PRACTICUM

A SYSTEMIC MODEL OF GROUP INTERVENTIONS WITH EARLY ADOLESCENT FEMALE INTRAFAMILIAL CHILD SEXUAL ABUSE VICTIMS AND A PARALLEL NON-OFFENDING CAREGIVERS' GROUP FOR LATENCY AGED VICTIMS

By

Barbara Elizabeth Gajdek

A Practicum

Presented to the Faculty of Graduate Studies

in Partial Fulfilment of the Requirement for the Degree

Master of Social Work

University of Manitoba

Winnipeg, Manitoba

1992

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ISBN 0-315-76953-X

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BARBARA ELIZABETH GAJDEK

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

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Abstract

Within a team approach, four Master of Social Work students joined to implement a treatment program for sexually abused latency-aged and early-aged adolescent girls and their families (i.e., primarily their non-offending caregivers). Over a period of fourteen and fifteen weeks respectively a "parallel group" treatment program was provided for seven latency-aged children and their caregivers and a group for five early-aged adolescent girls and their caregivers. Most of the families were referred by Child and Family Services and were multi-problem families with children who had experienced intrafamilial sexual abuse.

This practicum report specifically describes the early-aged adolescent girls victims group and then the parallel treatment program for sexually abused latency-aged girls focusing exclusively on their non-offending caregivers group. This report also describes the systemic interventions attempted with two of the four family systems involved in the early-aged adolescent victims group. Therapy with the mother-daughter dyads was incorporated to integrate treatment issues in the family system and to facilitate a more supportive relationship between the adolescent and her caregiver. Family systems and feminist perspectives were combined within an ecological framework, addressing issues such as empowerment, education,

peer support, establishing boundaries, roles, communication, and developing better social and coping skills. This treatment program also recognized the importance of coordination with other helping agencies (e.g., Child and Family Services). When viewed as a component of an overall treatment process, this program was considered to be successful. There were very few "drop-outs" and all the caregivers of the latency children and the adolescent girls alike subjectively reported having had a positive experience in the groups. Progress was made in the ares of sexual education, decreased isolation, socialization, awareness of sexual abuse issues and dynamics, decreased anxiety and shame, and improved communication and coping skills.

Conclusions are that group therapy is a viable treatment modality for sexually abused, early-aged adolescents. As well, the use of a parallel group treatment model in particular, successfully facilitates the involvement of the non-offending caregiver and increases her awareness of sexual abuse issues, thereby contributing to the family's overall healing. Family systems interventions attempted to further integrate the adolescents and their caregivers' treatment and provided an opportunity to further promote more open communication within this dyad.

Acknowledgements

I wish to thank Dr. Barry Trute for his patience and support in serving as my practicum advisor. I would also to thank Walter Driedger and Enid Britton for their guidance in making this a valuable learning experience for me.

I am most grateful to my two female colleagues, Karen Gamey and Kathy Anderson for their ongoing encouragement to "finish." As well I would like to thank my colleagues at the Acute Treatment and Consultation Team for their unending support and encouragement.

Finally, the successful completion of this practicum is in large part credited to two sources. Firstly I am most grateful to my parents, Florence and Aleksander for teaching me to value education and knowledge and for their unwavering love, encouragement, and support. Secondly, I am grateful to my good friends, Irene and Derek Shewchuk for their unending love, support and encouragement which nourished me from start to finish.

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CHAPTER ONE

INTRODUCTION AND PURPOSE

My interest in the area of child sexual abuse was stimulated by the first case of father-daughter incest referred to me for treatment during the time I was employed as a children's mental health worker in rural Manitoba. This was my first attempt at trying to engage with such an involuntary client system who maintained a very resistant stance to any outside intervention. The identified child victim in this family, a twelve year old adolescent, was subsequently disowned by her family as she would not be persuaded to recant her disclosure of incest. It was obvious that any successful intervention with the family would need to successfully confront their denial so that more healthy means of protection and support could be utilized.

In this case I proved unsuccessful in engaging the non-offending parent, the mother, to support her daughter. Therefore, I was left with the difficult task of providing individual treatment solely to the adolescent victim whose ,psycho-pathology steadily increased after the disclosure. This mother's reaction towards her daughter continued to be very negative and blaming which only served to further increase the trauma and sense of isolation for this

adolescent. This mother's reaction further complicated her daughter's potential for recovery. If this adolescent had been supported by her mother and had she felt less isolated, it seems that a great deal of damage could have been prevented.

Since that time I have worked with a number of child sexual abuse cases and each case continued to prove challenging to my skills as a clinician. In each case the child was an innocent victim who felt isolated and damaged and required a great deal of support to facilitate healing especially that of their non-offending parent, generally the mother.

Given the challenges presented by cases such as the one described above, I have been prompted to proceed with this practicum in an effort to expand my knowledge and clinical skills in the area of intrafamilial child sexual abuse. The intent of this practicum is to further my knowledge and skills so as to learn to better treat this unique client group whose family systems are often closed, isolated and leery of any outside intervention.

The purpose of this practicum was to employ a parallel treatment model in the treatment of multiproblem innercity families who had experienced intrafamilial child sexual abuse. The definition of intrafamilial sexual abuse, for the purpose of this practicum, will be expanded to include sexual abuse by a trusted third party. The treatment program was offered at

the Community Resource Clinic (CRC) and was comprised of parallel treatment for both latency and early adolescent females who had experienced sexual abuse and for their non-offending parents/caregivers (primarily mothers) for 14 and 15 weeks respectively. In addition to the parallel group treatment, each family system was also offered systemic work which focused primarily on the mother-child dyad but may have included individual, and/or family treatment as well. The purpose of the systemic work was to supplement the group therapy (i.e., reinforce issues raised in group) but also to deal with issues unique to each family system.

