usually the mother) will need assistance in dealing with family relationship issues and the aftermath of the abuse (Haugaard and Reppucci, 1988). Part of the mother's response to the abuse may be the disclosure of her own victimization in her family of origin. If this is the case, her victimization needs to be dealt with before she can deal with other issues concerning her child's victimization. The feminist approach to the mother, as identified previously, would be advantageous to implement at this time.

Individual Treatment with the Offending Person

It cannot be emphasized enough that one's clinical direction to treatment will depend on one's perspective of the etiology of the abuse and the roles that the family members played in the abusive relationship. Incest may be caused by "dysfunctional family systems, lack of societal standards, inequality between the sexes, or the pre-existing psychopathology of the father" (Haugaard and Reppucci, 1988, p. 250). The following are treatment issues addressing these various perspectives.

In reference to a psychopathological etiology, the offender's behavior "involve[s] preoccupation with one's own fantasies, wishes and needs, a lack of empathy for others, and a desire to control and dominate others rather than to engage in mutual relationships" (Herman, 1988, p. 702). Herman (1988) believes that this type of offender is usually incarcerated and account for "perhaps one percent of the total" (p. 701) number of offenders. Behavioral techniques appear to be used with this population. An example of a technique used "involves pairing aversive experiences with fantasy or pictorial representations of inappropriate sexual stimuli, such as verbal descriptions of sex between an adult and a child or pictures of nude children, and thereafter presenting appropriate sexual stimuli, such as pictures of adult nude women, with no aversive stimuli" (Haugaard and Reppucci, 1988, p. 255).

Feminist and systemic treatment with offenders have already been identified earlier. These would address the issues of social inequality between the sexes and lack of societal standards (feminist) and the issue of dysfunctional family systems (systemic).

Herman (1988) identifies another framework that can be used in working with offenders. Herman's model of addiction is based on the belief that "greater social latitude and tolerance accorded to antisocial behavior in males ... fosters addiction. [Males are said to lack] emotional resources of intimacy and interdependence ... [and therefore become more] ... susceptible to developing dependence on sources of gratification that do not require a mutual relationship with a human being: the bottle, the needle, or the powerless, dehumanized sexual object" (p. 711). The sexual offender has developed a dependence on sexual gratification which becomes addictive. His need to have a 'fix' is at the cost of another as sanctioned by society. Herman believes that if the pattern is established at an early age, the pattern will be harder to break than if it was established later on in one's development. Early sign of sexual addiction in adolescents are usually denied or overlooked and believed that the adolescent will 'grow out of it'. Herman (1988) describes the offender as going through a "cyclical pattern of altered mood and behavior" (p. 713) and that this altered mood is not within conscious control. Sexual fantasy may be triggered by external or internal stimulus followed by a craving to experience the fantasy. The offender is said to have a trance-like excitement which is "heightened by risk and danger" (p. 713). The offender is on a 'high' during the anticipation phases of satisfying his craving, yet afterwards feels "fear, disgust, depression and remorse, coupled with a short-lived resolve never to repeat the act" (p. 713). The offender uses control only when he perceives external controls that may result in a negative consequence, such as being 'caught in the act'. All offender relationships are "sacrificed or manipulated in the service of this activity" (p. 713). Anyone working with this type of offender

must realize that the offender has no "reliable internal motivation for change" (p. 715). Therefore focus of treatment is to provide the external controls for the offender, such as involving and maintaining legal involvement. Treatment also considers breaking the cycle of addiction by confronting offender denial and rationalizations. Behavior modification and medication is advocated in order to weaken the intensity of desire. Herman (1988) discusses the need for the offender to acknowledge his sense of powerlessness over the addiction, to encounter himself, to provide public testimony of his wrong doing, apologize to the victim and to accept responsibility to work with others who have the same problem, when his treatment is completed. The 'stages of recovery' are very similar to those used by Alcoholics Anonymous. When the offender has not abused for three years, he is considered a graduate of the program but is by no means cured. Herman states that one can never be cured of this addiction. In addition, individual sessions with the offending person should include determining if the offender has a substance abuse problem and ensuring treatment will be provided (Haugaard and Reppucci, 1988).

Dyadic Treatment with Family Members

Dyadic work in the family focuses on the following dyads; the victim/mother, mother/father, and father/victim. Dyadic work between the victim and mother is to encourage them to share their feelings about the abuse and the family in general, with the preferred outcome of strengthening the bond between the child and the mother (Haugaard and Reppucci, 1988). At this time, the child will have an opportunity to express her feelings about the mother (which will include anger due to the mother not protecting the child)

and to begin redefining their relationship, putting the necessary structure within the dyad to ensure protection of the child and the mother's accountability to the child. Giaretto (1982) believes that is essential to "cement and enhance the mother-child bond" (p. 35) in order to begin family reconstruction. It is believed that the child will defeat the father's attempts to "establish his function in the family is she [child] feels insecure about her relationship with her mother" (Giaretto, 1982, p. 35). It is this maternal support and relationship that has the greatest calming effect on the child.

Dyadic work between the mother and father "helps them to explore their emotional reactions to each other especially the anger that occurred both before and after the incest" (Haugaard and Reppucci, 1988, p. 297). It is a chance for the mother and father to discuss issues regarding the abuse and other issues that have not been discussed earlier due to their strained relationship. This time is not necessarily geared toward assisting the mother and father to reconcile, rather it is a time to help each of them explore issues in their relationship. The end result of this exploration may be that the couple or one partner may want to terminate the relationship. This is not considered a failure of treatment. "Strengthening the marital bond and parental role" (Haugaard and Reppucci, 1988, p. 297) may not be in the best interest of the family or the partners involved in the relationship. Dyadic work with the couple is an opportunity for the couple to discuss issues of concern in a safe, nurturing environment; the sexual abuse of the child being one of many issues. Parenting education is advocated by Swan (1985) and Bolton and Bolton (1987). Education would focus on helping the parents set appropriate boundaries (in order to avoid situations like role reversal in the future), to work at developing empathy for the child, being aware of what a

child at a particular developmental stage requires and improving their communication with their child. Parents may need to deal with their own pain, anger and disappointment left over from their childhood years before they can deal with their issues of parenting their children (Swan, 1985). Dyadic work with the parents is an opportune time to discuss issues of sexual satisfaction and their ability to maintain an intimate relationship (Swan, 1985).

Dyadic work between the father and victim is implemented to "allow the father to apologize to his child" (Haugaard and Reppucci, 1988, p. 297). This is not an opportunity for the child to forgive or have pity on the father (Haugaard and Reppucci, 1988). The father is to take responsibility for the abuse (an issue that was addressed in individual sessions) and to 'free' his child from this responsibility in order for the child to begin the process of healing the wounds caused by the sexual abuse.

Family Treatment

Before engaging in family treatment, the victim must be ready and feel safe to engage in the family process. Individual and dyadic treatment modalities are to prepare and assess the child's, and other family members', level of comfort and ability to engage in family treatment. Readiness of family members would be measured in terms of how available they are to discuss family issues in an appropriate manner, a manner that would not be abusive to any family member. Family members may not be ready to engage in family treatment if they have not dealt with issues of individual or dyadic importance. These unresolved issues would interfere with their ability to engage in family work. When doing family work it is important to be

sensitive to the issue of whether this family wishes to stay together or separate. Family treatment will focus on dealing with loss and separation issues, creating a new family form and dealing with family members' unspoken feelings and hostilities about the separation if the family was not to reunite (Haugaard and Reppucci, 1988). Families who work toward remaining together or reuniting have other issues to deal with, as identified below.

Generally speaking, the literature presents family treatment within a systemic framework. (See systemic intervention for more details.) Family treatment is said to be increasingly advocated with intrafamilial sexual abuse due to the incest being seen as a symptom of the dysfunction within the family and not only due to individual pathology. Therefore systemic issues such as the role of incest in the family is discussed along with establishing a strong parental coalition, a clear hierarchy of authority and firm boundaries between the parents and children (Haugaard and Reppucci, 1988). Eist and Mandel (1968) identify other issues to discuss, such as improving communication within the family system, dealing with the family's guilt, anger and other feelings directed at any member of the family or the therapist, and to decrease social isolation.

The sexual abuse needs to be discussed within the context of the family in order for everyone to be aware of the situation. Awareness is said to break intergenerational collusion (Ingram, 1985) and secrecy. By being aware of the abuse, other family members will be able to see the affects of the abuse on the child victim (which promotes empathy for the child) and others also learn how to foresee a potentially dangerous situation and protect

themselves against unwanted sexual advances in the future. Details of the abusive experiences should be disclosed including the type of abuse, over what period of time the abuse occurred and what actions the offender did to coerce or 'encourage' the victim to participate in the abuse. In addition to this, the family members should be informed of the affects of the abuse on the child victim, each family member should have an opportunity to discuss how the abuse has affected them and should hear the offender take full responsibility for the abuse and apologize to all family members for jeopardizing their feelings of safety and security. The mother and father, should inform the family members what they intend to do to change the situation and to protect each family member from further violence of any kind. The parents need to show the children that they will be accountable to them and for their safety.

In the treatment of intrafamilial sexual abuse, the use of individual, dyadic and family treatment are used. This approach is not specific to sexual abuse and is seen while working with other problems that affect family functioning, within an eclectic framework. What is different about this approach in the treatment of sexual abuse is that the individual and dyadic treatment is used for safety reasons, where the individual or the dyad can discuss relevant issues particular to them and not be afraid of retaliation by the offender or any other members of the family. The issue of safety appears to be the only issue that differs from the use of this approach with sexual abuse and other family problems.

The literature and professional community tend to 'map out' a special area for family violence. This is beneficial, as family violence has previously not

been dealt with adequately. 'Mapping out' a special area for family violence will increase the awareness in various social spheres; such as in the professional community, society and in our own families. However, by 'mapping out' a special area there is also a chance that the treatment of family violence will become so specialized that it is only within the domain of a choice few who are 'the experts' and who operate within the 'choice' treatment approach. Should this be part of the effect of making family violence a 'specialized area of work', family violence intervention may become mystified to other clinicians who do not have the 'choice few' or 'expert' membership. Unfortunately, this effect (believing there are the elite experts and there is one 'proper' way to deal with family violence) is seen in the literature and within the professional community. Upon review of the literature, there is nothing mysterious about the intervention in family violence cases. There are no 'experts' in this area and there is no 'choice' intervention. This type of family has special needs as all families do, and there are certain issues, identified previously (such as the no violence contract) that would be enforced in a violent family that may not be a part of the standard intervention with all families. However that does not mean that the no violence contract cannot be a standard intervention with all families. This is important to mention as the approach to this practicum is not concerned with knowing the 'choice treatment', rather is interested in using the information provided in this literature review to develop an approach that is effective, considering the developmental stage the clinician is at in working with intrafamilial child sexual abuse. It is not the plan of this practicum to replicate a treatment approach, because there are many treatment approaches. Instead the plan is to work with the literature to

guide, not direct, the work to be done in this practicum. This approach to treatment will provide the richest learning experience.

INTEGRATION OF SYSTEMIC AND FEMINIST THEORY

The theory behind Systemic and Feminist philosophies have been discussed previously. It is clear that one theory differs from the other. These theories provide a philosophical framework that guides intervention but also advocates for the use of specific interventions. I do not believe that the clinician has to pledge allegiance to either theory when working with family violence. There is a place for both theories and interventions. The following is a report on how I have benefitted from the two theories when working with intrafamilial sexual abuse.

The first thing that needed to be done was to determine what clinical role to play with the families in this practicum. It was decided to take a feminist, or linear approach to family members. Each family member was given the opportunity to discuss their thoughts and feelings and validation occurred unconditionally, except when any family member blamed another for the stress within the home. This means that an attempt was made to understand the identified offender and to view him or her as a previous victim of abuse. Past or recent abuse was not condoned. It was believed that even the identified offender needed the support and nurturing that the victim and non-offender received. After all, it is the offender who plays a key role in helping the victim resolve or deal with the trauma of the abuse. His participation is essential and will usually not be obtained initially through blaming or coercion. Although the feminist theory encourages clinicians to understand the plight of people and to not become entangled in social stereotypes, the feminist approach fails to understand the importance of connecting with the offender and not just demanding that he be accountable for his crime and that he become re-educated. The clinician's

role in this practicum was not to investigate the allegations. Responsibility for investigation was left with Child and Family Services. The responsibility for deciding whether the non-offending parent should leave the offender was left with the non-offending parent. This is contrary to Gordon (1986) who stated previously that one of the goals of individual therapy with the non-offending parent (mother) was to empower her to separate from her abusive partner.

Once an opportunity for validation and empowerment was given to all family members, it was determined to consider what dynamics maintained the abusive relationship. This practicum was not going to honor the belief that each player in an abusive situation (victim, non-offender and offender) needed to be isolated with their own kind (ie. mothers groups and daughter's groups) and that this isolation is the best and virtually the only treatment that needs to be done. It is important that each member of the family (including non-involved siblings) have a chance to discuss with others how this experience has effected them. This may be done in a group setting, however group work is not the end of therapeutic intervention.

Abuse involves at least two people; the abuser and the victim. When there are more than two people in a household, there are more linkages to look at. All family members appear to want to know how the abuse happened and what they could have done to prevent it from occurring. The family requires tangible, concrete information in order to really prevent abuse from re-occurring. To give a family an explanation about the power imbalance in society, provides them with some reassurance that abuse is a social problem and not just a problem within their family. However this intervention does

not offer the family tools or cautions in order to avoid further abuse. A systemic approach is required. Abuse does not only affect the offender and victim and is therefore not only a victim and offender issue. It is a family issue. Family members need to know how they are entangled in the violence in order to prevent becoming entangled in the future. The systemic approach is the only approach that can identify patterns and provide people with the insight that is needed to prevent a reoccurrence. For example, in one family with which I worked, the parents found that they had given their child very conflicting messages about his responsibility to his sibling and provided no avenue for the child to receive clarification on this message. This small pattern was part of the overall dynamics that lead to the child offending on his sibling. Once the parents were aware of this pattern, they were able to provide clearer messages to their child. This was one step that the family took to protect its members, offender and victim alike.

Generally speaking, any problem involves at least two people. Resolution of the problem therefore requires at least two people. From this practicum experience, it is clear that in order for one to find true empowerment and to change the status quo, in order to leave happier and freer lives, the best way to do this is within the relationship that the problem manifest itself. We all bring baggage with us from our family of origin. We all deal with this baggage through others. If we want to get rid of the baggage what better place to do it than the place the person felt comfortable enough to disclose or try to deal with the baggage. This translates into intervention in the following way. Let's take for example a non-offending mother who wants to leave her offending spouse. Both people carry baggage with them and have transferred these unresolved issues on to other family members. There will

never be a better opportunity to help each person to deal with their baggage. The couple should be seen with the intention of resolving some of their issues. If this does not happen with this context (as it is within this context that each partner choose to deal with their unresolved issues) then the clinician will be helping both partners remain victimized by these unresolved issues and maintain the partners status quo. Therefore, the next relationship they are in, the same dynamics will surface. How can the clinician say that he or she has helped?

Feminist theory adds a very humane side to therapeutic intervention, considers wider social issues and rightly questions the status quo. All people need to be validated and considered worthy. The systemic theory looks at the patterns of behavior that are crucial in preventing particular patterns of behavior to re-occur. There are writers such as Dell (1986), Willbach (1989), Bograd (1984) and Schechter (1982) who believe that systemic theory is not appropriate for dealing with family violence. Many other writers also believe this and believe that the feminist approach is the only approach to working with family violence. The integration of these two theoretical and philosophical frameworks have provided great therapeutic results as evident when reviewing the pre and post treatment measures. I will continue to use both theories of intervention. They are not mutually exclusive.

PERSONAL PHILOSOPHY REGARDING INTRAFAMILIAL CHILD SEXUAL ABUSE

Bolton and Bolton (1987) have identified the need for practitioners to develop their own philosophical and theoretical framework before working with families where intrafamilial child sexual abuse has occurred. The purpose of this section is to identify that framework in which I will be working with families. It is acknowledged that this framework will be modified as my philosophy, knowledge and skill develop in the area of intrafamilial child sexual abuse.

The responsibility of sexual abuse falls squarely on the shoulders of the offender, regardless of the situation under which the abuse has occurred. The patterns of behavior that are seen to 'maintain' the abuse are symptoms of the dysfunction family system. However, this does not imply that the dysfunctional family system is directly responsible in any way for the abuse. Yet, the dysfunctional family system needs to be addressed. The family needs to know that there are certain things that they can do that will prevent their victimization in the future. This is considered a preventative measure and not an issue of the family taking responsibility for the offender's behavior. The family members should be taught how to make choices about their family environment should they be faced with another violent experience; choices that protect them from further abuse. The emphasis is on teaching and nurturing and not on forcing or implying the issue of accountability or responsibility. If family members do not address the patterns of behavior that could leave them or others vulnerable for sexual abuse, it is believed that family members would not feel that they had any control over protecting themselves from future abuse. It has been

noted where this lack of knowledge of behavior patterns has contributed to and maintained feelings of victimization. There appears to be a fine line between family members acknowledging the dysfunctional behavior patterns in the family and taking the responsibility for them. In intrafamilial child sexual abuse, family members will need to be taught the difference. Due to some family members feeling guilty for the sexual abuse, it is anticipated that nonoffending family members, rather than offending family members, will attempt to accept responsibility for the abuse. Although nonoffending family members are not responsible for the abuse, it is necessary to allow them to express any feelings they have about feeling responsible or accountable for the sexual abuse and to redirect this guilt and other feelings on to the offender. Although the mother is not responsible for the abuse, it will be necessary for the children to express their feelings to their mother regarding her inability to protect them from the offender.

Both parents are responsible to ensure that their children are safe, protected, have good parenting models and are given a nurturing environment in which to develop. Also, both parents have the responsibility to deal with marital issues and to not subject their children to the related stress. In general terms, parents are accountable to their children to fulfill the role of caregiver. Considering the information on family dynamics presented previously, the children are not safe, not protected, do not have good parenting models, are not given a nurturing environment and are not protected from the stress of the marital situation (in fact the children are brought right into the marital relationship). In this light, both parents are responsible for the environment they have provided their children. However, this environment is not the offender. It is the individual who

abused who is the offender. It is not questioned that the living environment may have 'encouraged' the abuse, but it is not responsible for the abuse. Consider this for a moment. If a mother physically abuses her child, there is no discussion about the peripheral father taking responsibility for the mother's abuse of the child. The father taking a peripheral position in the family may have contributed to the mother's sense of isolation that may have resulted in child abuse, however the father did not physically abuse the child. The abuser (in this example, the mother), needs to accept responsibility for her behavior and her response to what may be a very isolated and oppressed living environment. However, believing that all individuals make choices (ie. to stay in or leave an abusive environment), the mother in this case is to be held responsible for her actions. In the same way, a father who sexually offends on his children, is the only one to be held accountable and responsible as he, not the family or any individual within that family, made the decision to sexually abuse.

There is some discussion in the literature about the possibility of the mother, or nonoffending parent, being consciously or unconsciously aware of the abuse (Rist, 1979). It is a useless exercise to determine whether the mother was consciously or unconsciously aware of the abuse. For how does one tap unconscious thoughts when there is great difficulty tapping conscious thoughts. If the mother states that she was aware of the sexual abuse, then this issue will be dealt with, however if the mother states that she was not aware of the abuse there should be little if any energy spent on determining this. Should the nonoffending parent be aware of the abuse and not admit this, the denial mechanisms used will surface in other areas of treatment and will be addressed through other issues. If the mother is aware of the abuse,

she is to be held accountable for not protecting her child, as mentioned earlier. However she is not to be held responsible for the sexual abuse of the child. Some may have difficulty believing that the mother should be held accountable for not protecting the child. As a parent, it is their role and responsibility to protect. As most offenders are male, it requires the female adult (mother) to act on behalf on the child's best interest. Apart from the male adult, the female adult is the only other adult that can protect the child. Unfortunately, due to most offenders being male, the female adult is left with the enormous job of dealing with the aftermath of abuse and is 'made' responsible by social services to protect the children from the male adult.