My general personal learning goals for this practicum were:

1) To increase my knowledge of existing literature in the area of child sexual abuse (particularly intrafamilial) and to incorporate this knowledge into my clinical practice, with an emphasis on current treatment modalities effective with the mother-daughter dyad.
2) To expand my clinical therapy skills and to more effectively utilize the "self" in the following: a) group therapy with child sexual abuse victims and their non-offending caregivers/mothers; b) in family systems interventions with families of intrafamilial sexual abuse; and
3) To evaluate the efficacy of my clinical practice (i.e., this clinical practicum) by incorporating the use of

appropriate clinical measures.

The guiding orientation for this intervention program included ecological, systemic and feminist perspectives. The practicum emphasized the importance of the non-offending caregivers overall contribution to the child's recovery. The focus of treatment was on group therapy as a primary treatment modality supplemented by family systems intervention. This treatment package was offered to a small number of innercity children/adolescents and their non-offending caregivers. A fundamental premise driving this approach was that supporting and strengthening the pivotal non-offending parent and child (victim) dyad would prove to be a critical means of advancing the family's healing process.

CHAPTER TWO

A REVIEW OF LITERATURE CONCERNING CHILD SEXUAL ABUSE, AN ECOLOGICAL APPROACH, FAMILY SYSTEMS THEORY, A FEMINIST PERSPECTIVE, CRITIQUE AND INTEGRATION AND GROUP TREATMENT MODALITIES

INTRODUCTION

Research that exists in the area of child sexual abuse does not easily nest in any single theoretical tradition. Instead several alternative models of etiology exist. Like other forms of child abuse, child sexual abuse models of etiology emphasize the causative role played by individual parental disturbances, and attitudes, child characteristics, disturbances in family-interaction patterns, and cultural beliefs and societal attitudes (Belsky, 1980). The family systems perspective has been increasingly utilized in the treatment of child sexual abuse over the last decade (Haugaard & Reppucci, 1988). However criticism has surfaced with respect to this perspective particularly from a feminist viewpoint of the problem. Nevertheless both these outlooks are essential in conceptualizing the problem of child sexual abuse and can be integrated within an ecological framework. An ecological framework is useful in conceptualizing the problem of child sexual abuse because it is directed at

looking at the total field of the problem (i.e., interactions between the individual and their environment and their reciprocal influences on each other) (Grace, 1984).

A COMMENT ON THE RESEARCH

Conte (1986) notes that most of the research in the area of child sexual abuse is based on clinical descriptions and is not accompanied by an kind of measurement or control procedures. Although this is slowly changing with research projects such as Kroth's (1979), still little empirical research is found. This lack of empirical research is probably in part due to the sensitive nature of the phenomena (e.g., underreporting of incidence due embarrassment, criminal and legal consequences) (Finkelhor, 1986). The sexual abuse research that does exist is lacking in rigor and acceptability, as it is plagued by inadequate samples, oversimplistic research design, conflicting definitions and unsophisticated analyses (Finkelhor, 1986).

HISTORY OF THE PROBLEM TO DATE

Rush (1980) cities the importance of viewing the sexual abuse of children within a historical context in order to uncover the overwhelming scope of this age-old practice. The sexual abuse of children has been commonplace over the

centuries, in various countries and within various cultures. Aside from being abused in their homes on an ongoing basis, children have also been raped and sold into prostitution or marriage (Rush, 1980). In so far as the sexual abuse of children is not a new phenomena, it is only in the last decade that the extent of the problem has been openly identified within our society. This is, in large part, a result of the women's/feminist movement which increased social awareness of the problem with its legal and educational emphases on preventing the sexual exploitation of females (Parker & Parker, 1986). The feminist movement also prompted women to disclose sexual assault including sexual victimization as children (Rush, 1980).

DEFINITION

It is important to begin by defining this phenomena. Sgroi (1982, p.9) defines child sexual abuse as "a sexual act imposed on a child who lacks emotional, maturational, and cognitive development." The offender's ability to seduce the victim is based on the all-powerful or dominant position of the adult or older adolescent which is in sharp distinction to the child's age and dependent, subordinate position Sgroi (1982, p.9). Sgroi's definition of sexual abuse, defined by an abuse of power, is particularly appropriate in that it points to the fact that the authority and power of the

offender are always used, in some way to coerce, the child victim either directly or indirectly (Sgroi, 1982).

STATISTICS

With respect to the scope of child sexual abuse, many studies have been accomplished with respect to both the incidence and the prevalence of the problem. Specific statistical findings vary greatly however due to conflicting definitions, methodological factors and the fact that the prevalence may truly vary amongst segments of the population (Finkelhor, 1986). Prevalence rates (as cited in Finkelhor, 1986) for females under eighteen in the United States vary for example from Burnam (1985) reporting 6% to Wyatt (1985) reporting 6%, while the Canadian Badgley report cities 34%. Statistics, though helpful, are somewhat confusing due to their wide variability.

To date, an overall consensus exist with regards to the fact that child sexual abuse offenses are predominantly committed by men (80 to 90 percent) and that the highest reported percentage of sexual abuse victims are girls (Haugaard & Reppucci, 1988; Finkelhor, 1986; Rush, 1980).

Finkelhor (1986) in comparing various statistical reports with regards to age of onset revealed that children are more vulnerable to sexual abuse starting in the preadolescent period. An increase in vulnerability was found at ages 6 to

7 with another dramatic risk period from ages 10 to 12 when children are victimized at more than double the average rate. (Finkelhor, 1986). Despite these statistics it is important to remember that a child may be as young as a baby and as old as an adolescent when the sexual abuse occurs (Horowitz, 1983).