Strengthening the parental subsystem is considered important providing the parents wish to stay together after they work out their issues regarding the sexual abuse. However, the manner in which strengthening is done is far more crucial. In terms of strengthening the parental subsystem, it would be important to look for the ability of the subsystem to communicate, negotiate, work out their difficulties within the boundaries of the subsystem and to meet each others adult needs. However, strengthening also implies strengthening this subsystem to allow for and encourage individualization and differentiation. Considering the characteristics of the offender and non offender, both need to be empowered and to express their individual power in a healthy manner. Therefore, part of the work with these families will be to strengthen the marital subsystem through the awareness and respect for individual differences, needs and choices. Within this framework, it is necessary to address the issue of gender sex roles within the subsystem, for individual differences, needs and choices will be influenced by the sex role beliefs of oneself, one's family of origin and society.

The family system will need to be restructured. Instead of family life centering around the patterns of violence, there will need to be the implementation of healthier patterns that are not so costly (in terms of emotional, psychological, physical and social costs) to all family members. It is obvious that sexuality will need to be addressed in terms of the marital subsystem and the family in general. However prolonged focus on issues of sexuality may, to some extent, maintain the family in their present mode of sexualized functioning.

Both systemic and feminist approaches acknowledge the impact of abuse on the whole family system, however there is no information regarding the need to address issues pertaining to the sibling group. Dyadic and group work are identified for the mother, father and the victim, yet no attention has been directed at sibling group issues. For the systemic approach, in particular, this is a gross oversight. Systemic therapists may believe that by strengthening the parental subsystem, the sibling subsystem will also be strengthened. However, considering the incredible level of need of all family members and the length of time it takes to help strengthen the parental subsystem, one cannot 'leave it to the chance of theory' that sibling subsystem issues will somehow be resolved. In some cases, the marital subsystem does not change or may even break up. The children need specific focus to help them work through the issues of the abuse and their abusive family relationships and environment.

In reference to the concept of balance in family functioning, it appears somewhat dangerous to help the family regain a sense of homeostasis if that balance will be detrimental to any of the family members. The feminist

approach uses underlying principles (such as, no one deserves to be abused) when helping the family deal with the sexual abuse. On the other hand, the systemic approach tries to be 'value free' and to 'go with' the family to create a balance. This aspect of the feminist perspective appears better suited to working with family violence than does the neutrality concept of the systemic therapist. In addition to this, there is some debate whether the family should learn how to cope (adjust to the situation for the survival of the family) or learn how to change the family situation to promote survival. The feminist approach advocates for change and implies confrontation of family values and beliefs while the systemic approach focuses on helping families to adjust, in order to create a (survival) balance. In family violence a balance is probably least likely to occur due to the impact of disclosure. Any stability of the family unit is usually short-lived until there is a meaningful change in, and not adjustment of, family members. Therefore this practicum would advocate for change.

Swan (1985) states that one should not focus on the child victim while doing family work and should just look at restructuring the family system. Brickman (1984) states that the child victim should play an important role in determining the appropriate levels of comfort in the family. Both of these approaches are not satisfactory. Not focusing on the child and related abuse issues, condones the abuse and minimizes the impact of the sexual abuse on the family. Although the other extreme, giving the child equal power as the parents in the family, works contrary to the existence of and need for a family hierarchy. The lack of a parental hierarchy was one of the reasons believed to promote intrafamilial abuse. Equal power between parents and child blurs boundaries, boundaries that are necessary for healthy family

functioning and family security. It is important to acknowledge the impact of the abuse on all family members and to assess the parents' ability to use power in a healthy manner. Teaching the child how to protect herself against further abuse is certainly necessary yet to encourage the family to give the child and parents equal power only promotes family destruction. If the child needs such power to survive in the family environment, she should not be residing with the family.

Feminist and systemic theory identifies their approach to the family. The feminist value cooperation, mutuality and an equal power base between the client and therapist. However this approach may not be in the best interest of the family. To some extent there needs to be some cooperative or mutual perspective between the client and the therapist. However, based on the profiles of the victim, mother and father, the therapist needs to take a nurturing control position with the family. In this way the therapist can model accountability, nurturance, protection and other healthy patterns of behavior.

INTERVENTION

i) Clients

The clients were families where a child had been sexually abused by a family member (intrafamilial sexual abuse). The offender could be a parent (including step-parent), a sibling, cousin, aunt, uncle or any member of the family of origin. Clients were referred from Eastern and North West Child and Family Services.

ii) Setting

All clients were referred to Psychological Service Centre (PSC). All client meetings were conducted at PSC unless meetings that involved the family's social network. In that case, these meetings were held at the most convenient location. The PSC was the best place for this practicum due to its audio-visual and one way mirror viewing equipment, it is within the University of Manitoba structure which allowed for greater access to other university professors for consultation and PSC is a recognized professional community service. It also gave the student the protection of malpractice insurance.

iii) Personnel

Committee members were used as resources along with other personnel at PSC and the University. Walter Driedger, advisor, and Elizabeth Hill, committee member, were responsible for case supervision. Marjorie Gazan, the third member of the committee, was kept abreast and consulted with on a regular basis. Also, Eastern and North West Child and Family Services staff were used as resources for case consultation.

iv) Procedures

The following is an outline of the procedure that was implemented for this practicum. The procedure outlines the general approach to working with families and the measures and assessment tools used.

Stage One - Introduction to the Family

A. Case Conference with the referring agency and other involved agencies.

Purpose: - to exchange information about the family and to identify the expectations the involved agencies had of the student's work with the families.

- to determine the role responsibility for each service provider involved, particularly in terms of the legal issues with each case.

B. Introduction of Worker to the Family by the Referring Agency

Purpose: - to discuss expectations of the family

- to discuss with the family the reason for referral

- to inform the family the nature of my work and the limitations to our involvement (ie. time factor).

C. Assessment of Family Functioning and History of Sexual Abuse

Purpose: - to complete an assessment of the family with the assistance of the following tools and measures.

Tools:

i) McMaster Model of Family Functioning

ii) Genogram, ecomap and a Social Network Inventory

Measures:

iii) Family Assessment Measurement Scales - General and Dyadic Scales

iv) Children of the family to complete the Index of Self Esteem

v) Parents to complete the Index of Sexual Satisfaction

The history of sexual abuse was explored with the family along with each available family member's perception of the abuse and previous counselling they have received due to the abuse and for any other reason. Once the initial assessment of the family was made (realizing that assessment occurs on an ongoing basis) the treatment approach was determined. Individual, dyad and family sessions were held during the assessment phase to ensure family members' safety, to address issues of individual importance and to negotiate a non-violence contract as a means to prevent abusive behavior between family members. Also, suggestions of what family members could do if they feel they will abuse or be abused was addressed.

Stage Two - Treatment

The treatment approach differed with each family, however the general process was as follows.

A. Negotiation and Treatment

The identified treatment plan was negotiated with the family.

B. Treatment Implementation

Once the need for individual, dyadic or family work was determined and agreed upon, the work began. The general structure for individual and dyadic sessions have already been identified by Haugaard and Reppucci (1988). Family dynamics, described earlier, would direct one into the treatment focus with the family. Family work focused on areas of roles; boundaries; social isolation of family members; feelings of rejection, abandonment and dependency.

Stage Three - Termination

A. Evaluation Procedures

The procedure for evaluation will be presented as follows:

i) presentation of the pre and post treatment measures that family members completed,

ii) an evaluation of the work with clients,

iii) evaluation of the student - self evaluation.

B. Family Follow-up

Three of the four families were referred to another community resource for continued treatment. One family terminated their counselling prior to the completion of this practicum and were not interested in being referred elsewhere.

v) Duration

The actual amount of time working with families was four months, from July 1989 to October 1989. The amount of time preparing and writing the report was approximately seven months.

vi) Recording

Recording was completed according to PSC standards. In addition to this, process notes were taken on clients.

DESCRIPTION OF FAMILIES, PROGRESS AND EVALUATION (PRE AND POST MEASURES)

A.

1) Family A

Family A consists of Mr. A, who is a mechanic, Mrs. A who is a housewife and the six children. Mrs. A had three children prior to her marriage with Mr. A. Mr. and Mrs. A had three children of their own. Mr. A married Mrs. A fifteen years ago. Their marriage has been chaotic, partly due to physical, sexual and emotional abuse experienced. Two of the six children were sexually assaulted by Mr. A's extended family. As a result of the sexual abuse, the home environment was sexualized, and family members had a very limited sense of their right for personal boundaries. The family had been on various social service waiting lists for over three and one half years. The parents wanted help for their marriage and general family functioning. The family presented with many problems, the most urgent being the abuse experienced in the marital relationship and the behavior of one of the two children who had been sexually abused. This child had been in individual therapy for nine months prior to working with this family. Unlike the other

families in this practicum, the A family was seen for a period of one year.

2) Intervention

Intervention consisted of marital therapy. family therapy, one individual session with Mrs. A and social network sessions with the varied and numerous resources that were involved.

3) Progress of Family A

a) Marital Therapy

The following is a list of their major achievements and progress.

1) There is a decrease in violence and an increase in respect from both partners. This couple identified the warning signs of their anger and was able to identify an approach to decrease the build up of anger and the subsequent explosion. Also Mr. A has become sensitive to Mrs. A's replies regarding her desire for sexual activity. Mrs. A believes that her husband is not as aggressive in his demand for sex. A lot of time was spent on Mrs. A disclosing to Mr. A the effects of his abuse on her. Due to Mrs. A's ability to inform him about her feelings, Mr. A was able to change his behavior to her. They now have a greater sense of responsibility for and accountability towards each other and in doing so, they have begun to renegotiate their own sense of privacy and other personal boundaries.

2) Both partners often used the threat of separation in order to control the other's behavior. Although this is still apparent, the frequency of use appears to have decreased. The concept of unconditional love was not part

of their belief system initially, however Mr. and Mrs. A have worked at implementing this in their relationship.

3) Each partner would not allow the other to clarify a thought once verbalized. Each would hold the other to what was said initially, even if one partner wished to clarify what he or she said. Mr. and Mrs. A are giving each other time to formulate a response and to make changes in their response. In addition, Mrs. A used to tell others about her relationship with Mr. A and would not inform him. Now Mrs. A is telling Mr. A more about the problems and the positive aspects of their relationship. Generally speaking, Mr. and Mrs. A's communication skills have increased.

4) There has been an increase in nurturing between the couple and an increased sensitivity in acknowledging when the other is trying to emotionally connect and let down his or her defenses.

5) In the past, when a problem was identified, both partners seemed to take the identification of the problem as a personal insult and withdraw from the conversation. At present both are acknowledging what the other has said and are attempting to work more as a team to resolve problems. The usual terms (winner or loser) stated at the end of a discussion are no longer heard during therapy.

6) The couple has been educated about their relationship dynamics and have tried to use this information in their relationship. For example, they were informed about the dynamics of violence, in terms of the victim role and abuser role. They were able to see how the dynamics of violence played a role in their life. In addition, the dynamics of their communication pattern

was identified and was used to help identify what was occurring in their relationship and what they could do to prevent the dynamics from fully expressing themselves. Once this couple was given the skills of how to identify dynamics in their relationship, they began identifying their own dynamics. For example, Mrs. A identified how she gave the role of disciplinarian to Mr. A and criticized him for using violence, when she would have also used violence to discipline the children. She gave Mr. A this role so she would not have to deal with the children in an abusive manner. Mrs. A was also able to see how her withdrawal from the role of disciplinarian, caused her to have no method or approach to intervene with the children. Another example would be when Mr. A states that he consciously withdraws from the family and the reason he does this. This allows for much improved communication and an opportunity for problem solving skills.

b) Family Therapy

The family has also worked on several issues. The following is a list of their major achievements and progress.

1) The family was able to set more clear boundaries around the parental subsystem and the sibling subsystem. As a result, there appeared to be more appropriate interaction between the parents and the children, such as nurturing and limit setting rather than challenging the children as one would challenge another adult. The children appear to enjoy the boundaries that are being set, as they have informed their parents of issues they should be dealing with, without their (child) involvement, such as to deal with their own feelings without projecting them on the children. Mr. and Mrs. A are providing the children with more feedback in terms of whether they are, for

example, angry with them or angry with someone/thing else. There is an increase in communication and empowerment of the children in the family to express their feelings and to make their parents accountable for their behavior. The children have become more vocal and demanding in the family sessions, as seen when they made the therapist and their parents accountable for taking up too much of the meeting time discussing 'adult things' and have been able to comment on how frightening Mr. A's loud voice can be.

2) Increasing their accountability to each other by attending family sessions. This would be considered a major achievement when one considered the previous inconsistency of home life and commitment to each other.

3) There appears to be a decrease in threatening to give the children to Child and Family Services. Whenever the children presented a situation to their parents that elicited some negative feeling from them, Mr. and Mrs. A would 'jokingly' inform the children that they would bring them to the mall where the Child and Family Services offices were located. This previously used technique was extremely effective in decreasing the feedback from the the children and providing them with a powerful sense of insecurity.

4) Mr. and Mrs. A were able to use and modify behavior modification programmes.

5) Mr. and Mrs. A are aware that Mrs. A and one of her children are similar in their respective family of origins. Both have and do play the role of scapegoat. Mrs. A stated that she wanted to be treated the same way that her other siblings were. Due to this insight, Mrs. A now has some tools to

break her child from his long reinforced role as scapegoat. In turn, she may also rid herself of this same role in her family of origin.

4) Evaluation (Pre and Post Measures)

Family A was engaged in therapy for one year, therefore there are three occasions in which the FAM General and Dyadic were given. It is important to include all three measure administrations as it will give the reader an accurate picture of how hard this family has worked. Mr. and Mrs. A completed the Index of Sexual Satisfaction on a pre and post treatment basis and the two eldest children completed the Index of Self Esteem on a pre and post treatment basis however the period between both measures was less than one month.

a) FAM General - Completed by Mr. and Mrs. A and the two eldest children, David and Gwen.

In November 1988, all scale items were considered to be a family problem. (See figure A-1) There were many problems identified at this time and family involvement appeared limited to negative feedback and identifying those in the family who irritated others. In July 1989, the family completed this measure again. (See figure A-2) The interesting feature about the outcome of this measure was that the results showed the tightening of the subsystems within the family. As one will note, Mr. and Mrs. A have very similar scores for the scale items and the same overall rating of fifty-one (51) while David and Gwen's scores are similar and have only one point difference in their overall rating (64 and 63 respectively). Not only did this measure identify that this family views their family functioning as being

more healthy than it was in November 1988, this measure also provided information of the development of subsystems within the family. In October 1989, the family completed their post measure assessment. (See figure A-3) This measure is similar in presentation to the measure completed in November 1988, as it does not have the clarity of the July 1989 measure. In October 1989, this family had to adjust to many changes. Mr. A was laid off from work however did find employment quickly, the family was in the process of changing counsellors and the youngest child was hospitalized for a suicide attempt. This may account for some part of the scale presentation. In addition to this, it is believed that some issues identified by the family have been dealt with and that new, not as clearly defined issues, are being raised to be worked. It appears that the family has left their period of stability and has ventured into uncharted problem areas.

The October 1989 ratings by the family shows a significant decrease in family problems. The highest overall individual rating in October 1989 is sixty (60), in July 1989 it was sixty-four (64), and in November 1988 it was seventy-four (74). The decrease in family problems was due to the progress the family made which was identified previously. An interesting observation in the post measure shows Mr. A and David having the same overall score and Mrs. A and Gwen have similar scores (fifty-five (55) and fifty-six (56) respectively). This may signify an increased bonding between Mr. A and David and between Mrs. A and Gwen. This appears to be an appropriate developmental place for these four family members, teenagers developing their relationship with the same sexed parent.

When the numerical results of the FAM and the placement of family members on the graph were discussed, the family considered both to accurately reflect their current family situation.

b) FAM Dyadic - Completed by Mr. and Mrs. A

In November 1988, Mr and Mrs. A completed their first FAM Dyadic. (See figure A-4) The scale provided a clear picture of this relationship. It was clearly problematic and they did not see any area of their relationship in a similar manner. Both agreed that their relationship was problematic. Mr. A's overall rating was sixty-one (61) while Mrs. A's overall rating was seventy-eight (78). In July 1989, there was a significant change in the results when this couple completed the FAM Dyadic. (See figure A-5) The overall scores had decreased for Mr. A (61 in November 1988 to 57 in July 1989) and for Mrs. A. (78 in November 1988 and 63 in July 1989). These results showed that Mr. and Mrs. A had noted a positive change in their relationship. In particular, there was a considerable dyadic rating decrease in the areas of control, values and norms and role performance. This change was supported by clinical observation as Mr. and Mrs. A were able to make their relationship more predictable, with fewer overt power struggles (control); began to discuss the standards for behavior in the home, such as no physical violence (values and norms) and talked openly about their roles within the family and the need for change (role performance).

In October 1989, Mr. and Mrs. A completed the post measure for the FAM Dyadic. (See figure A-6) There is considerable change from November 1988 and July 1989. The overall rating for Mr. and Mrs. A in the post measure was fifty-one (51) and fifty (50) respectively. This couple not only saw their

relationship in the same healthy way, they gave the same rating on three scale items; involvement, affective expression and task accomplishment. The largest variation between individual scores was in the area of value and norms, where Mrs. A rated this scale item at forty-two (42) while Mr. A rated it at fifty-one (51), a nine point difference.

When compared to the November 1988 and July 1989 measure, the October 1989 post measure signifies that Mr. and Mrs. A have completed a clinically significant amount of work. This observation is supported by Mr. and Mrs. A's self-reports.

c) Index of Sexual Satisfaction

Like the FAM, this index also reflected the significant progress made by Mr. and Mrs. A. The pre test measure was given in July 1989. Mr. A scored a thirty-one (31), a mark which denotes a borderline level of satisfaction. Mrs. A scored a sixty-eight (68), a mark which clearly states a great deal of dissatisfaction in her sexual relationship with Mr. A. These marks are not surprising due to the sexual violence Mrs. A had experienced from Mr. A. From the index, Mrs. A had many concerns about her sex life, ranging from sex being too hurried, lacking quality and boring to sex not being a normal function of their relationship.

The post measure showed that progress was made. When Mr. and Mrs. A completed the index in October 1989, Mr. A's score was twenty-eight (28), a mark which indicates a slight increase in sexual satisfaction from pre measure results, and Mrs. A's score was forty (40), signifying that she is more sexually satisfied in her relationship when compared to the pre

measure results, however a score of forty (40) still indicates that Mrs. A is not sexually satisfied. For Mrs. A, the post measure indicates the following changes: 1) sex was considered more fun, less monotonous and less hurried, 2) sex was more of a normal function in her relationship and added more to her relationship with her husband and 3) feeling more confident about self performance. Significant changes in Mr. A's post measure was that he believed that Mrs. A does not avoid sex as often as previously noted in the pre test measure and Mrs. A appears more sensitive to his needs and desires.

Mr. and Mrs. A verify that their sexual relationship has improved, however Mrs. A states that it could be better, as indicated by her post measure. Mr. and Mrs. A's increased ability to feel more comfortable with intimacy issues and their notable change in their ability to nurture each other, may have influenced the post measure results.

iv) Index of Self-Esteem - Completed by David and Gwen

Due to the short period of time between administrations of this Index, a pre/post treatment assessment cannot be made, however the details of each administration will be provided. David scored twenty-two (22) in September 1989 and twenty-six (26) in October 1989. This indicates the David has a healthy self esteem. From reviewing the index, David appears to have self-confidence in social situations and a firm belief in his self-worth. Gwen's scores were thirty-one (31) in September 1989 and twenty-four (24) in October 1989. Generally speaking, the index states that Gwen also has a good self-esteem. Gwen generally views herself as a good and likeable person and who has support from her peers. Unfortunately, due to summer

vacations, David and Gwen were not given this measure in time in order to do a pre and post measure analysis. However both children appear to have good self-esteem. This is supported by clinical observation and parental and child self-reports.

B

1) Family B

Family B consists of Mrs. B and her two daughters April (14 years old) and June (10 years old). Mr. Z, Mrs. B's common-law partner of ten years, is the final member of this family. April was apprehended in January 1989 due to allegations of sexual abuse by Mr. Z. Mr. Z denied the allegations while Mrs. B stated that April was lying. April has not resided with her family since her apprehension, however visits with the family frequently. Mr. Z and Mrs. B are alcoholics, which is verified by April and the involved Child and Family Services workers. Mrs. B completed a M.A.S.T. questionnaire, and the results verified that she was an alcoholic. Mr. Z would not attend any meetings that discussed the sexual abuse on advise from his lawyer. Mr. Z's criminal court hearing was not heard at the time of the family's involvement with PSC. Mrs. B would not allow June to be involved with counselling as it would 'contaminate' her by hearing allegations that were not true, for example. There were indications from Mrs. B that Mr. Z was emotionally abusive to her however upon investigation, Mrs. B denied that Mr. Z was abusive to her or to the children in any way. It was very difficult to engage Mrs. B and April in the therapeutic process. They missed several scheduled meetings and there was some consideration given to terminate involvement with this family.

2) Intervention

Intervention included individual work with Mrs. B and April, dyadic work with Mrs. B and April and service sector network meetings with Child and Family Services.

3) Progress of Family

a) Individual Therapy with Mrs. B

Mrs. B was able to identify issues however was not prepared to follow through on discussing them. Whenever an issue that she identified was acknowledge, validated and probed, Mrs. B would minimize the significance of the issue or state that what was paraphrased by the worker was incorrect. Very little could be done as Mrs. B could not commit herself to discuss an issue. Mrs. B was not able to acknowledge that she had an alcohol problem, which influenced her ability to benefit from therapy. One issue that she almost began to deal with was how Mr. Z would emotionally degrade her. After this issue was raised and discussed on a superficial level, Mrs. B missed almost six weeks of individual sessions. Individual therapy was very difficult for her.

b) Individual Therapy with April

April was able to disclose information that pertained mostly to her present life outside of the family residence. Little information was shared about present family dynamics, while there was more attention given to previous occurrence in her childhood, such as the divorce of her parents and the

introduction of Mr. Z. April was able to discuss the facts about the abuse but did not feel comfortable to deal with the affect of the abuse. April used the individual sessions to educate the student about her and to obtain validation for her thoughts, feelings and behavior towards others, including her family.

c) Dyadic Work with Mrs. B and April

It was a major achievement for Mrs. B and April to attend meetings regularly. Mrs. B and April learned how to discuss some issues without being abusive to each other. Mrs. B would often elicit a guilt response from April when April would challenge her. It became evident that Mrs. B was so preoccupied with her own issues (yet would deny that she had any issues to resolve) that she was unable to hear what April was saying and her interpretation of what occurred outside and within the therapy session was extremely inaccurate. (Mrs. B's alcoholism would account for a great deal of her inability to participate effectively in dyadic sessions.)

The most influential piece of work that was done during this time was when Mrs. B was able to make her position clear to April, regarding the allegations of sexual abuse. Mrs. B informed April that she believed that Mr. Z innocent and that there was no room for April in their household. This message was difficult for April to hear, although she had expected this. Due to Mrs. B's clear message, April was allowed to begin to plan her future knowing the parameters of her relationship with her nuclear family.

4) Evaluation (Pre and Post Measures)

Family B completed pre and post measures on the FAM General and Dyadic and the Index of Self-Esteem. Mrs. B did not complete the Index of Sexual Satisfaction due to her reluctance of discussing any marital issues and her fear that the information could be used to prosecute Mr. Z in an upcoming criminal court proceeding due to the sexual abuse allegations.

a) FAM General - Mrs. B and April

In the pre treatment measure, given in August 1989, Mrs. B scored scale items task accomplishment and communication in the family problem range and rated the remaining five scales in the average range (although role performance and values and norms were bordering on a score of sixty). April scored all scale items in the family problem range. (See figure B-1) It would appear appropriate for April to score all seven scales in the family problem range as she was residing in a foster home since January 1989 and had received no assistance to help her make sense of her present situation. Mrs. B contributed her high ratings to the allegations of sexual abuse made by April. Mrs. B believed that her family was fine except for April's behavior. The pre treatment measure overall rating was sixty (60) for Mrs. B and eighty-two (82) for April.

In the post treatment measure, administered in October 1989, Mrs. B's overall rating was fifty-nine (59) and April's was seventy-seven (77). (See figure B-2) This difference does not appear to be clinically significant. The minimal decrease in the overall rating may be due to the fact that intervention had access to only two of the four nuclear family members and that most of the intervention was geared at connecting with family members and 'hooking' them into the therapeutic process.

b) FAM Dyadic - Completed by Mrs. B and April

Although the pre treatment measure results fell almost exclusively in the family problem range, (See figure B-3), their view of their relationship was very similar. However they each had very different reasons to explain why their relationship was so troubled. This relationship was very stressful. The FAM results were supported by Mrs. B and April and by clinical observation. Mrs. B's overall rating was sixty-nine (69) and April's overall rating was seventy-three (73).

The post treatment measure (see figure B-4) was able to identify the most important issues in this relationship. For Mrs. B, this issue was role performance (having a mark of seventy-seven) and for April, the issue was involvement (having a mark of eighty-six). The results were supported clinically. Mrs. B was very unclear and uncertain about her role with April. She would often express confusion around this issue. April wanted more involvement with her mother, however Mrs. B made it conditional upon April retracting her allegations of abuse against Mr. Z. Mrs. B's overall rating was seventy-one (71) while April's was sixty-six (66).

It is noteworthy to mention that April's overall rating decreased from seventy-three (73) in the pre treatment measure to sixty-six (66) in the post treatment measure. Most evident changes were in the areas of affective expression, communication and task accomplishment. Ratings for these scale items were at least ten (10) points BELOW her pre treatment scores. Mrs. B's post treatment scoring was also noteworthy. Most evident changes were in the areas of values and norms and affective expression. Ratings for these

scale items were at least nine (9) points ABOVE her pre treatment scores. Mrs. B and April's relationship was changing. The post treatment scores may indicate that April is beginning to feel more comfortable with the restructuring of the relationship, while Mrs. B is experiencing increasing stress. Part of this stress may be due to her strong belief that family should be together regardless of the cost. This is not possible under the present circumstances. It is therefore not surprising that values and norms is one of two scale items that were scored higher in the post treatment measure.

c) Index of Self-Esteem - Completed by April

April had a pre treatment measure score of seventy-one (71) when she completed this measure in August 1989. This high score signified a serious problem with self-esteem. In October 1989 April completed the Index again. Her post treatment measure score was twenty-eight (28), which may lead one to believe that April has made extraordinary gains in self-esteem and at present has a good sense of self-esteem. Due to her limited involvement in treatment, it would appear that the great improvement, from 71 to 28, is somehow misrepresenting reality. Clinical observation supports the finding that April's self-esteem has increased but not to the numerical significance the post treatment measure would lead one to believe. When comparing the questionnaires of pre and post measures, the post measure showed a positive increase in peer relations, self-image and feelings of competence.

C

1) Family C

Family C consists of Mr. C, who is employed on a seasonal basis as a construction worker, Mrs. C who does volunteer work and occasional clerical work, and their three children; John (12 years of age), Peter (10 years of age) and Lynn (4 years of age). Mr. and Mrs. C have both been sexually abused as children by family members. John was sexually abused by a non-family member and sexually abused his sister Lynn. Both Mr. and Mrs. C are in Alcoholics Anonymous support groups due to their alcohol abuse. Mr. C often physically, and on at least one occasion, sexually abused Mrs. C in the past while he was intoxicated. Mr. and Mrs. C report that the chaotic and abusive home environment of the past no longer exists due to their newly found sobriety. (John sexually abused his sister just prior to his parents recognizing their need for alcohol treatment.) Although sober, this couple, along with their children, was faced with new problems; learning how to live without alcohol. The C family had received counselling previously due to John's sexual victimization, John's behavior (at five years of age John was diagnosed as being schizophrenic) and due to John's academic problems in school. The diagnosis of schizophrenia was made without the investigation of the family situation. If the clinician who made the diagnosis had completed a thorough systemic assessment, he/she would have found that both parents drank heavily throughout John's prenatal development, at the time of his delivery and during his early years of life. All counselling, including their referral to PSC, focused on John. The family had not received counselling for their chaotic past and uncertain present. Mr. and Mrs. C were somewhat angered when they were brought into therapy as they believed that the referral to PSC was specifically for 'fixing' John's tendency to sexually victimize others.

2) Intervention

Intervention included individual sessions with Mrs. C and John, one individual session with Mr. C, marital therapy, dyadic work with Mrs. C and John, family work and social networking with child welfare and other resources.

3) Progress of Family

a) Individual Therapy with Mrs. C

1) John is no longer the presenting problem. Previously, Mrs. C saw him as the one who needed to be placed in a foster home. She has refocused on herself and her relationship with her husband and now is available to nurture and believe in John.

2) Alcohol is no longer a negative influence at this time.

3) Mrs. C had difficulty with the conflicting messages from her AA and PSC meetings. However she learned to have more confidence in taking the message that best fits with her. The phrase 'self pity' was often used by Mrs. C to describe nurturing. As AA informed her that self pity was not good, Mrs. C also lost the opportunity to nurture her family. Much work was needed to identify and separate self pity from nurturing.

4) 'Acting' was another word that carried negative connotations with it. Mrs. C felt that when she was acting, her presentation (such as presenting one way to someone and another way to someone else) did not reflect who she was. She believed that she was negatively manipulating others for her

own benefit. In some cases Mrs. C began to see how her acting was a positive skill to have and that she was able to be flexible, by meeting people on their level of presentation.

5) Mrs. C is doing things for herself and not always for others. She is beginning to satisfy some personal needs that have been repressed for a long period of time. She is more prepared to invest in herself and has seen the positive results such as increased self awareness and self esteem. She has appeared to have gone from one extreme (martyr) to the other extreme (self serving). Mrs. C was informed that this was a necessary step in order to find some balance between meeting others needs and meeting her own needs.

6) She is making others accountable for their behavior and recognizes that she has a choice. She no longer has to tolerate inappropriate behavior from others, whether that be from her family of origin or her nuclear family members. Mrs. C is gaining a sense of self power.

7) Mrs. C is much more aware of the children's needs and tries to discipline in a healthy, growth producing way. She puts a lot of thought into his disciplinary measures, trying to calculate the effects of discipline prior to its implementation.

8) Mrs. C is more aware of her old patterns of behavior and 'catches' herself slipping into these from time to time. When she slips, she acknowledges the slip and corrects it with a more appropriate pattern of behavior. Mrs. C is also broadening her definition of self and not accepting her old pattern where she was either daddy's 'dessert' (her father sexually abuse her for a

number of years) or an alcoholic. She has the permission to see herself in a different, less narrow manner.

b) Individual Therapy with John

1) John has been able to identify the dynamics of the family situation prior to his sexual abuse of Lynn. He was able to discuss his anger and hurt about how he was responsible for Peter and Lynn and how he really needed to be cared for and loved. He recognized that the level of responsibility given to him was inappropriate and that his parents should have been responsible for caring for all children. In particular, John recognized that his parents gave him conflicting messages about whether he should care for Lynn. Also John understood that Lynn would come to him for protection, when his parents were intoxicated and fighting. Lynn was said to be afraid of daddy's loud voice. John discussed his feelings of excitement when Lynn was in his bed (as he was the older brother who was able to protect his baby sister) and talked about the feelings of anger he felt when protecting Lynn became an annoyance.

2) John has insight into what his feelings are, however does not easily express them. He is able to match a particular feelings with a physiological and behavior response. For example: When I feel mad, my body gets tight and I punch out. John is also aware of how he and others in his family deals with anger. All deal with anger by striking out at someone.

3) John has learned to trust the therapist and can learn to trust others. The issue of trust surfaced when John allowed the therapist to physically restrain him when he could have 'escaped'. John is physically strong for his age and

large is stature, and could have easily resisted the restrain. John also mentioned that he could have left the session (escaped) if he wanted to.

At this time, John does not require individual sessions. His issues can be dealt with within the context of family meetings.

c) Marital Therapy

1) Both Mr. and Mrs. C are beginning to look at how their commitment to each other, their behavior patterns, their picture of the world and their relationship have been organized under the influence of alcohol. Both believe that there are areas that need to be re-organized. Mr. and Mrs. C are more aware of their present day functioning and are beginning to see the areas in which they want to work on. Areas they have identified are power within their relationship, decision making, affective expression and their involvement with each other.

2) Communication patterns were identified, such as answer a question with a question. Mr. and Mrs. C worked at communicating clearing and not assuming that they know how the other feels or what each is thinking. The couple learned how to provide feedback to each other and are working on destroying their myth that THE sign of love is the ability of the partner to know what the other is thinking and feeling.

3) Mr. and Mrs. C had an opportunity to talk in the session without the demands of the children and others interfering. They increasingly made better use of their time in therapy and have mentioned that therapy is the only time that they talk with each other.

4) Mr. and Mrs. C have identified to each other that they have built 'walls' between them. This pattern had it's origins in their respective family of origin. Both are afraid to deal with each other on an intimate level and ensure that an opportunity for intimacy does not occur. If they do only talk to each other during therapy sessions, therapy may be a safe place where both can practice being emotionally intimate.

5) Mrs. C has been very demanding of Mr. C by setting unrealistic expectations, such as demanding that Mr. C tell her how he feels 'NOW'. Mr. C has difficulty expressing his thoughts and more difficulty expressing his feelings. Mrs. C is aware of this and has tried to 'slow down' to give her husband a chance to respond within his time frame. On the other hand, Mr. C has been able to verbally inform his wife that he cannot talk about his thoughts or feelings as well as she can. Mr. C is beginning to do some work around this issue.

6) Mr. and Mrs. C have discussed how Alcoholics Anonymous philosophy does not always provide a healthy route to marital harmony. AA members have informed them that they have nothing to offer each other as alcoholics and that they have to live for themselves, today. In addition to this, both have learned not to expect anything from their partners, as they have nothing to give in return. As a result Mr. and Mrs. C have shared their views about this part of AA philosophy and (somewhat) believe that they have something to offer each other and that in order for a relationship to grow and be mutually satisfying, they need to have expectations for each other. Their present expectation to expect nothing from their partner is being fulfilled.

7) Due to Mr. C's abusive behavior, referrals were made to groups who specialized in dealing with perpetrators of violence. Mr. C agreed to attend group treatment.

d) Dyadic Work with Mrs. C and John

1) This part of intervention has been critical in increasing Mrs. C's understanding and empathy for John. Instead of seeing John as a controlling defiant child, Mrs. C now views John as a child who has strengths, despite the abusive home environment in which he has lived.

2) There has been an increase in direct and clear communication between Mrs. C and John.

A word of caution: It has been noted that due to Mrs. C and John's improving relationship, Mrs. C has relied on him to meet some of her needs that I believe should be met by Mr. C and not John. If Mr. and Mrs. C's relationship should continue to improve, there will be no concern. However if their relationship does not become mutual satisfying, it is believed that Mrs. C will request inappropriate amounts of nurturing from John.

e) Family Therapy

1) The family has disclosed the following dynamics. Mr. C has been identified as the 'monster' (a similar label has been given to John). When Mr. C interacts with anyone in the family, a third family member becomes involved and focuses the attention onto him/herself. Therefore, no one in

the family can talk with Mr. C alone, as long as others are present. The reason for this is that family members become anxious and fear for the person Mr. C is speaking to. The fear comes from Mr. C's previous display of abusive behavior. This pattern results in Mr. C feeling ostracized by the family. In particular, his relationship with Mrs. C is often blocked by John who has been put in a position by Mrs. C to protect her from Mr. C. Family members were given permission to interact with Mr. C without someone interfering.

2) John appears stuck in a pattern where he feels he can love only his mother or his father and not both. Peter, John and Lynn are also stuck in a pattern where there needs to be at least one child who is the 'bad' one. Work was done to reframe John's annoying behavior as caring and nurturing to Peter. As long as John responds for Peter, Peter does not have to. As a result John is identified as the 'bad' child and Peter is the 'good' child. In addition, Peter does not learn how to express his feelings.

3) When John tried to connect with his father, John's behavior was considered bothersome. John would pick at his father's boot heels or mimic his behavior, such as telling Peter not be pull his t-shirt over his knees. John's behavior was reframed as an attempt to connect with Mr. C. Mr. C was identified as an important person to John.

4) The expression of anger was discussed. All family members stated that they express anger in an appropriate manner. The only indication of problems with the expression of anger was Peter, who would cry whenever anyone raised their voice to him. Peter may be carrying the burden of unexpressed anger for the family.

5) The family had an opportunity to discuss the changes that have occurred in the past year, such as parental sobriety and intrapersonal changes within family members.

Work not Attempted but Considered Important

It will be necessary at one time to assess Lynn's level of understanding of the abuse and the affects it has on her. A suggestion was made that work be done with Mrs. C to help her deal with Lynn's responses to the sexual abuse. In other words, prepare Mrs. C to be Lynn's therapist.

4) Evaluation (Pre and Post Treatment Measures)

Family C completed pre and post treatment measures on the FAM General and Dyadic and on the Index of Sexual Satisfaction. John was unable to complete the Index of Self-Esteem, therefore there will be no scores presented on this index. All measures presented were completed by Mr. and Mrs. C.

a) FAM General

In the pre treatment measure administered in July 1989, Mr. C scored communication, affective expression and control in the family problem range and the remaining four scales in the average range. Mrs. C scored role performance, involvement and control as problem areas, with the remaining four scales in the average range. (Values and norms had a borderline score of sixty [60] and affective expression had a borderline score of forty [40].) See figure C-1 for details. Overall ratings by Mr. and Mrs. C were fifty-nine

(59) and fifty-seven (57) respectively. The scores were supported by the clients' statements and clinical assessment.

The post treatment measure clearly showed the amount of work that the family had done while in treatment. (See figure C-2) Mr. C identified the only family problem area which was control. All other scale items, including all of Mrs. C's ratings, were within the average range. Control was an issue for Mr. C who felt that he did not have control of anything that occurred in the family and felt unable to change the things he thought needed to be modified. Overall ratings for Mr. and Mrs. C were fifty-three (53) and forty-seven (47) respectively. This was a significant numerical change which was supported by client self-reports and clinical observation. Prior to the completion of the post treatment measure, Mr. and Mrs. C had recognized the changes in their family.

b) FAM Dyadic

In the pre treatment measure, Mr. C identified most areas of the scale as being in the family problem range, except for the scale items of role performance and involvement, which were in the average range. Mrs. C identified all scale items as being in the average range, with norms and values bordering on a rating of sixty (60). (See figure C-3) Mr. C's ratings were supported by his statements and by clinical observation, however Mrs. C's ratings were not supported by her statements or by clinical observation. Mrs. C often stated how unsatisfactory her relationship was with Mr. C and believed that their relationship would remain the same as long as they were together. She often spoke of leaving Mr. C, however she found this difficult to enact due to her religious beliefs. Mrs. C's ratings tend to reflect how

successful she believes she has dealt with and survived in this relationship. It appears that she has survived this relationship with the help of avoidance and denial techniques. She had virtually disregarded her husband as a part of this relationship due to his previous violent behavior towards her and her unresolved family of origin issues. In summary, the scale may be more accurately used if Mr. C's ratings are taken as an indicator on how he sees his relationship with his wife, while Mrs. C's ratings are probably more a reflection on how effective she believes her coping mechanisms were for her survival in this relationship. Mr. C's overall rating was sixty-two (62) and Mrs. C's rating was fifty (50).

The post treatment measure clearly identifies areas for work and appears to show an increase of involvement of Mrs. C with her husband, as seen by the numerical increase in Mrs. C's ratings. An increase in Mrs. C's scores may indicate the increased level of stress she is experiencing due to working on issues between her and her husband. (See figure C-4) Areas for work are communication, affective expression and involvement, which were all rated by Mr. C to be in the family problem range. All other scale items rated by Mr. C and all seven scale items rated by Mrs. C were in the average range. The post measure appears to show that Mr. and Mrs. C view their relationship more congruently than was indicated on the pre treatment measure, which may imply that they have done considerable work in trying to deal with marital issues. The post treatment measure was supported by client self-reports and clinical observation. This couple has worked on issues and have clearly identified future issues to be discussed. those being communication, affective expression and involvement. The changes noted in

the post measure are clinically significant. Mr. C's overall rating was fifty-eight (58) while Mrs. C's rating was fifty-one (51).

c) Index of Sexual Satisfaction

The pre treatment measure was completed in August 1989. This measure showed that Mr. C was sexually satisfied in his relationship with Mrs. C (Mr. C had a score of thirteen [13]) and that Mrs. C was not sexually satisfied in her relationship with Mr. C (Mrs. C had a score of forty-one [41]). Mr. and Mrs. C confirmed that these results were accurate. Mrs. C described how Mr. C was preoccupied with sex, wanted sex without thinking about her needs and that she would often allow her husband to have his needs met while being unresponsive and dissociated from the sexual experience. Mr. C was not aware of his wife's feelings until the Index was discussed.