Haugaard & Reppucci (1988) in comparing much statistical research in the area also found the stereotype of the offender as a stranger inaccurate but instead found that the highest percentage (80 percent) of perpetrators to be a family relative or friend of the victim and her family. In keeping with these statistical findings, this practicum report will focus specifically on the intrafamilial child sexual abuse of girls. Intrafamilial child sexual abuse, for the purpose of this practicum report, occurs when: the offender is the victim's parent or is acting in this role, is related to the child (e.g., uncle, grandfather, cousin) or when the offender is known to or trusted by the child and or the family (e.g., babysitter, neighbour, friend of the family).

The crucial psychosocial dynamic, in intrafamilial child sexual abuse is the <u>trusted</u> relationships between the child and her family and the offender. The offender is in a trusted power position in relation to the child victim and it is the offender's aberrant misuse and abuse of this power that is used to coerce the child into secret participation, often over a continued period of time, pending some sort of disclosure.

FACTORS INFLUENCING THE IMPACT OF THE SEXUAL ABUSE ON THE CHILD

The theme in the literature in the last decade is that the sexual abuse of children is both more common and damaging to individuals and to society than has ever been acknowledged before by clinicians and social scientists (Summit, 1982). The impact and the trauma of the sexual abuse experience will effect children differently in accordance with several contributing factors. Groth (1978) as cited in (Finkelhor & Brown, 1986) contends that the greatest trauma occurs in sexual abuse that:

> (a) continues for a longer period of time, (b) occurs with a more closely related person, (c) involves penetration, and (d) is accompanied by aggression. To that list MacFarlane (1978) as cited in (Finkelhor & Brown, 1986, p.72) added experiences in which (e) the child participates to some degree, (f) the parents haven an unsupportive reaction to disclosure of the abuse, and (g) the child is older and thus cognizant of the cultural taboos that have been violated. (p.72)

Other salient mediating influences on the child's development and ability to cope include: whether or not the child is placed outside of the home upon disclosure, parental response to the sexual abuse, the previous emotional climate or level of family functioning, child's age and psychosexual

development, (many studies on effects have ignored developmental levels), the mental and emotional well-being of the child prior to the abuse, the degree of guilt the child feels, and the sex of the victim (Gil, 1991; Steele & Alexander, 1981).

All of these factors need to be considered by a clinician when assessing the victim's perception of the event and its overall emotional impact. However parental involvement and concern of the non-offending parent (i.e., generally maternal support) has been identified as having the most significant influence on the child's experience and ultimate healing (Everson, Hunter, Runyon, Edelsohn and Coulter, 1989; MacFarlane & Waterman, 1986).

As well, systems induced or institutional trauma should be assessed and minimized as this also contributes to the impact on the victim and her family (Rush, 1980; Trepper & Barrett, 1986). This kind of trauma can be created by the various human service professionals and agencies that are drawn into the life of the family by the disclosure of sexual abuse (Trute et al., 1991, Abstract). For some child victims the trauma associated with the investigative process, which may involve legal, medical, mental health, and child protective services, may be experienced as even more acutely traumatic then the sexual abuse itself (Trute et al., 1991). In so far as the initial impact and later effects of sexual abuse may not simply be related to the sexual abuse, it is

important for clinicians working in the area to be sensitive in assessing and addressing their own impact, in an effort to minimize any "systems-induced trauma" (Conte, 1984, p.260).

EFFECTS OF SEXUAL ABUSE

With heightened awareness of the problem of child sexual abuse, clinicians and researchers have become concerned with uncovering both the initial and long-term effects for the victim. Initial effects generally are thought to occur within two years of the termination of the abuse (Finkelhor & Browne, 1986). Hence studies on the initial effects tend to examine the effects of the abuse on the child in childhood while long term effects are studied based on the experience of adult survivors. Recently studies have been able to substantiate clinical impressions that sexual abuse is traumatic and presents as a serious mental health problem for a significant portion of its victims (Finkelhor & Browne, 1986). There is much consensus that child sexual abuse likely produces a variety of negative emotional effects, establishes a vulnerability to stress, and sets the stage for interpersonal problems (Maddock, 1988).

Sgroi (1982) has capsulized ten striking initial effects on the child victim which include:

1. "Damaged Goods" syndrome
2. Guilt

3. Fear,

4. Depression

5. Low self-esteem and poor social skill

6. Repressed anger and hostility

7. Impaired ability to trust

8. Blurred boundaries and role confusion

9. Pseudomaturity coupled with failure to accomplish developmental tasks

10. Self-mastery and control. (Sgroi, 1982, p.109)

Other characteristic effects include: a tendency for social isolation or withdrawal, difficulty establishing and maintaining close human relationships, and a poor sense of identity (both general and sexual identity) and increased vulnerability to being revictimized (Steele & Alexander, 1981). Adult women who were victimized as children are more likely to manifest guilt, low-self esteem, depression and self-destructive behaviour (e.g., alcohol/drug abuse, suicidal ideation), interpersonal adjustment problems, such as problems parenting (e.g., maintaining too much emotional and physical distance from the child leaving the child feeling unsafe and insecure) and are at greater risk to become involved in relationships with abusive, violent men (Corder, Haizlip & DeBoer, 1990; Finkelhor & Browne, 1986; Jehu & Gazan, 1982). A serious effect is that the child victim evolves an adult role as either a victim or a perpetrator. Any form of treatment must address this risk.

THE INTERGENERATIONAL EFFECT

Incest is often inter-generational with the family operating as a very closed system limiting growth, renewal and self-differentiation (Courtoise, 1988; Larson & Maddock 1986), and without any outside intervention the incest behaviour will likely carry on (Fredrickson, 1982). A mother's own unresolved victimization and its subsequent long-term effects, put her at risk for contributing to a family structure which would repeat the incestuous family constellation (i.e., her husband would go on to sexually assault one or more of her daughters thereby making her the mother of the victim and wife of the offender) (Gelinas, 1983). A mother's own unresolved victimization will affect her ability to successfully parent and support her own daughter through the crisis of disclosure (Larson & Maddock, 1986). As these mothers have often themselves experienced harsh or emotionally deprived upbringing, they tend to be emotionally dependent and needy women. This neediness makes any intimacy with their own children a difficult task (Hildebrand & Forbes, 1987).