The post treatment measure, which was completed in October 1989, identified that both Mr. and Mrs. C were sexually satisfied in their relationship. Mr. C's score of seventeen (17), was an increase of four (4), and Mrs. C's score was twenty-two (22), a decrease of nineteen (19). Mr. C's post treatment score appeared to symbolize the work he had done in re-evaluating his beliefs about his sexual satisfaction and the role of a sexual relationship in a marriage. In the post treatment measure he identified Mrs. C was wanting too much sex from him and that she was not sensitive to his sexual needs and desires. Mr. C did not believe that their sex life added substantially to their relationship. These statements by Mr. C are in direct contrast to his pre treatment measure scores. Mrs. C's post treatment measure showed that sex was more fun, had more quality and was generally more satisfying. Mrs. C believed that Mr. C no longer saw her mainly as a

sexual object. Both Mr. and Mrs. C made great leaps towards re-negotiating their sexual relationship. It is believed that Mrs. C's significant decrease in this post treatment measure is due to her feelings of empowerment (her ability to say 'no') due to the control she now has in her sexual involvement with Mr. C.

D

1) Family D

Family D members include Mr. and Mrs. D and children Doris (14 years), Susan (10 years) and James (8 years). None of the children were fathered by Mr. D. Mr. D has a history of short term employment placements while Mrs. D has been the steady financial provider. Both Mr. and Mrs D's extended families are involved in an Evangelical church. The D family is presently involved in this religion. Their religion encourages patriarchal practices and has very clear and rigid (and somewhat punitive) guidelines on how to discipline those church members who commit a 'sin'. Mr. D is very controlling and degrading to family members and believed that his own parents and upbringing was excellent, yet could not provide one example of this 'excellence'. Mrs. D was passive and submissive (she sometimes refers to herself as a door mat) in her relationship with Mr. D, however was active and assertive in her place of employment. Mrs. D has experienced family dysfunction in her family of origin and was sexually provocative prior to meeting Mr. D. This family was referred to PSC due to the allegations that Mr. D sexually abused Doris and due to the allegations that Doris sexually abused Susan and James. Mr. and Mrs. D do not believe that Doris was sexually abused by Mr. D however do believe that Doris has victimized her

siblings. Mr. and Mrs. D would not allow Susan and James to participate in therapy. At the time of referral, Doris had resided in a foster home since her apprehension in the winter of 1989 and remained in foster care for the duration of treatment.

2) Intervention

Intervention with Family D included individual sessions with Mrs. D and Doris, dyadic work with Mrs. D and Doris, marital therapy and social service sector meetings with Child and Family Services and other community resources.

3) Progress of Family D

a) Individual Therapy with Doris

When Doris entered therapy, she was literally hanging on to the belief and hope that her mother would somehow believe that Mr. D sexually abused her. However, Mrs. D was unable to provide Doris with this reassurance. As a result, Doris' behavior grew more erratic, sexually provocative and self-abusive. Individual therapy assisted Doris in looking at i) her efforts to make her mother believe her and the high psychological price she paid for her efforts, ii) the dynamics of the family and iii) the need to feel some control in her life. Specific progress noted includes:

i) Doris became better educated in the dynamics of abuse and how it related to her family.

ii) Doris began investing her energy and time into herself rather than investing time and energy in trying to control her mother's beliefs and feelings. As a result of self investment, Doris began to feel more empowered, which resulted in her allowing her mother and Mr. D to take the responsibility for their own decision making and making Mr. D accountable for the abuse. By doing this, Doris confronted the mixed messages she received from her family and made an attempt to make the family accountable to her. All of this work helped Doris to release herself from the pathological ties of her family and to gain more self-control. This work also helped to decrease her negative behavior that resulted from being enmeshed in such a pathological family system. Doris was also freed to remember past events, which included Mr. D physically abusing all children. Doris now has the task of re-thinking her childhood from her new empowered perspective.

b) Individual Therapy with Mrs. D

It has been very difficult to see progress with Mrs. D. Her abusive past and present relationships helps to maintain her role as a victim. Her present framework of understanding relies heavily on self-blaming. Her presentation in therapy on occasion was verbally and behaviorally child-like. Mrs. D had great difficulty using her insight gained in therapy and her past experience to help her to empathize with Doris. For example, Mrs. D and Doris have experienced some similar victimizations. Mrs. D could express how devastated she was due to the experience, but did not have any ability to generalize her feelings and see that her daughter was experiencing similar affect. Also, Mrs. D was not able to 'carry' the insight she gained in one session to the next session, regardless of the length of the session or the time

between sessions. This made it very difficult to build on insight or work completed in a previous session. It often, if not always, felt that one had to start at 'square one' on every occasion when meeting with Mrs. D. In addition to this, Mrs. D would sometimes not even remember talking about an issue addressed in a previous session, regardless of the emotional impact of the issue.

Progress in individual sessions was not noted for the reasons described above.

c) Dyadic work with Mrs. D and Doris

Progress was noted in one major area. Mrs. D and Doris began to communicate clearly and shared feelings about past family events and Doris' biological father. During these sessions, Mrs. D communicated to Doris that she would not be returning home, regardless of the work done with the family or the disposition of family court hearings. This clear communication gave Mrs. D and Doris permission to separate from each other, thereby breaking some of the pathological ties.

d) Marital Therapy

Mr. D's influence was strongly felt during marital therapy. He was able to keep a conversation away from pertinent issues mostly by refocusing on inadequacies of Doris or Mrs. D. He accepted no responsibility for any problems within the home and had taken the position of Savior. Mr. and Mrs. D heavily invested in the belief that Mr. D made life so much easier for Mrs. D and her three children.

Progress noted includes:

i) Mr. D realizing that he was also part of the problems his family was experiencing. Mr. D eventually agreed that he could not communicate effectively with Mrs. D. This process began to redefine Mr. D's position in the family.

ii) Mrs. D was able to openly challenge and disagree with Mr. D's opinions in the therapy session. Mr. D stated that he also noticed that Mrs. D was more assertive.

iii) Mrs. D did not as often come to Mr. D's defense (she allowed him to deal with the situation) and she would correct others when they paraphrased her statements incorrectly.

4) Evaluation (Pre and Post Treatment Measures)

Family D terminated their involvement prior to the completion of the post measures in the FAM General and Dyadic and in the Index of Sexual Satisfaction. However, Doris completed the Index of Self Esteem on a pre and post treatment basis.

a) FAM General - Completed by Mr. and Mrs. D and Doris

The pre treatment measure was completed in June 1989. The results of this measure can best be assessed by reviewing the individual scores of family members. Mr. D rated his view of the family as average in all seven scales. Mrs. D identified communication, role performance and task accomplishment in the family problem range. The remaining four scale items were rated as

average. Doris rated affective expression and role performance in the average range and the other five scale items were rated as a family problem. Generally speaking, Doris identified more problem areas than Mr. or Mrs. D. (See figure D-1) When Mr. D expressed his disagreement and disappointment to Mrs. D's rating of three scale items in the family problem range, Mrs. D quickly stated that these three scale items were rated in this manner due to Doris' behavioral and psychological problems. She further stated that if she rated her family as it was at that time (without Doris, as she was residing in a foster home), her ratings would be comparable to her husband's. Overall ratings by family members are as follows: Mr. D, forty-four (44), Mrs. D, fifty-seven (57) and Doris, sixty-seven (67).

It is believed that if the post treatment measure would have been completed, Mr. and Mrs. D would score significantly lower than Doris. These ratings may reflect the strong denial mechanisms used by Mr. and Mrs. D.

b) FAM Dyadic - Completed by Mr. and Mrs. D

In June 1989, Mr. and Mrs. D completed this pre treatment measure. They both viewed their relationship as within the average range, bordering on family strength. (See figure D-2) Mr. D's overall rating was fifty-four (54) while Mrs. D's overall rating was fifty-five (55). Both stated that the allegations brought them closer together to 'fight' a common enemy, which was the allegation of sex abuse. The results of the FAM Dyadic directly conflict with clinical observation and client self-reports about the marital relationship. For example, in marital therapy Mr. D would often comment on how inadequate Mrs. D was in fulfilling her role as a wife and as a support system to him. In individual therapy, Mrs. D would often state that she

resented the fact that she had to be the stable financial provider and referred to Mr. D as being lazy. On many occasions she expressed interest in leaving Mr. D. Lastly, Mrs. D stated that her sexual responsiveness to Mr. D significantly decreased since the allegation of sexual abuse was made by Doris. Mr. and Mrs. D's concerns about each other were not reflected in the FAM Dyadic. If a post treatment measure was completed, it would be anticipated that the results would be similar to the pre treatment measure; reflecting their use of denial.

c) FAM Dyadic - Completed by Mrs. D and Doris

The pre treatment measure was administered in August 1989. Mrs. D's ratings were all in the family problem range while Doris identified only affective expression, communication and involvement as problem areas. The four other scale items were rated within the average range. In general Mrs. D believed that her relationship with Doris was more problematic than Doris did. (See figure D-3) Mrs. D gave an overall rating of sixty-nine (69) while Doris gave an overall rating of sixty-four (64). These results were supported by clinical observation. Mrs. D had a very difficult time connecting with Doris as long as she remained committed to the fact that she was sexually abused. On the other hand, Doris often tried to connect with her mother, even to the point of minimizing some of her own feelings about their relationship. This dyadic profile appeared to not only reflect the present view of this relationship, but also seemed to reflect the motivation each partner had to work on improving the relationship. Both saw their relationship as problematic, however Doris had more hope and therefore more motivation, to improve the relationship. A post treatment measure

may have shown an increase in the intensity of the dyadic problems, particularly on Doris' results. If this was to occur, it could have been interpreted as Doris' willingness to see the relationship as it presented, rather than hoping it would change.

d) Index of Sexual Satisfaction - Completed by Mr. and Mrs. D

The pre treatment measure was administered in July 1989. Mr. D scored twenty-three (23) and Mrs. D scored forty-one (41). Mr. D's score is well within the range of feeling satisfied with his sexual relationship with his wife. However Mrs. D's score of forty-one, reflects that she is not satisfied with her sexual relationship with Mr. D. Mrs. D appeared to have concerns about the quality of their sex life and the frequency (sex being too frequent). These concerns would be supported by her statement of not being responsive to Mr. D since the allegation of sexual abuse was disclosed. However there were some contradictions in Mrs. D's responses. The contradictions found in this Index reflects the confusion and double messages that were consistently present during individual therapy with Mrs. D. Mr. and Mrs. D stated that the results of this measure were accurate. It is believed that Mr. D's score would remain the similar in the post treatment measure and that Mrs. D's score would decrease (symbolizing more satisfaction) due to sensitivity of the issues discussed prior to their termination and their need to present as a happy couple, which in turn maintains their denial system and allows them to avoid dealing with pertinent issues regarding their marital relationship.

e) Index of Self-Esteem - Completed by Doris

This is the only measure that was completed on a pre and post treatment basis. In July 1989, Doris completed this pre treatment measure and scored thirty-five (35). This score signified that Doris had a marginally low self-esteem. In October 1989, Doris completed the post treatment measure and her score was thirteen (13). This score reflected a significant statistical improvement which was supported by Doris' self-report and by clinical observation. Major rating differences in the post treatment measure scoring reflected increased levels of self-confidence, self-validation, self-worth and confidence in peer relationships. It is firmly believed that change in self esteem was mostly due to Doris' ability to separate from her family's pathological ties. Doris was able to invest time and energy into her own needs and future plans and therefore became more empowered, resulting in a high degree of self-esteem.

viii) Results of Evaluation

The results of evaluation are completed in two parts. One part discusses the results of working with the families and the second part addresses the issue of self-evaluation; the evaluation of the student.

A) Results of Evaluation of Working with the Families

Pre and post treatment measures provide an important vehicle in which to discuss evaluation. The results of these measures have been presented previously. On a general note, it appears that intervention was effective. Families A and C seemed to benefit most from intervention. Family B was very difficult to motivate and therefore limited time was spent with them. Conversely, a connection was made with Family D and a great deal of time

was spent working with them. Family B and D had one influential similarity, that being that both used denial as a primary survival technique. Denial is very difficult to deal with, due to the repercussions of honesty, which may include court action and/or imprisonment. However, some work was done in these families. In both families, the child victim appeared to benefit most from intervention. Therefore it is therapeutically correct and clinically appropriate to work with families where the perpetrator is denying. In addition to denial, both families wanted to maintain the status quo and did not have the ability or investment to work on personal issues that directly influenced their ability to deal with the allegations of sexual abuse. It appears that the four months of direct work with these two families was not sufficient to promote change and that a longer period of time was necessary.

Relationship building is a key issue in working with these families. It is important to spend time with the families to develop trust and security and to provide them with constant nurturing. It is difficult to talk about non-sexual issues. In cases of intrafamilial sexual abuse where sexual issues are discussed, it is much more stressful for the client system. However, a therapeutic relationship between the therapist and the client can facilitate discussion of pertinent, intimate issues. Due to relationships taking time to develop, a period of much longer than four months (as in this practicum) is required.

It is extremely important to develop and maintain contact with the family's social networks. These networks also provide direction to the family that may contradict or reinforce the clinician's direction. Assisting networks in understanding family needs is an important systemic intervention that

promotes a unified approach to healing. Networks require understanding and nurturing. The clinician must take the time to nurture networks into providing an integrated therapeutic response to the family. In this practicum, a lot of time was invested in nurturing networks.

In closing, it is believed that intervention was effective and that the families who participated in treatment received a service that assisted them to experience personal growth. The measures, client self-reports and clinical observation support this belief.

B Evaluation of the Student - Self Evaluation

One way to evaluate self would be to re-consider the previously stated educational benefits. It is my belief that these educational benefits have been met and to some extent, surpassed. Knowledge of systemic and feminist approaches to family violence has been increased due to the extensive literature review and due to working with committee members who have shared their perspectives of the feminist and systemic perspectives. In the process of building knowledge, I have had the opportunity to evaluate prior learning and knowledge and to consolidate a more structured approach in dealing with intrafamilial sexual abuse. In doing so I have developed new expertise and skills in working with this population and other client systems who are experiencing family violence. The expertise and skills developed have been most applicable to working in a community with limited resources. This practicum has given me the opportunity to learn skills in family, marital, dyadic, individual and social network intervention.

In addition to the benefits of academic or skill learning, this practicum has offered me the opportunity to develop a philosophy about the treatment of intrafamilial sexual abuse and abusive relationships in general. It is this philosophy that helps to design a clear approach to treatment. I have noticed personal and professional growth through the re-evaluation of values, beliefs and previous learning. I feel committed to what I believe, which reflects both academic and self knowledge; the two essential prerequisites for good clinical intervention.

APPENDIX ONE

Description of Pre and Post Measures

APPENDIX ONE - MEASURES

i) Family Assessment Measure

The Family Assessment Measure (FAM) was developed by Skinner, Steinhauer and Santa-Barbara (1983). The model was developed within the Process Model of Family Functioning Framework (Skinner et al, 1983). The authors believed that the overriding goal of the family is "the successful achievements of a variety of basic, developmental and crisis tasks" (p. 91) that are said to be central to family functioning. There are seven tasks that are assessed by family members. The task are task accomplishment, role performance, communication, affective expression, involvement, control and values and norms. All of these issues are assessed by FAM. This measure is not seen as a substitute for clinical assessment, rather is used in addition to clinical assessment of the family (Skinner et al, 1983). In addition to an assessment device, this measure can be used "as a measure of therapy outcome" (Skinner et al, 1983, p. 92).

FAM includes i) a general scale that looks at the family system, ii) a dyadic scale that assesses the relationship between two people in the family and iii) a self rating scale which obtains perceptions of individual family members regarding that individual's functioning in the family. For the purposes of this practicum, only the general and dyadic scales were used. It was decided to used the dyadic scale because the dyadic scale can be used to measure a relationship between any two people in the family while other scales used for dyadic relationships, are usually appropriate for only the marital couple. In working with intrafamilial sexual abuse families, it would be important to get a measure of the mother/child relationship. FAM will be used in this

practicum due to its ability to assess families, to be used as an outcome measure and due to its significant level of reliability (Skinner et al, 1983).

ii) Index of Self-Esteem

The Index of Self Esteem (ISE) is a standardized scale which "measures the degree or magnitude of a problem the client has with the evaluative component of self-concept" (Hudson, 1982, p. 230). This scale is one of a number of scales that Hudson and co-workers have developed. The ISS scale (to follow) is another scale developed by Hudson and co-workers. Bloom and Fischer (1982) recommend the use of these scales as the scales have been developed to be used as repeated measures, "all scales are short (25 items each), easy to administer, easy to interpret, easy to complete, easy to score" (p. 149) and appear to be a stable measure even after repeated administrations. The Index of Self Esteem, as with other Hudson scales, is said to have high test-retest reliabilities and internal reliabilities. In addition to this the scale has "high face, concurrent and construct validity" (Bloom and Fischer, 1982, p. 149) and has the ability to discriminate between clinical and nonclinical populations. However, Hudson (1982) recognizes the potential for response bias (particularly social desirability) to affect the client's rating on each items. In addition, one must then be cautious about how the results are being interpreted. If one wants to present well on this scale, this can easily be done.

All Hudson's scales are scored in the same way, by using an equation (as identified below in the description of the ISS scale) and by reversing the scores of every positively worded item (Bloom and Fischer, 1982). The item scores to be reversed in the Index of Self Esteem are

3,4,5,6,7,14,15,18,21,22,23, and 25. Bloom and Fischer (1982) suggest that the clinical cut off point be 30 and that the scale be used as one part of the assessment process. The value or clinical significance of the results of this measure needs to be evaluated by clinician. For example, a score of 29 or 31 does not mean that the person is healthy or unhealthy. The score of 30 as a cut off point is a "very rough guide" (Bloom and Fischer, 1982, p. 151). Hudson (1982) recommends that the scale be administered to children 12 years and over due to the literary and cognitive integration skills needed to complete this measure.

The scores obtained on this measure will provide an indication on the level of self esteem of the child. The child's level of self esteem is an indication of how traumatic life events are for the child and how well the child is able to cope with the situation. The clinician can use the scoring of self esteem to indicate the child's progress in coping with the sexual abuse. Everstine and Everstine (1983) noted that the child experiences guilt, worthlessness and low self esteem due to the sexual abuse. It is believed that if the level of self esteem increases, one may assume that the child's feelings of guilt and worthlessness has decreased and that the child has begun to reconstruct his/her life in a healthy, growth producing way. In the Index of Self Esteem, the lower the score, the more self esteem is predicted.

iii) Index of Sexual Satisfaction (ISS)

This index is a twenty five item self-report scale that "measures the degree or magnitude of sexual discord or dissatisfaction of one's relationship with a partner" (Hudson, Harrison, Crosscup, 1981, p. 157). The ISS can be used for

repeated administration and as a global measure for diagnosis, assessment and outcome results.

When scoring the ISS it is necessary to first reverse the scores on items numbered 1,2,3,9,10,12,16,17,19,21,22 and 23. These items are the positively worded items. When the client has completed all the items on the scale, the following equation is used to calculate the scores: (sum Y-N) (100) over N (4). (Y is the score for each items and N is the number of items completed.) Hudson et al (1981) state that if the client does not score five or more of the items, the score is not calculated. The therapist will need to explore with the clients the reasons why the items were not completed. However if the client completes all items, the following equation is used to calculate the score: Y-25.

Hudson et al (1981) consider a score of 28 to be the critical point between health and pathology. Those scores higher than 28 are believed to have a sexual problem, while those lower than 28 are believed not to have a sexual problem. However, the authors note that no single score for the ISS should be taken seriously without evaluating the score in comparison to other available clinical information. The authors believe that four items in this scale (items numbered 14, 16, 20, and 24) need to be replaced and have suggested replacement items. These replacement items will be used in the scale for this practicum.

The ISS has strong psychometric properties and can discriminate between a clinical and nonclinical sample (Hudson et al, 1981). This measure is important to the practicum due to the dynamics of intrafamilial child sexual abuse, particular those issues that focus on the role reversal of mother and

child, the sexualization of family relationships and the belief that the marital subsystem lacks intimacy and a healthy relationship.

APPENDIX TWO

Graphic Presentation of the Pre and Post Family Assessment Measures

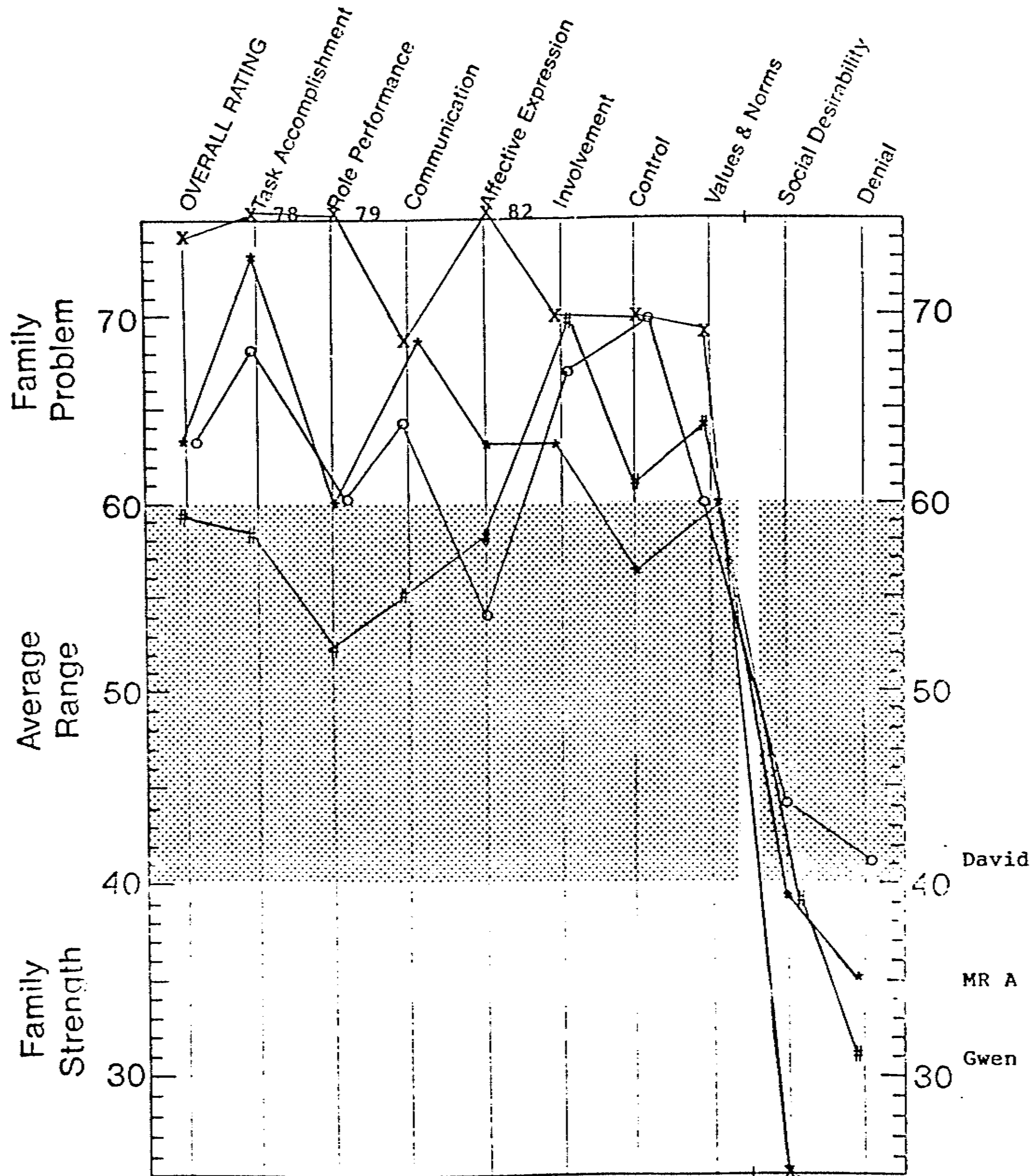

Figure A-1

November 1988 rating of the FAM General by Family A

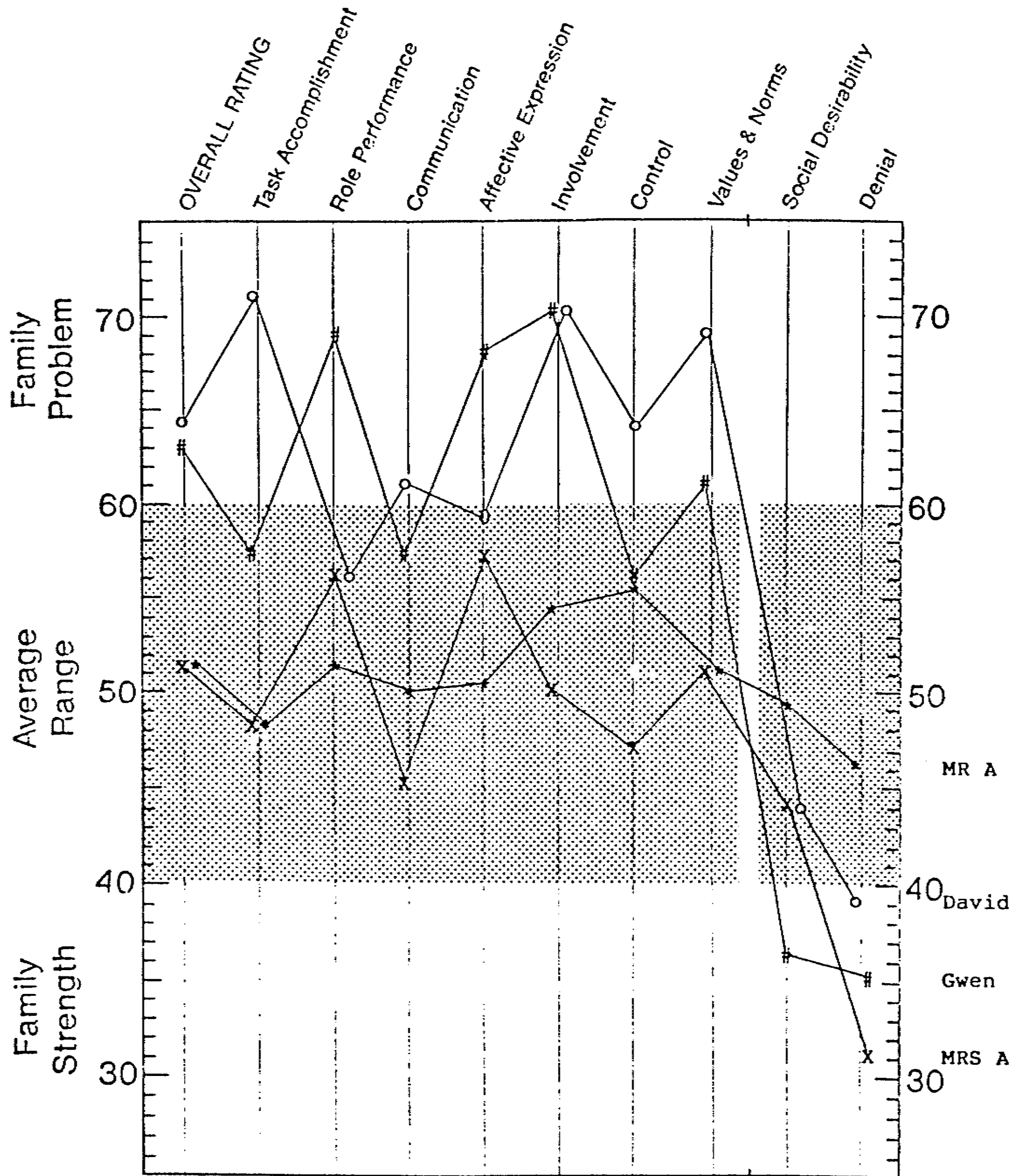

Figure A-2

July 1989 rating of the FAM General by Family A

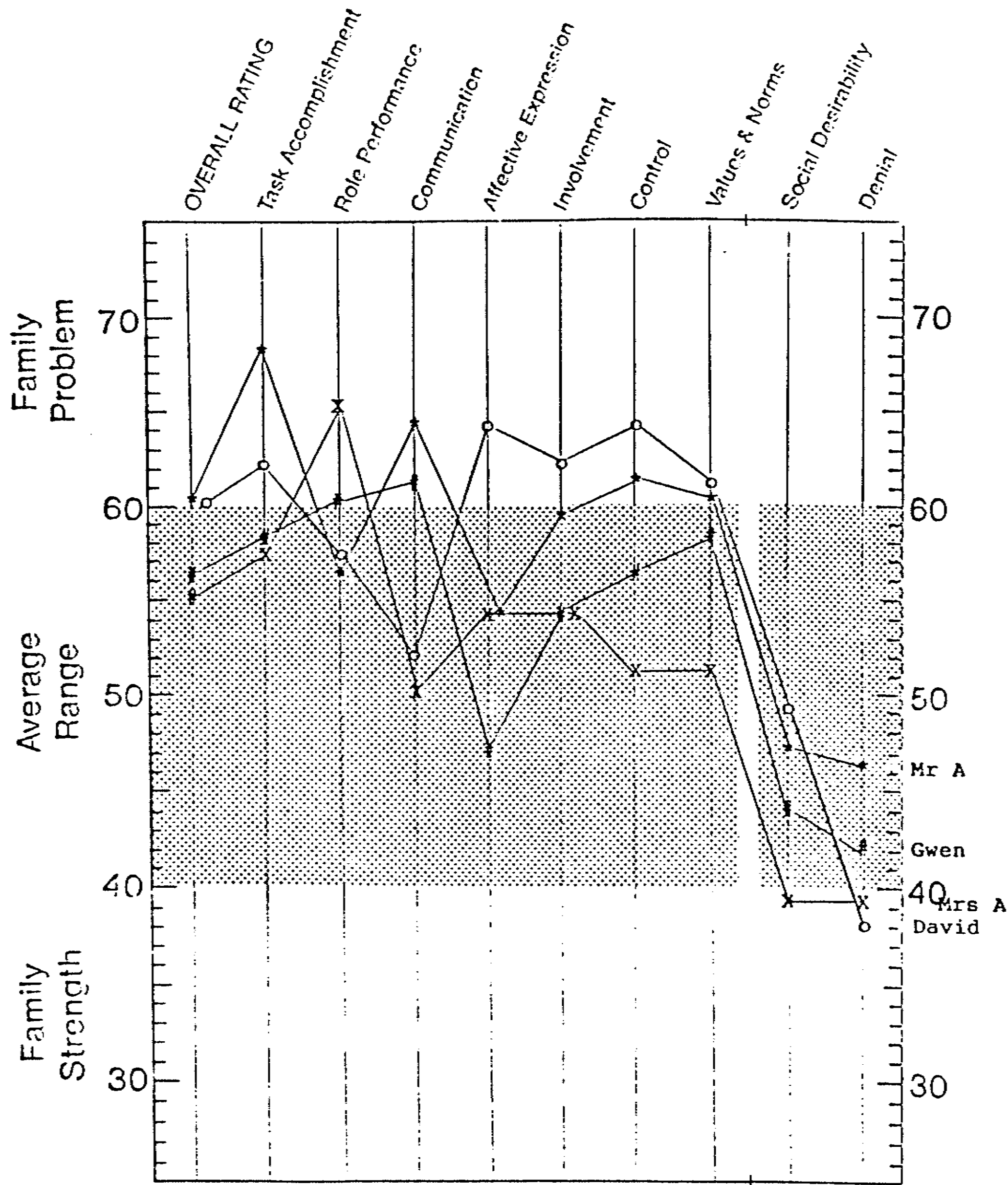

Figure A-3

October 1989 rating of the FAM General by Family A

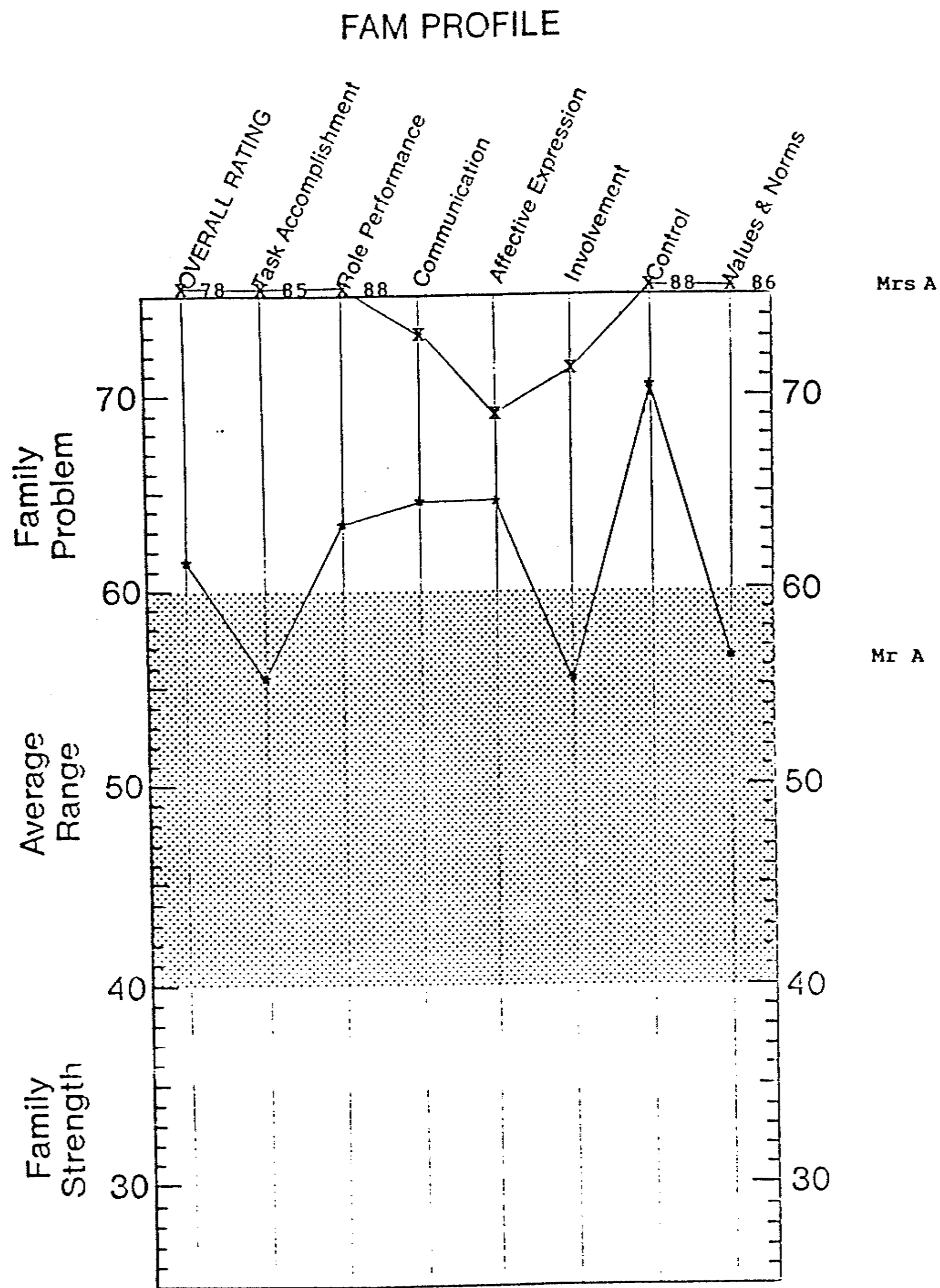

Figure A-4

November 1988 rating of the FAM Dyadic by Mr and Mrs A

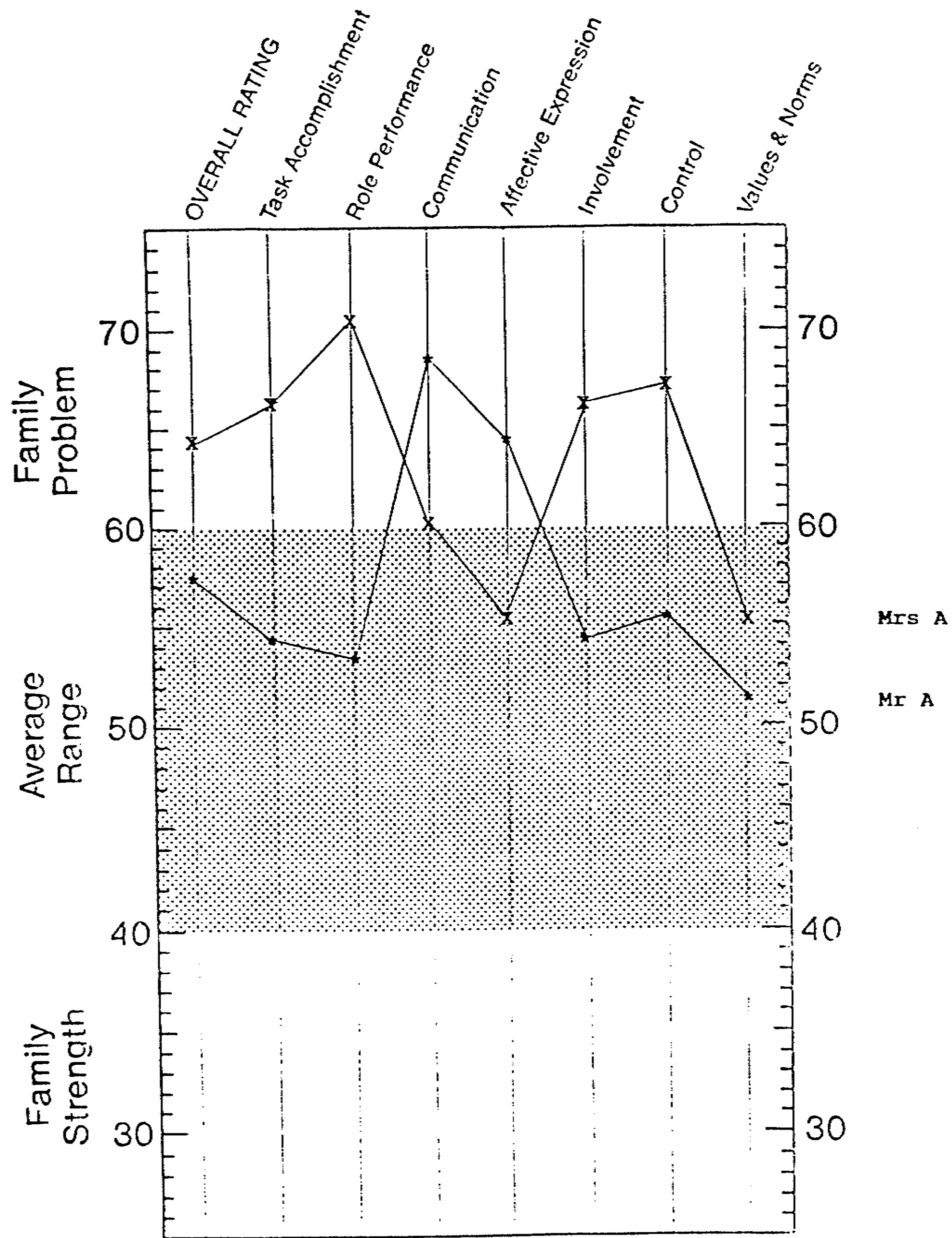

Figure A-5

July 1989 rating of the FAM Dyadic by Mr & Mrs A

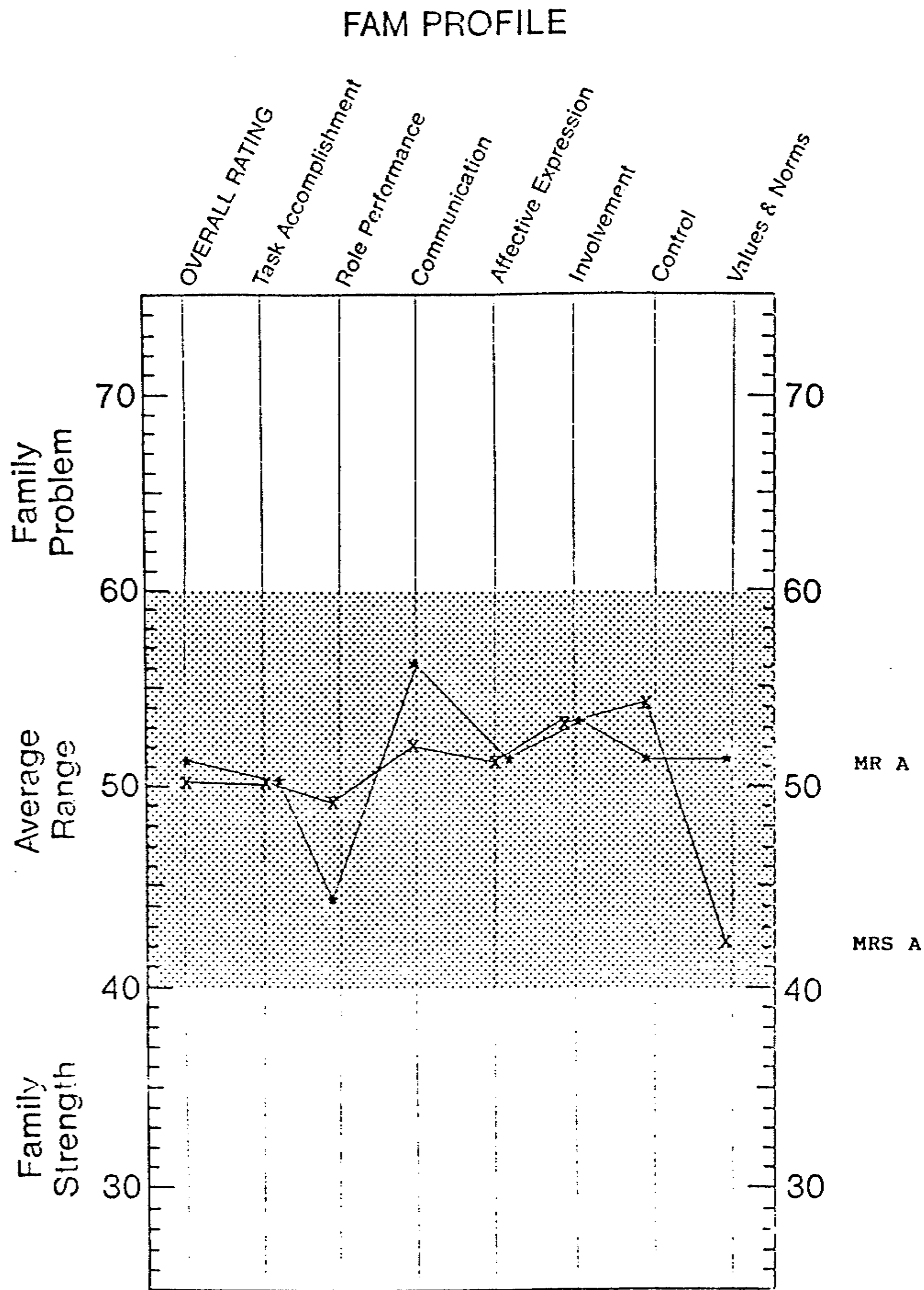

Figure A-6

October 1989 rating of the FAM Dyadic by Mr & Mrs A

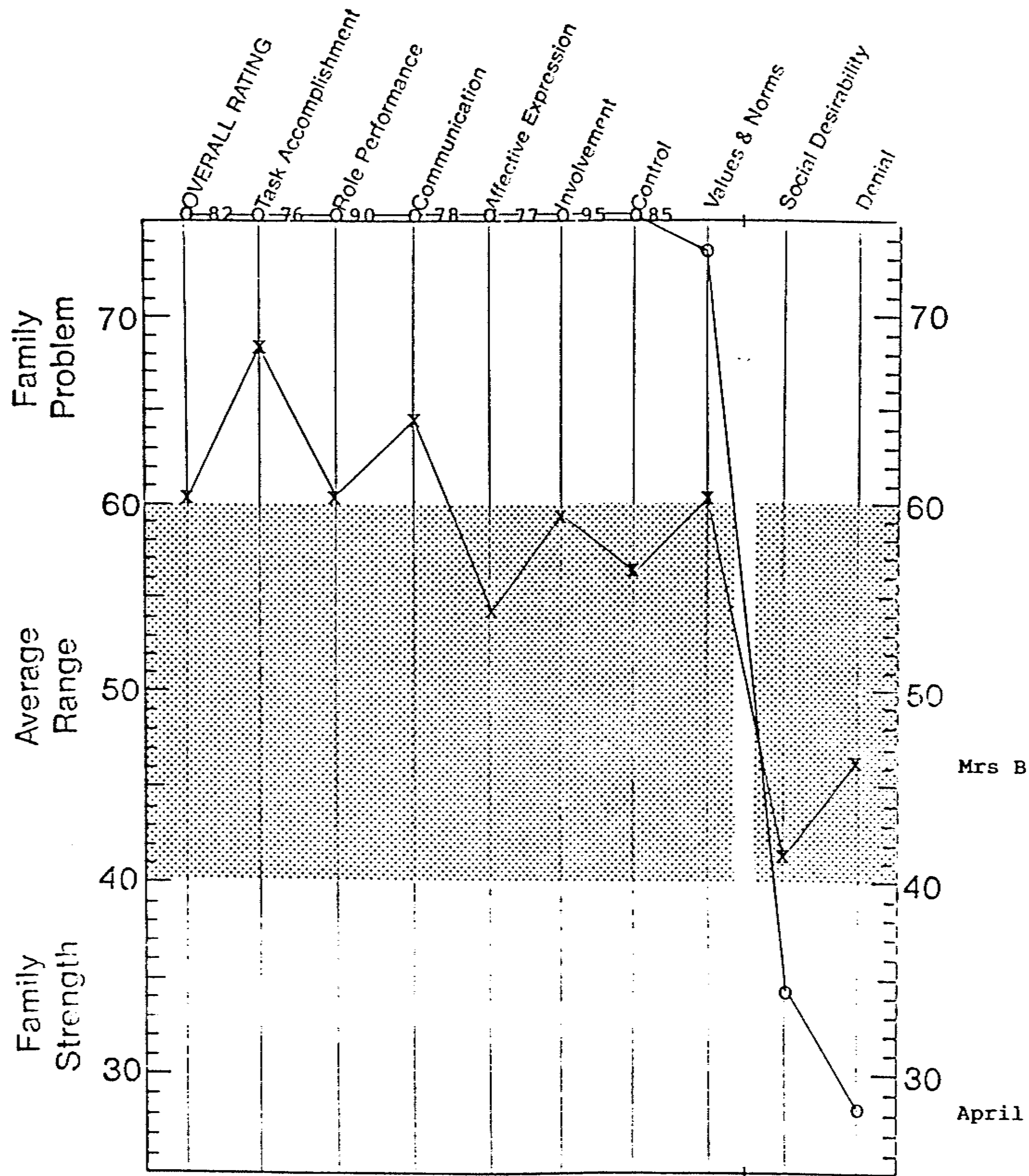

Figure B-1

August 1989 rating of the FAM General by Family B

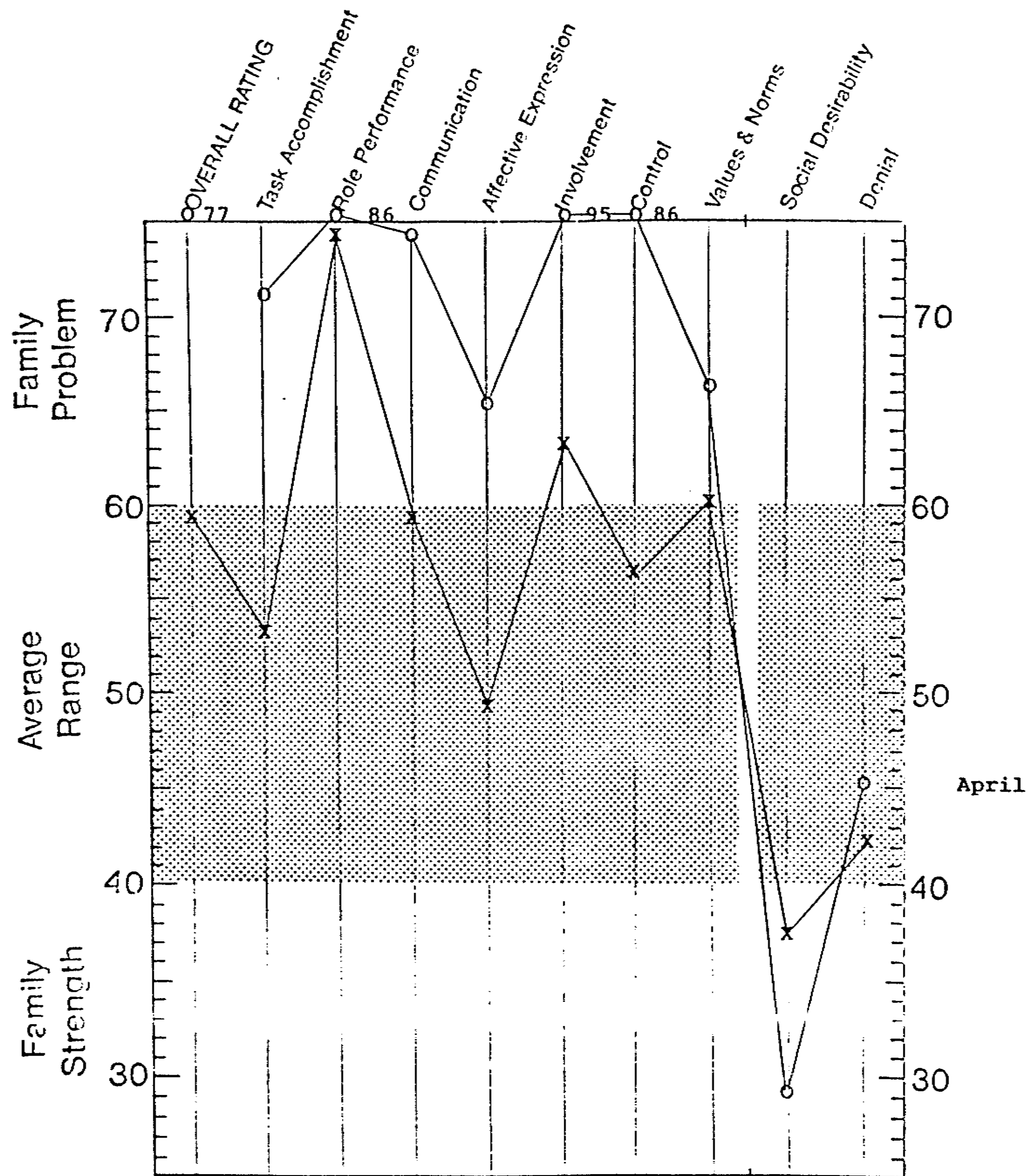

Figure B-2

October 1989 rating of the FAM General by Family B

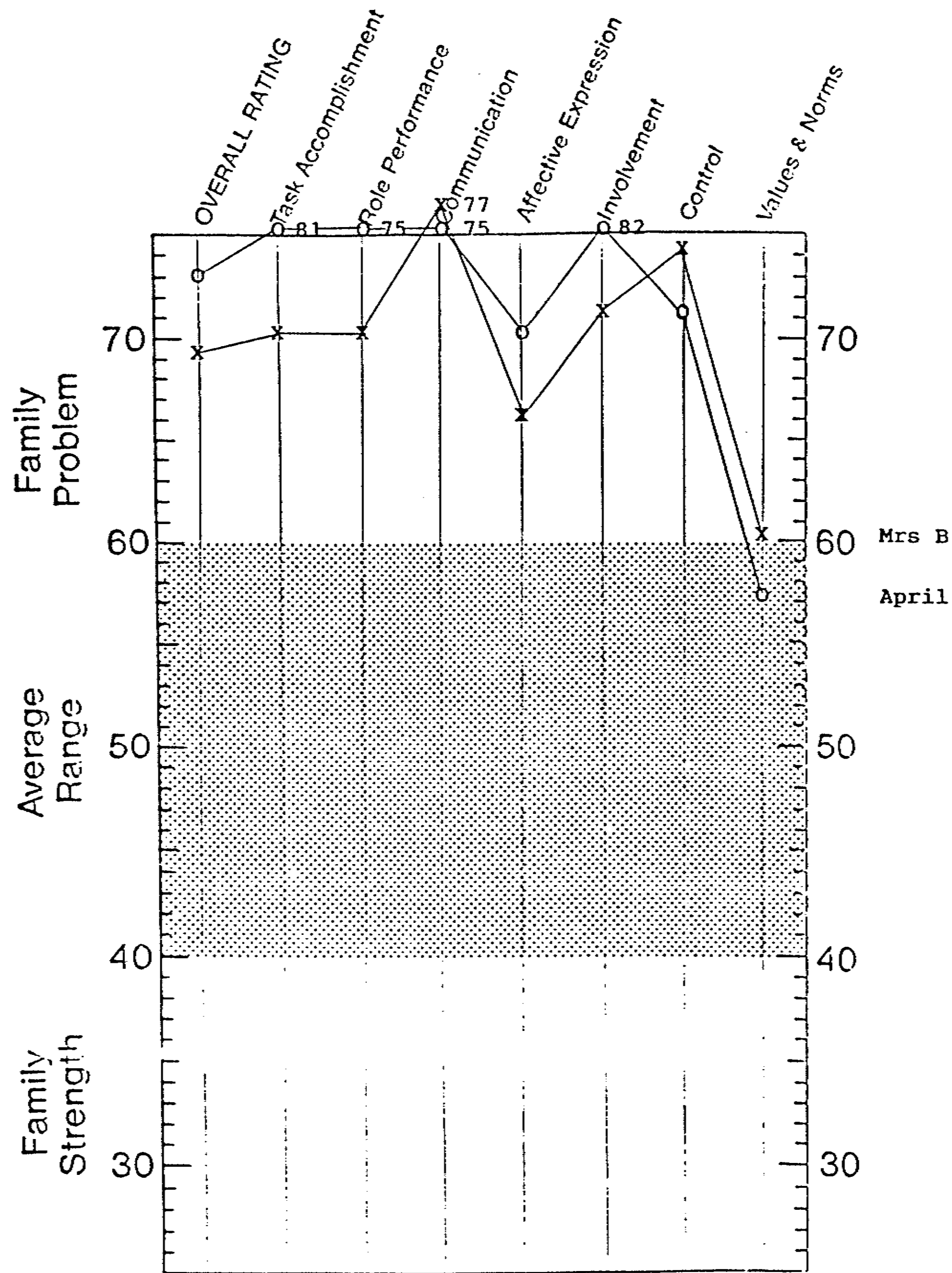

Figure B-3

August 1989 rating of the FAM Dyadic by Mrs B & April

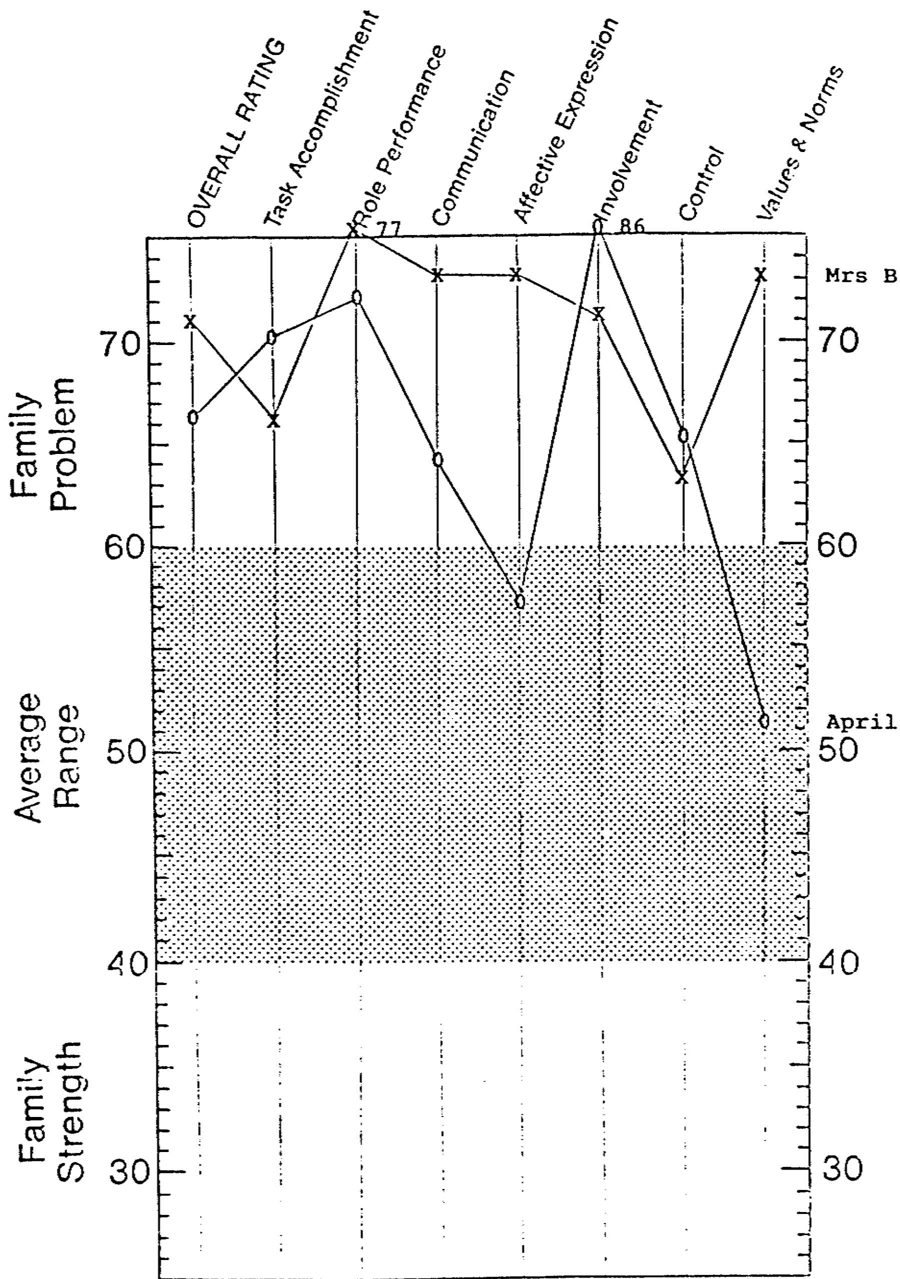

Figure B-4

October 1989 rating of the FAM Dyadic by Mrs B & April

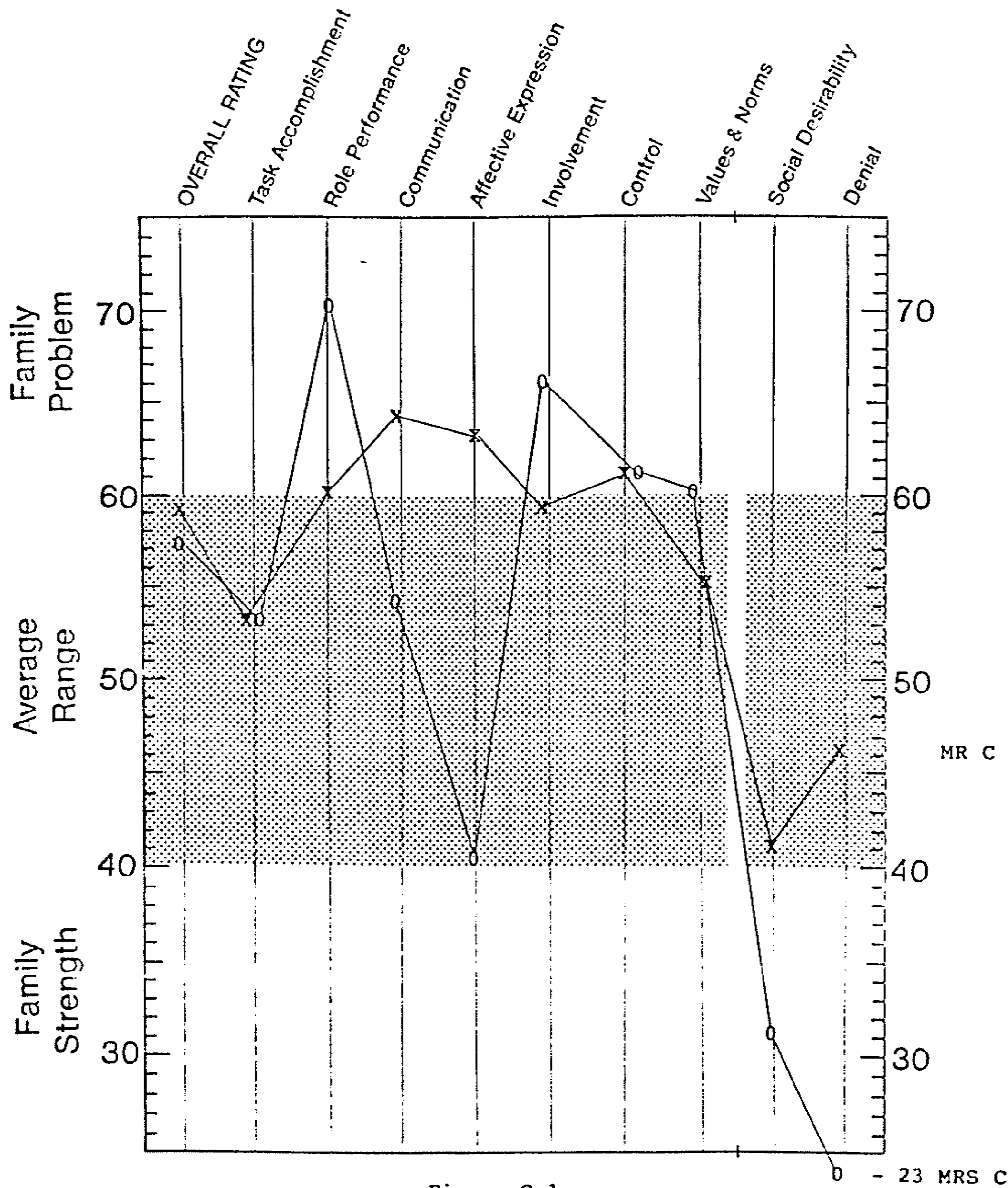

Figure C-1

July 1989 rating of the Fam General by Family C

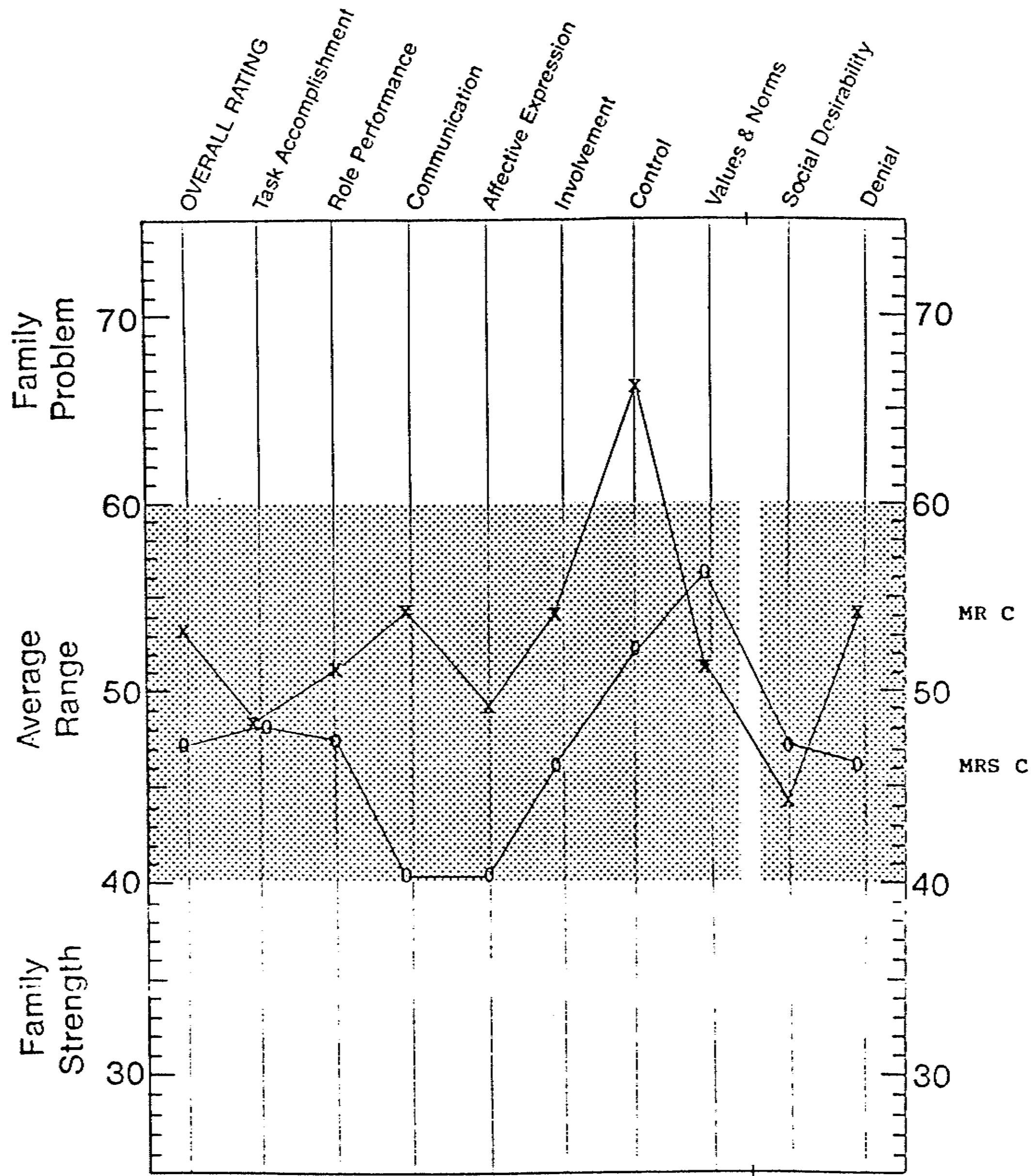

Figure C-2

October 1989 rating of the FAM General by Family C

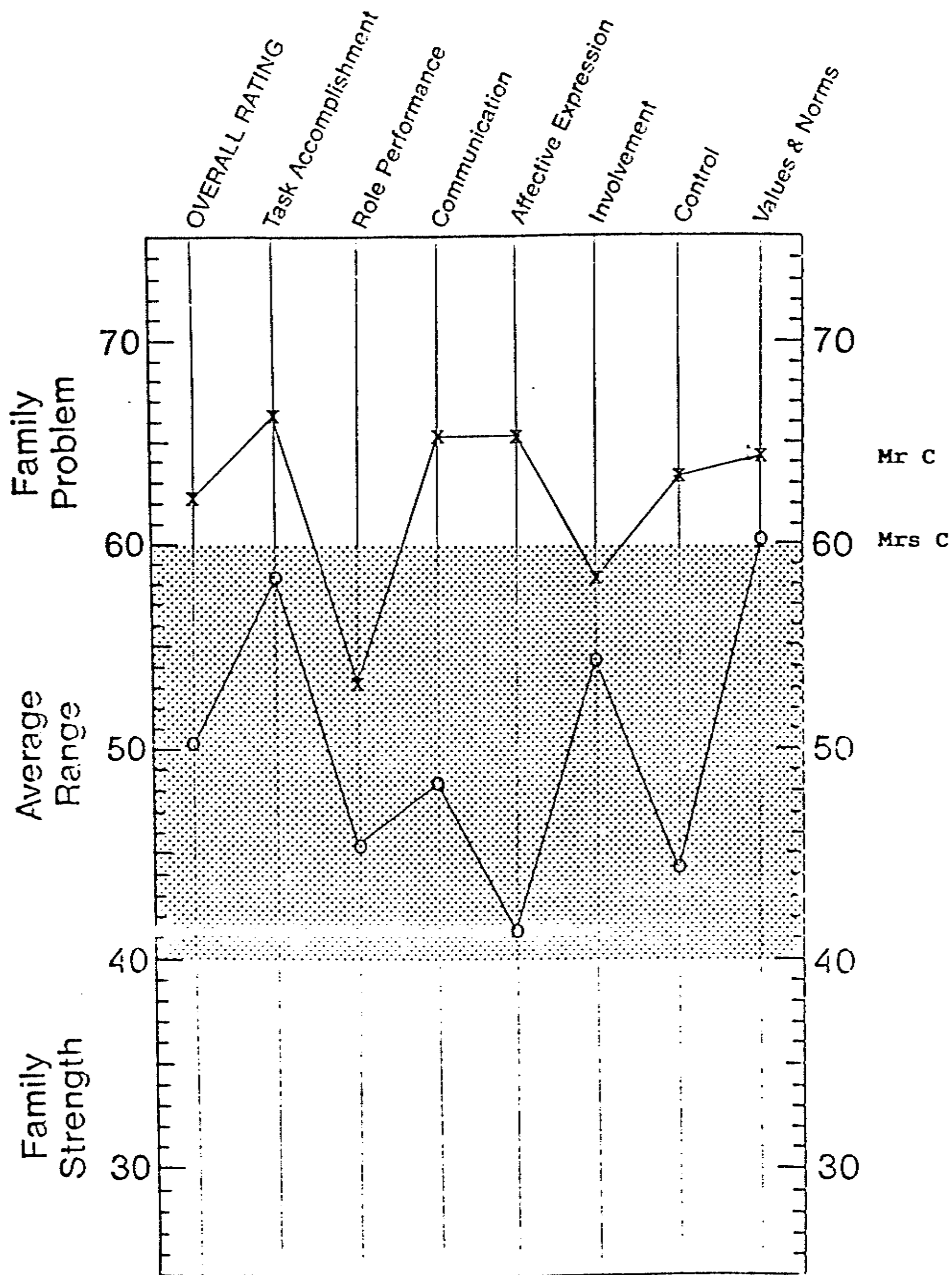

Figure C-3

July 1989 rating of the FAM Dyadic by Mr & Mrs C

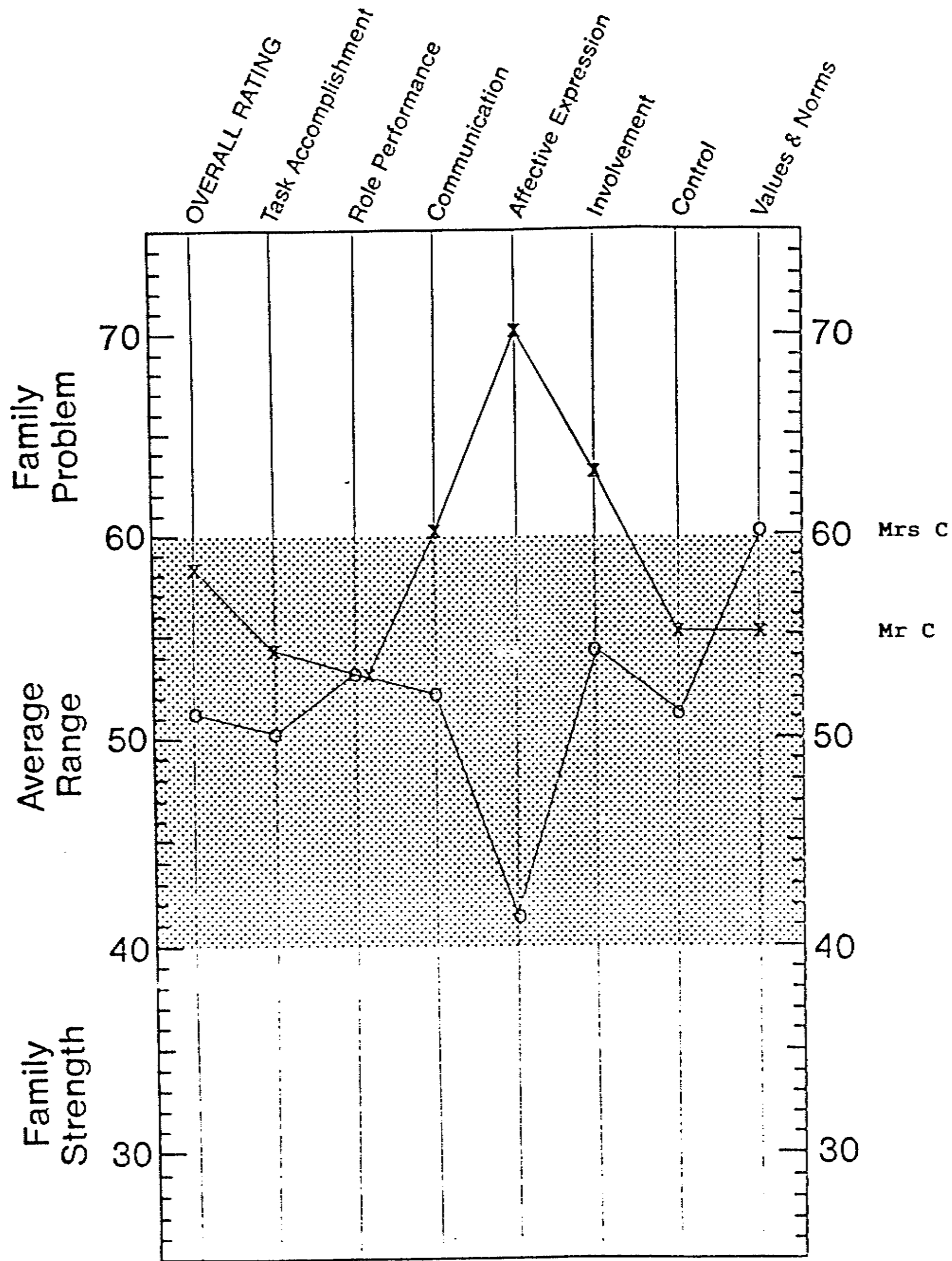

Figure C-4

October 1989 rating of the FAM Dyadic by Mr and Mrs C

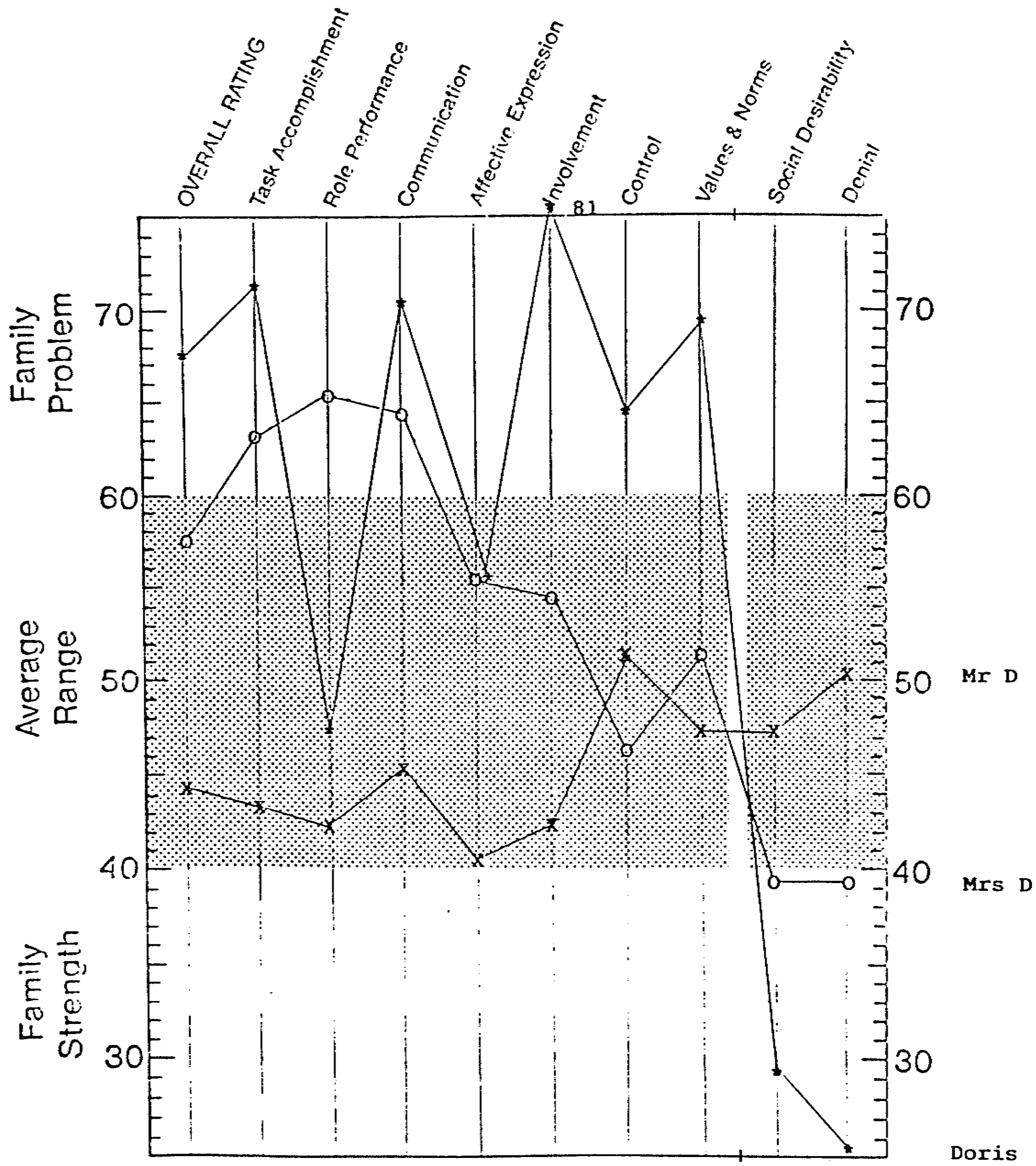

Figure D-1

June 1989 rating of the FAM General by Family D

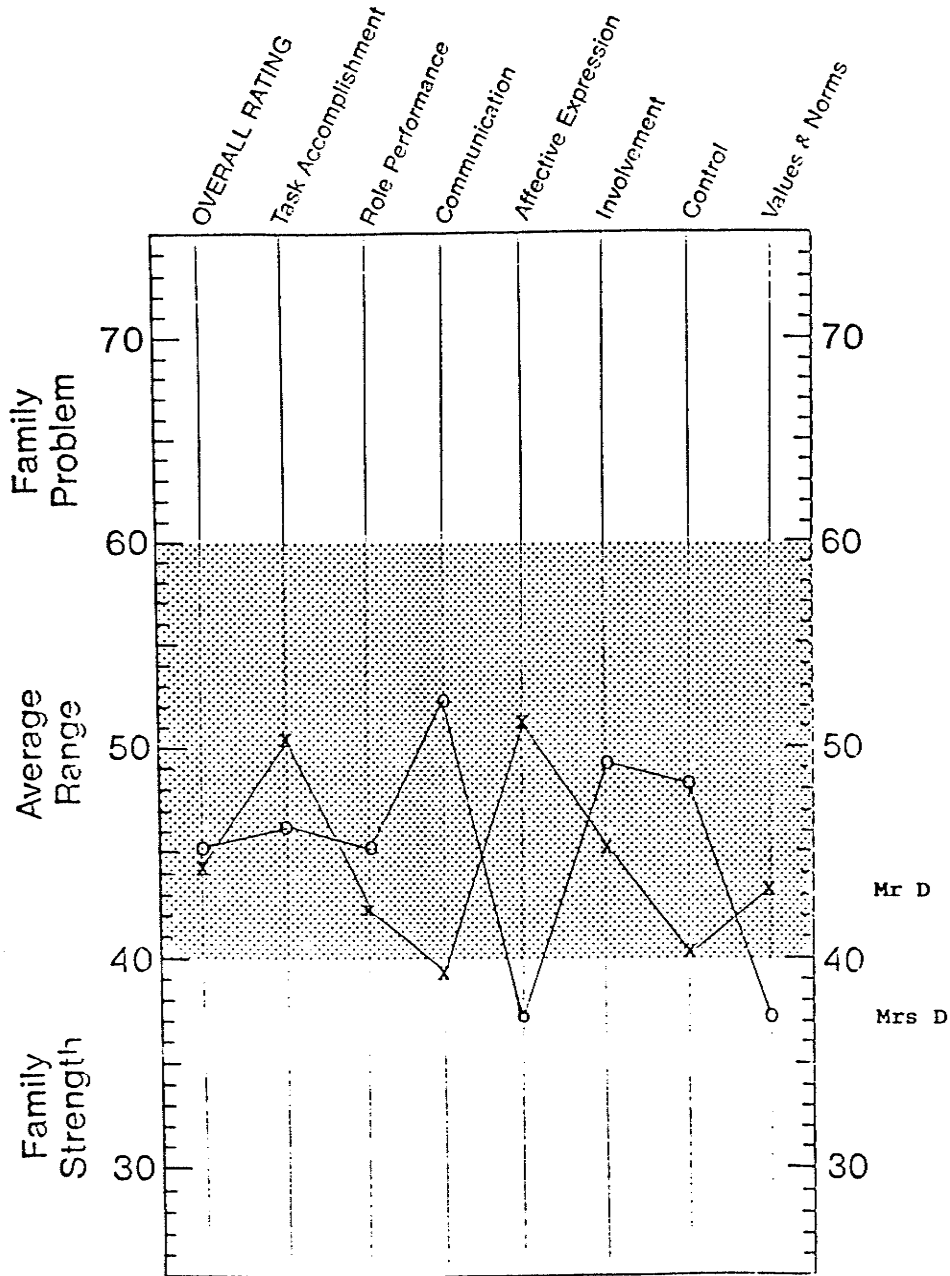

Figure D-2

June 1989 rating of the FAM Dyadic by Mr & Mrs D

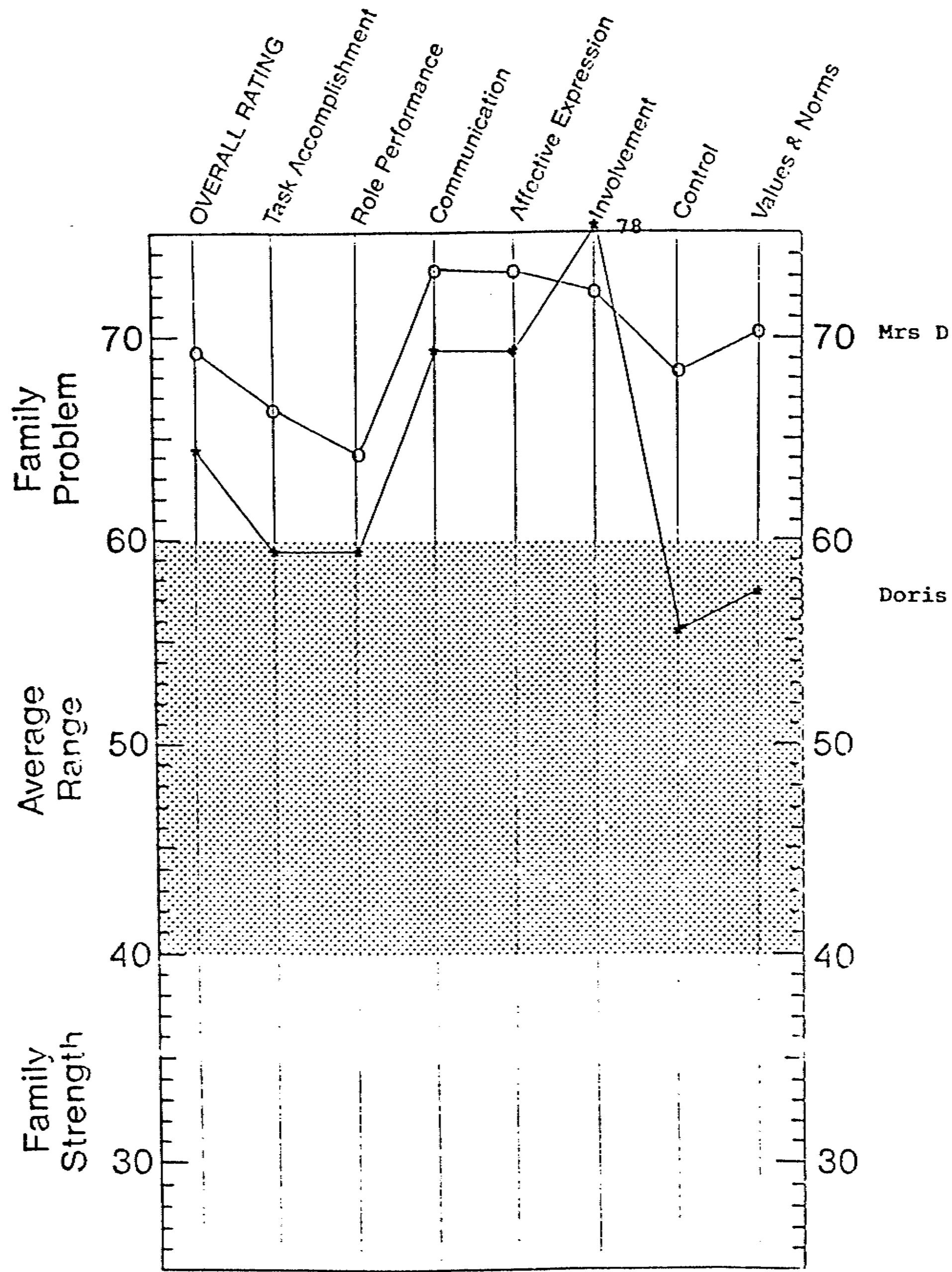

Figure D-3

August 1989 rating of the FAM Dyadic by Mrs D & Doris

REFERENCES

Alexander, P. C. (1985). A systems theory conceptualization of incest Family Process, 24, 79-88.

Amanat, E. (1984). Rape Trauma Syndrome: Developmental Variations, Chapter 3, in Stuart, I. and Greer, J. (1984). (Eds.) Victims of Sexual Aggression: Treatment of Children , Women and Men. New York: Van Nostrand Reinhold Company.

Anderson S. C., Bach, C., M. and Griffith, S. (1981, April). Psychosocial Sequelae in Intrafamilial Victims of Sexual Assault and Abuse. Paper presented at the Third International Conference on Child Abuse and Neglect in Amsterdam, The Netherlands, cited in Browne, A. and Finkelhor, D. (1986). Impact of Child Sexual Abuse: A Review of the Research. Health and Welfare Canada.

Arens, W. (1986). The Original Sin: Incest and It's Meaning. New York: Oxford University Press.

Arndt, W. B. and Ladd, B. (1981). Sibling incest aversion as an index of oedipal conflict. Journal of Personality Assessment, 45, 52-58.

Bagley, C. (1984). Mental health and the in-family sexual abuse of children and adolescents. Canada's Mental health, 17-23.

Bateson, G. (1971). The Cybernetics of 'self': A theory of alcoholism. Ballatine in Brundage, 1985.

Bateson, G. (1979). Mind and Nature: A Necessary Unity. New York: Bantom Books.

Becker, J., Skinner, L., Abel, F., Axelrod, R. and Cichon, J. (1984). Sexual problems of sexual assault survivors. Women and Health, 9, 5-20.

Belsky, J. (1980). Child maltreatment: an ecological intergration. American Psychologist, 35, 320-335

Bergh, N and Cooper, L. (Eds.) (1986). Feminist Visions for Social Work. Maryland: National Association of Social Workers Inc.

Bloom, M. and Fischer, J. (1982). Evaluating Practice: Guidelines for the Accountable Professional. New Jersey: Prentice Hall Inc.

Bograd, M. (1982). Battered women, cultural myths and clinical interventions: a feminist analysis. Women and Therapy, 1, 69-77.

Bograd, M. (1984). Family systems approach to wife battering: a feminist critique. American Journal of Orthopsychiatry, 54, 558-568.

Bograd, M. (1986). A feminist examination of family therapy : what is women's place. Women and Therapy, 5, 95-106.

Bolton, F. G. and Bolton, S. R. (1987). Working with Violent Families:

a Guide for Clinical and Legal Practitioners. California: Sage Publications.

Brickman, J. (1984). Feminist, nonsexist, and traditional models of therapy: implications for working with incest. Women and Therapy, 3, 49-67.