FINKELHOR'S FOUR TRAUMAGENIC DYNAMICS

Further to the effects already described above Finkelhor (1986, p.180) presents a widely respected model that postulates that the experience of sexual abuse can be examined

in terms of four trauma-causing factors, referred to as "traumagenic dynamics". According to Maddock (1988, p.208), "trauma is defined as an intense experience that occurs without a suitable framework of meaning within which it can be placed for understanding and mastery. That is, the experience has significance without an adequate internal explanation."

Finkelhor's (1986, p.180) four dynamics include "traumatic - sexualization, stigmatization, betrayal and powerlessness ... the conjunction of these four dynamics are what make the trauma of sexual abuse unique." When present these dynamics are said to alter the child's cognitive and emotion world view and create trauma by distorting the child's self-concept, world view, and emotional capacities (Finkelhor, 1986). Maddock (1988) agrees with Finkelhor (1986) in that when victims attempt to cope through these distortions the effects discussed above are often evident. However, Maddock cautions that the complexity of these processes should be considered and that drawing simple conclusions about the incest trauma can be misleading. Maddock (1988) goes on to clarify this, noting that

> if a child's map of reality is organized around continuous patterns of abuse and/or neglect, then given an incident of incestuous contact is less likely to be experienced as traumatic because it is expected ... further confirmation of the child's map of the world as a cruel and exploitive place characterized by

perpetrator-victim interaction patterns." (p.209)

Yet Maddock agrees that regardless of this every child victim will still feel very negative about the experience.

As Finkelhor's model has frequently been used with regards to organizing themes to address in the treatment of child sexual abuse (as in Berliner's (1984) treatment groups with pre-adolescent victims) this model requires elaboration. The four traumagenic dynamics postulated will be elaborated below with the use of complimentary examples. Firstly, traumatic sexualization refers to a process in which the child's sexuality becomes developmentally inappropriate and or dysfunctional as a result of their sexual abuse experience (e.g., when a child associates sexual activity with an adult as a sign of affection). Secondly, betrayal refers to the process of a child discovering that someone they trusted and were dependent on has abused them (e.g., children who are disbelieved following disclosure feel an even greater sense of betrayal). Thirdly, powerlessness is the process of continually violating the child's will, desires, and sense of efficacy (e.g., the child is continually offended against despite her will and efforts to stop this). Finally, stigmatization occurs when guilt, shame, and a sense of being bad are communicated to the child about the experience which then eventually are incorporated into the child's self-concept (e.g., keeping the abuse secret reinforces the sense of being different from others) (Finkelhor, 1986).

AN ECOLOGICAL SYSTEM'S APPROACH

An ecological perspective began to emerge in the 1970's with its focus on person-in-environment which is the distinguishing characteristic of social work practice (Grace, 1984). Hoffman as cited in Grace (1984) describes an ecological systems approach as examining the total range of the problem (i.e., individual, family, extended family, professionals, community institutions) and all the overlapping influences, forces, and effects a therapist working with a family need to consider.

Belsky (1980) provides a coherent ecological framework for gathering and conceptualizing data concerning the etiology of child abuse, such as child sexual abuse. Here the four levels of analysis include: ontogenic development, the microsystem, the exosystem, and the macrosystem. Ontogenic development refers to what the individual parents bring with them to the family setting such as what they bring to the parenting role. In family systems language this might be considered that which the individual brings with them from his or her family of origin. What appears to be especially critical in the area of child sexual abuse is the parents own childhood history, that is, whether or not they were abused as children, more specifically whether they had been sexually victimized in childhood. The microsystem refers to the immediate family setting or environment. It is believed that

much of what occurs at this level is based on the parents ontogenic development (Belsky, 1980; Grace, 1984). Therefore, again it is important during an assessment to include family of origin work in both assessment and intervention. The exosystem points to the embedded of the individual and the family in the social structures, both formal and informal such as work, school, church, peers, social circles, the neighbourhood and so forth (Belsky, 1980). Here the critical focus for assessment and intervention will be the social networks of the family (Grace, 1984). Finally, the macrosystem refers to both societal and cultural attitudes and values which foster violence and child sexual abuse. Here it is important to consider not only societal attitudes but also the family's own cultural background and its influences (Belsky, 1980). Finally, as previously mentioned under effects of child sexual abuse, any intervention, in order to be effective must consider the impact and effects of all the professionals and agencies that become involved with the family and their attitudes and values. This addresses the important need to co-ordinate all resources and interventions.

ETIOLOGICAL THEORIES/PERSPECTIVES REGARDING CHILD SEXUAL ABUSE

Again, no theory supported by empirical evidence exists to adequately describe the cause of child sexual abuse (Conte, 1984). Instead, there are a variety of descriptive viewpoints

regarding its etiology which differ according to various ideologies but can be subsumed, within an ecological perspective. Each perspective emphasizes a different aspect of the problem. Both the family systems perspective and the feminist perspective have contributed much to the professional recognition of the longstanding, neglected problem of child sexual abuse (Trepper & Barrett, 1986). As evidenced by the literature on child sexual abuse a family systems and feminist perspective have both contributed greatly to the understanding and to the treatment of a sexual abuse and appear prevalent within the child sexual abuse over the last decade. Therefore,the major tenets of each perspective will be explored, critiqued and ultimately integrated.