Brown, S. (1979). Clinical illustrations of the sexual misuse of girls. Journal of Child Welfare League of America, 108, 435-442.

Browne, A. and Finkelhor, D. (1986). Impact of child sexual abuse: a review of the research. Health and Welfare Canada.

Brundage, V. (1985). Gregory Bateson, alcoholic anonymous and stoicism. Psychiatry, 48, 40-51.

Burton, C. (1985). Subordination: Feminism and Social Theory. North Sydney: George Allen and Unwin Australia Party Ltd.

Caprio, F. S. (1955). Deviations in Sexual Behavior: A Psychodynamic Study of Deviations in Various Expressions of Sexual Behavior. New York: Citadel Press.

Chambles, D. L. and Wenk, N. M. (1982). Feminist vs non feminist therapy: the client's perspective. Women and Therapy, 1, 57-65.

Check, J. V. P. and Malamuth, N. (1985). An empirical assessment of some feminist hypothesis about rape. International Journal of Women's Studies, 8, 414-423.

Cole, E. (1982). Sibling Incest: The myth of benign sibling incest. Women and Therapy, 1, 79-89.

Comfort, R. L. (1985). Sex, strangers and safety. Journal of Child Welfare League of America, 154, 541-545.

Courtois, C. A. (1988). Healing the incest wound. New York: W. W. Norton.

D'Amico, R. (1984). The meaning of pornograpy. Humanities in Society, 7, 87-101.

Dalton, R. D. (1986). The psychology of fathers and daughters: a feminist approach and methodology. Women and Therapy, 5, 207-218.

Damon, L., Todd, J. and MacFarlane, K. (1987). Treatment issues with sexually abused young children. Journal of Child Welfare League of America, 156, 125-529.

Daly, M. (1984). Pure Lust: Elemental Feminist Philosophy. Boston: Beacon Press.

Dell, P. F. (1986). Toward a foundation for addressing violence. Family Process, 25, 527-529.

de Shazer, S. (1989). Wrong map, wrong territory. Journal of Marital and Family Therapy, 15, 117-121.

DeYoung, M. (1987). Disclosing sexual abuse: the impact of developmental variables. Journal of Child Welfare League of America, 156, 217-222.

Doan, L. and Levy, R. (1983). Male sexual assault. The Journal of Emergency Medicine, 1, 45-49.

Eckersley, R. (1987). Whither the feminist campaign?: an evaluation of feminist critiques of pornography. International Journal of the Sociology of Law, 15, 149-178.

Eisenstein, H. (1983). Contemporary Feminist Thought. Boston: G. K. Hall.

Eist, H. I. and Mandel, A. U. (1968). Family treatment of ongoing incest behavior. Family Process, 7, 216-232.

Epstein, N. B. and Bishop,, D. S. (1981). Probem-Centred Systems Therapy of the Family , in A. S. Gurman and D. P. Kniskern (Eds.), Handbook of Family Therapy, New York: Brunner/Mazel Inc.

Erickson, G. (1988). Against the grain: decentering family therapy. Journal of Marital and Family Therapy, 14, 225-236.

Everstine, D. S. and Everstine, L. (1983). People in Crisis: Strategic Therapeutic Interventions. New York: Brunner/Mazel.

Faller, K. C. (1988). Decision making in cases of intrafamilial child sexual abuse. American Journal of Orthopsychiatry, 58, 121-128.

Ficher, I. (1976). Sex and the Life Cycle. Oaks, W. W., Melchiode, G. A. and Ficher, I. (Eds.). Chapter 8. New York: Grune and Stratton.

Finkelhor, D. (1979). What's wrong with sex between adults and children: ethics and the problem of sexual abuse. American Journal of Orthopsychiatry, 49, 692-697.

Finkelhor, D. (1979). Sexually Victimized Children. New York: The Free Press.

Finkelhor, D. (1984). Child Sexual Abuse: New Theory and Research. New York: The Free Press.

Finkelhor, D. (1986). Abusers: Special Topics. In D. Finkelhor and associates (Eds.), A Source Book and Child Sexual Abuse, Beverly Hills: Sage Publications.

Giaretto, H. (1982). Intergrated Treatment of Child Sexual Abuse - A Treatment and Training Manual. California: Science and Behavior Books Inc.

Gebhard, H. P. et al (1965). Sex Offenders: An Analysis of Types. New York: Harper Row as cited in Santiago, L. P. R. (1973). The Children of Oedipus: Brother-Sister Incest in Psychiatry, Literature, History and Mythology. New York: Libra Publishers Inc.

Gerber, G. L. (1986). The relationship balance model and it's implications for individual and couples therapy. Women and Therapy, 5, 19-27.

Goodrich, T. J., Rampage, C., Ellman, B., and Halstead, K. (1988). Feminist Family Therapy: A Casebook. New York: W. W. Norton.

Gordon, L. (1986). Family violence, feminism and social control. Feminist Studies, 12, 453-478.