FAMILY SYSTEMS THEORY

The family systems perspective is based on Bertalanffy's general systems theory (Baker, 1981) which is not a causal theory but generally a theory describing the functioning of systems. A family perspective applied to child sexual abuse, has to date, focused primarily on the descriptive identification of variables which characterize families in which child sexual abuse takes place (Conte, 1986). There exists no single family perspective to child sexual abuse, but taken as a whole family perspectives tend to share a common view of the sexual abuse of children. A family system's

perspective to child sexual abuse has presented as the most popular and effective model for understanding and responding to child sexual abuse (Haugaard & Reppucci, 1988; Trepper & Barrett, 1986; Waterman, 1986).

Conte (1986) postulates that the primary elements of a family systems perspective include: "the importance of a multi-generational view in understanding the problems, the notion that the problem (sexual abuse) is symptomatic of an unhealthy or dysfunctional family system in which every member of the family contributes to the development and maintenance of the problem; and the belief that the problem or symptom may not in itself have significance but that it may hold meaning in the family." (p.115) As described above, sexual abuse is conceptualized as an indication of a dysfunctional family system rather than based solely on individual pathology. In this way, the family systems perspective goes beyond the traditional individual model of diagnosis and treatment, by viewing the locus of pathology as the "individual within his context" (Mrazek & Bentovim, 1981).

Conte (1986) asserts that a family systems perspective primarily utilizes descriptive analysis, particularly of intrafamilial forms of sexual abuse, more specifically father-daughter incest. Relationship dynamics and family patterns are extrapolated from theoretical formulations in general systems theory and family systems literature (Waterman & Damon, 1988). Maddock's (1989) descriptive analysis of the

sexually abusive family is used to illustrate a typical family systems perspective regarding the sexual abuse of children as Maddock's work proves to be the most current descriptive analysis within current literature. This descriptive analysis will be used to highlight particular elements of child sexual abuse family systems which create extraordinary challenges for the clinician working in this area. In keeping with the idea that the child's sexual abuse serves a particular function in the family, Larson & Maddock, as cited in Maddock (1989) propose the following four categories of possible functions:

> first a misguided attempt to show affection and to feel emotionally close ... second an inappropriate eroticization of everyday interaction patterns based upon an attempt to bond family members (i.e., "pan-sexual" family) ... third, the sexualization of anger to deal with frustration and disappointment over various aspects of personal and/or family life, and fourth, an expression of existential rage by one or more family members, often reflecting individual psychopathology. (p.134)

A systems approach according to Trepper & Barrett (1986) "operates on the premise that intrafamily sexual abuse is attributed to and maintained by a variety of interconnecting systems, family, individual, and societal". (p.86) Larson & Maddock as cited in Maddock (1989) describe an incestuous

family structure as typically reflecting "boundary disturbances in at least four areas: overly rigid boundary between the family and the outside world, boundary confusion between the generations (e.g., intergenerational transmission of sexual abuse), overly diffuse boundaries between individuals; and intrapsychic boundary difficulties."(p.134). As these systems are relatively closed, undifferentiated, rigid systems they exhibit little informational exchange with their environment (Maddock, 1989). These families respond to intrusion by the environment (as often occurs upon a child's disclosure to an outside authority such as the school) with a loss of organization and a family crisis ensues (Alexander, 1985).

These families are therefore typically socially isolated and hence insulated from critical social feedback. This leads to an unhealthy overdependence on family members to meet all important needs. These family systems are extremely enmeshed which often results in a blurring of boundaries especially between parent and child. There is a tendency for role reversal and role confusion (e.g., parentified children) (Maddock, 1989). As well, nurturance necessary for healthy development may not be available, creating deficits in development. Hence two important roles have typically not been carried out by the parental subsystem, that is: nurturance has typically been minimal or sexually deviant and socialization of the child has been minimal, or in part

deviant (Mrazek & Bentovim, 1981).

In these enmeshed families, members are forced to yield their autonomy in order to belong. As an example, any kind of personal privacy is lacking as privacy may indicate differentiation or individuality which is viewed as disloyalty (Maddock, 1989). Characteristic "dysfunctional interaction patterns include: keeping secrets, double binds and manipulative self-serving behaviours" (Maddock, 1989, p.189). The most significant paradox these children live is that their families which are to provide them with protection, safety, and nurturance, have instead become a source of pain (Maddock, 1988). This crucial paradox becomes the primary issue to redress in any treatment program. This is done by ensuring that children live and are treated within an environment in which they feel safe and nurtured. As well, these families typically lack differentiation or autonomy producing a shame based family system resulting, in all members suffering from low-self esteem (Maddock, 1989). This again becomes an essential element to amend in treatment.

The defense mechanism, denial is most commonly relied on in these families to rationalize distorted, symptomatic behaviour (e.g., incestuous father who tells his daughter he is engaging her in sex in order to educate her). Denial is often used by all family members as a self-protective mechanism whose goal is to preserve the family's stability (Hoke, Sykes & Winn, 1989). This protectiveness is definitely

dysfunctional! As in the area of family violence, it is both a challenge and a dilemma for the clinician, to intervene in such a way as to engage and support each family member while simultaneously making the distinction and acting in accordance with the fact that the abusive behaviour is insupportable and will not be tolerated. In order to facilitate open and honest communication within the family, clinicians need to address members fears and ambivalence surrounding honesty, intimacy, family loyalty and confrontation (Hoke et al., 1989). A useful technique suggested by Hoke et al., (1989) is to use metaphors to access the family's unconscious processes and facilitate client co-operation without engendering the family's self protective mechanisms.

Hoke et al., (1989) distinguish four distinct types of denial commonly present in sexually abusive families. These include:

> denial of the facts ... members act as if the abuse has not occurred), denial of awareness ... members acknowledge the abuse occurred but maintain that recollection is beyond their conscious mind, denial of impact ... members are unable to recognize the traumatic effect for the victim and or family, and denial of responsibility ... members assume the abuse occurred but shifts the locus of control onto a non-parental figure (Hoke et al., 1989. p.45).

Hoke et al., (1989) stress the need for clinicians to remain

aware that appropriate parental protectiveness can not be possible until all family members acknowledge what has happened, who is responsible and the impact the abuse has had on the victim and all family members. These become essential goals for family treatment.

With regards to the family systems perspective on the abuse of power, power is always found to be extremely unequally distributed. A male "power principle" dominates the family and often there is an extreme rigidity of gender role expectations based on traditional stereotypes (Maddock, 1988, p.207). Direct expression of power by men is common with coercion as the primary regulatory mechanism. A cardinal "family rule is that power only really counts and belongs exclusively to males .... females are typically viewed by both genders as relatively helpless victims of male prerogative." (Maddock, 1989, p.134).

FEMINIST PERSPECTIVE

A feminist perspective views child sexual abuse as a continued extension of the male abuse of power and privilege in our society. In the case of incest, for example, it points to the man's abuse of power over children and women rather than a failure of family functioning (Dale, Waters, Davies, Roberts, & Morrison, 1986). Child sexual abuse is regarded as an extension of the patriarchal view of women and children as

chattel, that shaped and determined the historic male attitude towards rape. This perspective contends that offenders, who are primarily men, perceive children as possessions and objectify children to meet their own needs as opposed to meeting their children's needs appropriately (Rush, 1980).

The feminist perspective highlights the political aspect of the problem and advocates the need for political change at the level of societal beliefs, attitudes and practices. This perspective assertively advocates that child sexual abuse is a muted crime in our society as exemplified by the small percentage of offenders either prosecuted and or convicted. Feminists contend that, historical male power and privilege within society, pervades the criminal justice system obstructing the successful prosecution of sexual offenders. Feminists believe that as so few sexual offenders are prosecuted, a haze of unclarity pervades within our society as to who is responsible for the crime of child sexual abuse. Meanwhile feminists stress that child victims become revictimized as they are often thrown into foster care, mental health institutions or are returned home to be reoffended (Armstrong, 1989). Feminists concede that clinicians genuinely have little time or energy left for the political analysis of sexual abuse because they are too busy treating the casualties i.e., victims of sexual abuse. But without this attention to the political process and without confronting the political/power abuse, feminists contend that

society is doing nothing about actually stopping child sexual abuse and having fewer child victims in the future (Armstrong, 1987).

A feminist perspective typically takes exception to the systemic interpretation that all members share in the development and maintenance of the problem and that an offender is the product of a dysfunctional family system. Willbach (1989) contends that feminist concerns regarding family violence, center on the potential for inadequate attention to the significance of power differences and on control and adult responsibility for their own thoughts and behaviours. Feminist theorists such as Armstrong (1987) much more adamantly and assertively characterize their concerns regarding child sexual abuse.

Armstrong (1987) directs her criticisms at the mental system's view and describes how government funding and public policy have defined incest as a mental health problem using a "family disease/illness" model, thereby almost obliterating a feminist "political analysis of the problem of incest as a power abuse - one with longstanding tacit societal permission". (p.7) Feminists regard this medicalization of the problem as contributing to the de-criminalization of paternal child molestation. Armstrong (1987) further contends that this "family disease" model is rooted in faulty assumptions i.e., "that the mother either condones the sexual abuse or by altering her behaviour could have prevented it."

(p.266) Feminists accuse mental health experts, including some family therapists, of diminishing the central, power abuse issue in child sexual abuse by reinforcing the strategy of blaming the victim and/or her mother, (i.e., the female for what the male offender has done) and in this way, diverting responsibility away from the offender (Armstrong, 1987; Rush, 1980).

CRITIQUE AND INTEGRATION

A family systems perspective essentially differs with a feminist perspective, with regards to the unit the clinician chooses to focus upon and study (i.e., who to treat and what treatment resources to advocate for). Each of these two perspectives tends to emphasize and advocate a slightly different treatment focus. Feminists have historically, more typically advocated for treatment resources and modalities primarily directed at child victims, adult survivors of child sexual abuse and rape and more recently at the non-offending mothers of the child victims. Whereas family systems therapists typically go beyond exclusive advocacy for child victims and their non-offending mothers and support and encourage comprehensive therapy to all members of the family (Giarretto, 1982). Family therapists support the eventual reintegration of the offender back into the family, only in those situations where: parents assume total responsibility

for the abuse, where offenders have already assumed legal responsibility for the sexual molestation, and when individuals have been engaged in individual therapy (Giarretto, 1982; Sgroi, 1982). Family therapists also generally only advocate family therapy (i.e., marital counselling, sibling sessions, offender-victim sessions and ultimately conjoint family therapy) as a final stage in sexual abuse treatment, typically after individual and/or group therapies (Giarretto, 1982; Sturkie, 1983; Trepper & Barrett, 1986). Family therapists generally agree that family treatment, the case of child sexual abuse certainly does not necessitate seeing all family members together.

Feminist approaches are critical of family therapy treatment approaches and insist the male offender must be separated from the home until the victim eventually leaves (Dale et al., 1986). Yet this insistence on the removal of the offender until the victim leaves proves especially challenging and perhaps limiting in cases of sibling incest. A feminist perspective generally does not advocate nor concentrate efforts on treatment of the offender nor does it necessarily support the family systems goal of the reintegration of the offender into the family, when possible. The feminist perspective instead focuses predominantly on treatment for victims and their mothers such as the parallel groups project and mother-daughter dyadic interventions which will be the focus of this practicum (Damon & Mandell, 1989;

MacFarlane & Waterman, 1986).

Other general limitations of the family systems perspective cited in the literature are as follows. Firstly, most of the literature on the family's role in sexual abuse of children, describes small samples and therefore it is difficult to determine how representative these cases are to the large number of identified child sexual abuse cases (Conte, 1986; Finkelhor, 1986).