Greenspan, M. (1986). Should therapists be personal?: self-disclosure therapeutic distance in feminist therapy. Women and Therapy, 5, 5-17.

Greer, G. (1975). Seduction is a Four Letter Word in L. G. Schultz (Ed.). Rape Victimology, Springfield: Thomas cited in Katz, S. and Mazur, M. (1979). Understanding the Rape Victim: A Synthesis of Research Findings. New York: John Wiley and Sons.

Hartsock, N. C. M. (1984). Gender and sexuality: masculinity, violence and domination. Humanities in Society, 7, 19-45.

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

Hechler, D. (1988). The Battle and the Backlash: The Child Sexual Abuse War. Massachusetts: D. C. Health and Company.

Herman, J. L. (1986). Histories of violence in an outpatient population: an exploratory study. Amercian Journal of Orthopsychiatry, 56, 137-141.

Herman, J. L. (1988). Considering sex offenders: a model of addiction, Signs, 13, 695-724.

Hof, L. and Berman, E. (1986). The sexual genogram. Journal of Marital and Family Therapy, 12, 39-47.

Hooks, B. (1984). Feminist Theory: From Margin to Center. England: South End Press.

Hudson, W. W. (1982). A measurement package for clinical workers. Journal of Applied Behavioral Science, 18, 229-238.

Ingram, T. L. (1985). Sexual abuse in the family of origin and unresolved issues; a gestalt/systems treatment approach for couples. Family Therapy, 12, 175-183.

Katz, S. and Mazur, M. (1979). Understanding the Rape Victim: A Synthesis of Research Findings. New York: John Wiley and Sons.

Kerr, M. E. (1981). Family Systems Theory and Therapy , in A. S. Gurman and D. P. Kniskern (Eds.), Handbook of Family Therapy, New York: Brunner/Mazel.

L'Abate, L., Ganahl, G. and Hansen, J. C. (1986). Methods of Family Therapy. New Jersey: Prentice Hall Inc.

Libow, J. A., Raskin, P. A. and Caust, B. L. (1984). Feminist and Family Systems Therapy - Are They Irreconcilable? in D. H. Olson and B. C. Miller (Eds.), Family Studies Review Yearbook, 2, California: Sage Productions.

Long, K. A. (1986). Cultural considerations in the assessment and treatment of intrafamilial abuse. American Journal of Orthopsychiatry, 56, 131-136.

Lugtig, D. (1988). Neighbourhood parenting support project: social network intervention. Perspectives: The Child and Family Services Research Group, December 1988, 1-3.

Machotka, P., Pittman, F. S. and Flomenhaft, K. (1967). Incest as a family affair. Family Process, 6, 98-116.

MacLeod, L. (1987). Battered But Not Beaten ... Preventing Wife Battering in Canada. Ottaawa: Canadian Advisory Council on the Status of Women.

McGrath, C. (1979). The crisis of domestic order. Socialist Review, 9, 11-30.

Meiselman, K. C. (1978). Incest: a psychological study of causes and effects with treatment recommendations. San Francisco: Jossey Bass Publishers.

Meyer, W. S. (1987). An abused child grows up and enters treatment. Clinical Social Work Journal, 15, 136-147.

Mezey, G. (1985). Rape: victiminological and psychiatric aspects. British Journal of Hospital Medicine, 33, 152-158.

Minuchin, S. (1982). Reflections on boundaries. American Journal of Orthopsychiatry, 52, 655-663.

Mitra, C. L. (1987). Judical discourse in father and daughter incest appeal cases. International Journal of the Sociology of Law, 15, 121-148.

Moos, R. M. and Schaefer, J. A. (Eds.) (1986). Coping with Life Crisis: An Intergrated Approach. New York: Plenum Press.

Mrazek, P. B. (1981) The Nature of Incest: A review of Contributing Factors in Mrazek, P. B. and Kempe, C. H. (Eds.) (1981). Sexually abused children and their families. Oxford: Peragamon Press Ltd.

Mrazek, P. B. and Kempe, C. H. (Eds.) (1981). Sexually Abused Children and Their Families. Oxford: Pergamon Press Ltd.

Nelson, J. A. (1986). Incest: self report findings from a nonclinical sample. The Journal of Sex Research, 22, 463-477.

Newberger, C. M. and De Vos, E. (1988). Abuse and victimization: a life span developmental perspective. American Journal of Orthopsychiatry, 58, 505-511.

Porter, R. (Ed.) (1984). Child Sexual Abuse Within the Family. CIBA Foundation, New York: Tavistock Publications.

Rakow, L. F. (1986). Rethinking gender research in communication. Journal of Communication, 36, 11-26.

Rance-Wentworth, V. (1982). Feminist social process. Women and Therapy, 1, 89-96.

Randell, J. (1973). Sexual Variations. Great Britian: Priory Press Ltd.