Secondly, the bulk of the literature has narrowly focused primarily on father-daughter incest cases which make up only a small portion (anywhere from 3-7%) of child sexual abuse cases (Conte, 1986; Finkelhor, 1986). Although there appears to be evidence that some incestuous fathers also sexually abuse children outside of their home, there is great variation in whether men have exclusive or multiple sexual relations with their daughters and children outside the home (Conte, 1986).

Thirdly, a family systems perspective claims that the problem (child sexual abuse) is not necessarily a sexual problem but purports it to be a symptom of something else. This view appears to negate the <u>sexual</u> nature of the problem and negates a necessary precondition, that is: the offender's sexual interest in children. Adults can exert their abuse of power and control over children in many forms other than child sexual abuse (e.g., corporal punishment). Finkelhor (1986) and Berliner (1983) alike, point to the necessity of four

preconditions on the part of the offender: the offenders sexual interest in children, the ability to rid oneself of internal inhibitors, the ability to overcome external inhibitors, and the overcoming of the child's resistance (e.g., resistance undermined because of favoured status or attention/affection given to the victim).

These preconditions lead into the final but most ubiquitous criticism of the family system's perspective, that is, concern over the extent to which responsibility for the child sexual abuse moves away from the adult, male offender who initiates and maintains the abuse to either the child and or the non-offending mother. As previously noted, if an adult views a child as seductive or sexual, it is always up to this adult to set limits on himself not to act on this interest. Although a child victim may experience closeness, extra attention or special status from the offender this can never be perceived as seduction nor consent. Clearly, prepubertal children do not have the knowledge of sex to seduce an adult (Grace, 1984).

Further to this, with respect to the non-offending parent (most often the mother), as previously mentioned, family systems theorists are often criticized by feminists (Armstrong, 1987) for exaggerating the mother's roles and for unfairly "mother blaming" (i.e., unjustly holding the mother morally responsible for the sexual abuse of her child). This view of the mother is criticized for not valuing shared

parental responsibility and was especially explicit in earlier psychiatric and family systems literature (Koch & Jarvis, 1987). As an example, in 1954 Kaufman et al., as cited in Koch & Jarvis (1987), concluded that the mothers abdicated their maternal responsibility in creating a role reversal with their daughters setting the stage for overt incest to begin. Yet more recent family systems theorists like Giarretto (1982) and Sgroi (1982) appear to effectively address shared parental responsibility by firstly, holding the male offender responsible for his abuse of power and his failure to set limits on himself, by insisting he be held accountable to accept responsibility for his behaviour (initially through the authority of the criminal justice system) while secondly suggesting the non-offending mother's contribution as her "failure to protect ... and her "failure to set limits (e.g., blurring of boundaries or role confusion with her daughter)" (Sgroi, 1982, p.191). Clearly, acceptance of responsibility by the adults for inappropriate interactions and child protection are successfully integrated within a family systems perspective (Giarretto, 1982; MacFarlane & Waterman, 1986; Sgroi, 1982).

Hildebrand and Forbes (1987), more recently suggest that the way professionals ascribe role and function is likely to affect the degree to which they hold mothers responsible for the abuse. Strand (1990) cites mother blaming as a longstanding, pervasive characteristic common in our society

that affects mental health and other professionals as well. This probably results from the centrality of women as nurturers and caregivers in our society which makes us prone to ascribe feelings of childhood deprivation to the mother (Strand, 1990). It is important to point out that more recent family systems literature takes a less judgemental, less negative view of the mother. Herman (1981) exemplifies this by describing how often a mother does not protect her daughter because she is fearful of violence or retaliation from her husband. On the contrary, family systems theorists criticize the feminist perspective for its refusal to acknowledge the passive role of the mother in "failing to protect" the daughter as they propose this can be perceived as a very powerful position (Dale et al., 1986).

For many clinicians, a family systems perspective such as Sgroi's (1982) appears very convincing. That is some mothers may be perceived as contributing to their child's <u>vulnerability</u> to being abused/misused in some way, perhaps sexually, by being neglectful (e.g., using poor judgement with regards to alternate caregivers) with regards to protecting their children or failing to set appropriate limits. Nevertheless, it is important to remember that these mothers do not all fit into a homogenous category and it is unwise to assume that all mothers contribute to or condone the abuse. Mothers certainly <u>do not cause</u> the sexual abuse nor should they be held <u>responsible</u> for the sexual nature of their

child's abuse as most mothers are not even aware of the sexual abuse until disclosure. Therefore, a fundamental task for the clinician working in this ares is the development of empathy for the mother. As mothers play a central role in their child's recovery and in future prevention, this becomes an essential task for the clinician.

As evidenced above, a conceptualization of the etiology and treatment of child sexual abuse is most comprehensive when both a family systems perspective and a feminist perspective are integrated. Such an integration of these two perspectives guides the next section of this literature review which will focus on clinical intervention for the child/adolescent victim and her non-offending parent/mother.

CLINICAL INTERVENTIONS:

TREATMENT IMPLICATIONS FOR THE MOTHER-DAUGHTER DYAD

The family's reaction to the discovery of the child sexual abuse and the extent of support the daughter receives from her non-offending parent acts as the first important dynamic/role in contributing to mitigate the final psychological outcome for the child (Mandell & Damon, 1989; Pelltier & Handy, 1986). Further to this the author shares Sgroi's (1982) contention that the first family treatment goal needs to be building in one functioning, supportive adult ally

for the child. A growing body of literature supports this contention by pointing to social support as an effective mediator of stress, more particularly, affective support from the non-offending parent, primarily the mother as a protective mechanism (Everson et al., 1989). This author agrees with Everson et al., (1989) that as clinicians we need less emphasis on the mother's contribution to the sexual abuse and more emphasis on her contribution to her child's recovery.