Reilly, P. and Gruszski, R. (1984). A structured didactic model for men for controlling family violence. International Journal of Offender Therapy and Comparative Criminology, 28, 223-235.

Ring, J. (1987). Toward a feminist epistemology. American Journal of Political Science, 31, 753-772.

Rioch, M., Coulter, W., and Weinberger, D. (1976). Dialogues for Therapists. San Francisco: Jossey-Bass.

Rist, K. (1979). Incest: theoretical and clinical views. American Journal of Orthopsychiatry, 49, 680-691.

Rose, D. (1986). "Worse Than Death": Psychodynamics of Rape Victims and the Need for Psychotherapy. American Journal of Psychiatry, 143, 817-824.

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

Sales, E., Baum, M. and Shore, M. (1984). Victim readjustment following assault. Journal of Social Issues, 40, 117-136.

Santiago, J., McCall, F., Gorcey, M and Beigel, A. (1985). Long-term psychological effects of rape in 35 rape victims. American Journal of Psychiatry, 142, 1338-1340.

Santiago, L. P. R. (1973). The Children of Oedipus: Brother-Sister Incest in Psychiatry, Literature, History and Mythology. New York: Libra Publishers Inc.

Saunders, B. E. and Schuchts, R. A. (1987). Assessing parent-child relationships: a report of normative scores and revalidation of two clinical scales. Family Process, 26, 373-381.

Schechter, S. (1982). Women and Male Violence: The Vision and Struggles of the Battered Women's Movement. Boston: South End Press.

Schlesinger, B. (1981). Sexual Abuse of Children: A Teaching Guide. Faculty of Social Work, University of Toronto. Ministry of Community and Social Services, Ontario.

Schultz, B. and Anderson, J. (1986). What do we know and where do we go? American Behavioral Scientist, 29, 368-376.

Sesan R., Freeark, K. and Murphy, S. (1986). The Support Network: Crisis Intervention for Extrafamilial Child Sexual Abuse. Professional Psychology: Research and Practice, 17, 138-146, cited in Haugaard and Reppucci, (1988). The Sexual Abuse of Children. San Francisco: Jossey-Bass.

Selvini, M. P., Boscolo, L., Cecchin, G., and Prata, G. (1980). Hypothesizing - circularity - neutrality: three guidelines for the conductor of the session. Family Process, 19, 3-12.

Shapiro, R. (1986). Passing the buck: too often therapists stay clear of violent cases. Family Networker, 10, 64-66.

Simrel, K., Berg, R., and Thomas, J. (1979). Crisis Management of Sexually Abused Children. Pediatric Annals, 8, 59-72, cited in Haugaard and Reppucci, (1988). The Sexual Abuse of Children. San Francisco: Jossey-Bass.

Sink, F. (1988). A hierarchical model for evaluation of child sexual abuse. American Journal of Orthopsychiatry, 58, 129-135.

Skinner, H. A., Steinhauer, P. D. and Santa-Barbara, J. (1983). The family assessment measure. Canadian Journal of Community Mental Health, 2, 91-105.

Skynner, A. C. R. (1981). An Open-Systems, Group Analytic Approach to Family Therapy, in A. S. Gurman and D. P. Kniskern (Eds.), Handbook of Family Therapy, New York: Brunner/Mazel.

Sonkin, D. A., Martin, D. and Walker, L. E. A. (1985). The male batterer: a treatment approach. New York: Springer.

Strong, B. (1973). Toward a history of the experiential family: sex and incest in the nineteenth century family. Journal of Marriage and the Family, 35, 457-466.

Swan, R. W. (1985). The child as an active participant in the sexual abuse. Clinical Social Work Journal, 13, 62-77.

Swink, K. K. and Leveille, A. E. (1986). From victim to survivor: a new look at the issues and recovery proces for adult incest survivors. Women and Therapy, 5, 119-141.

Thorman, G. (1983). Incestuous Families. Springfield: C. C. Thomas.

Weinbach, R. and Curtiss, C. R. (1986). Making child abuse victims aware of their vicitimization: a treatment issue. Journal of the Child Welfare League of America, 155, 337-346.

Weiner, B. (1964). in Excerpta Criminologica, 4, 137-155 cited in Machotaka, P., Pittman, F. S. and Flomenhaft, K. (1967). Incest as a family affair. Family Process, 6, 98-116.

White, S. L. (1978). Family theory according to the Cambridge Model. Journal of Marriage and Family Counselling, , 91-100.

Willbach, D. (1989). Ethics and family: the case management of family violence. Journal of Marital and Family Therapy, 15, 43-52.

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

Wodarski, J. S. (1987). An examination of spouse abuse: practice issues for the profession. Clinical Social Work Journal, 15, 172-187.