A number of factors influence a mother's ability to support her daughter following disclosure. For example, mothers are found to be more supportive of their child if the offender is an ex-spouse versus someone with whom the woman currently is in a relationship. Another obvious factor affecting the mother's ability to be supportive of her daughter would appear to be the emotional support and nurturance available to the mother. As these mothers are often isolated and alienated their ability to naturally receive such support is limited (Koch & Jarvis, 1987).
Barrett, Sykes & Byrnes (1986, p.65) describe the non-abusing parent as the "secondary victim" who may initially experience much anxiety or depression coupled with guilt as to her perceived role in the abuse and this may be reinforced by the systems involved as previously noted in the discussion on systems-induced trauma. Therefore, a primary treatment goal, which also proves therapeutic for the child victim and others in the family, would appear to be removing the non-offending

parent from her own victim role, in an effort to enhance her genuine ability to support her daughter. In accordance with family systems theory, if the mother can change in positive ways the parent-child relationship within the family system will also change in a positive manner.

GROUP TREATMENT FOR THE MOTHER-DAUGHTER DYAD

More recent literature increasingly supports the benefits of offering mothers groups as an essential part of any sexual abuse treatment program (Hildebrand & Forbes, 1987; Mara & Winton, 1990). Different types of groups have surfaced over time. Early in the 1980's Giarretto began group work with mothers of children who had been abused and explored their distressing experiences. Giarretto (1982) incorporated various members of incestuous families into self-help groups (e.g., Parents United, Daughters and Sons United) as an integral part of the Child Sexual Abuse Treatment Program (CSATP) of Santa Clara County, California. Giarretto (1982) is credited with making greater use of self-help groups within the CSATP than any other program. These groups go beyond therapeutic support and offer the pragmatic support (e.g., babysitting, help finding jobs, transportation) which is often so essential for these families (Haugaard and Reppucci, 1988).

Mara & Winton (1990) found the need to develop parent support groups based on the following observations:

> parent's ineffective means of dealing with their child's inappropriate behaviour ... parents sexualized normal sexual development ... parent's had unrealistic expectations of their children ... parents tried to sabotage their child's treatment and there was a lack of parental involvement in treatment ... individual parent's meetings were ineffective and above all there was a lack of support systems available for the parents (p. 67).

Mara & Winton (1990) summarize the goals of a support group for parents as being: "to help the parent deal with the sexual abuse through educational, therapeutic, and supportive intervention". (p. 64) The group is conceptualized as a system composed of its members and therapists and is designed to help facilitate changes in the family system by teaching the parents to teach themselves and their children how to cope with sexual abuse (Mara & Winton, 1990).

The benefits of group as a primary treatment modality for these parents is that it allows mothers to gain support and reduces their sense of isolation and stigmatization. As well, they may benefit from trying new behaviours and parenting skills learned in group. They can also be confronted in a supportive atmosphere and taught new communication skills. Hildebrand & Forbes (1987) provide a model of a less structured mothers group. While reiterating the need for therapists to have a set of group themes, they stress the

importance of having the mothers draw up their own aims and concerns to address in group whereby establishing a pattern of empowering the mothers to actively participate and make decisions (Hildebrand & Forbes, 1987). In this way, each mother can be seen as having something to offer and worthy of being heard. And as such each can be expected to take on more responsibility. This is seen as contributing to improving the mothers self-esteem.

In keeping with this, Mandell & Damon (1989) who propose a more structured model for group, also emphasize the need to create a safe environment in which mothers should be encouraged to raise any personal family problems that affect their ability to support their child's treatment. Pertinent aims of (Hildebrand & Forbes, 1987) group include:

> to provide a peer group in which to share their experiences ... improving the mother's relationship with the child victim and improving communication between them while confirming generational boundaries; ... boosting self-esteem, assertiveness and independence so mothers can appropriately protect their children; ... and helping manage anger and ambivalent feelings towards the abused child, siblings and the perpetrator (p.290).

Through such objectives/goals it is argued that group work with mothers can prove to be an economic, means of avoiding the cyclical nature of child sexual abuse by reducing the

likelihood of further abuse within these families (Hildebrand & Forbes, 1987). This serves as a major objective of this practicum.

Strand (1990) states that mothers' reactions to sexual abuse parallel that of the child victims in many respects, even if the mothers have never shared the experience of having been sexually victimized themselves. Regardless, mothers clearly share many common issues and conflicts with their children in relation to the sexual molestation (Damon & Waterman, 1986). More specifically, recent literature supports the benefits of systematically addressing these common themes between child victim and non-offending parent through curriculum offered in a parallel children's and mothers group (Damon & Waterman 1986; Mandell & Damon, 1989). A growing body of recent literature advocates the benefits of group therapy as a primary treatment modality for child victims (Berliner, 1984; Corder, 1990; Sturkie, 1983), and for non-offending parents alike (Corder, 1990, Mandell & Damon, 1989, Waterman & Damon, 1986). Koch and Jarvis (1987) suggest that group therapy may not prove to be as threatening as individual therapy because it allows some distance between the mother and the therapist while relieving the mother's sense of isolation and providing support.

Parallel mother-child therapy groups (developed for children under eight) by Damon & Mandell (1986) utilize a structured model, (i.e. there are a predetermined number of

sessions covering progressively difficult themes using specific techniques and exercises to explore the themes). A structured, short-term format is preferable for children in the developmental phase of latency as it was seen as enhancing the ability to cover all the themes in the shortest time (Sturkie, 1983). As well, Hildebrand & Forbes (1987) support the notion that a short-term group intervention that may be sufficient for children who respond to peer group learning. However, they caution that this intervention alone may prove inadequate for the respective mothers who require a longer time to change their lifetime attitudes. Damon & Waterman (1986) and Mandell & Damon (1989) both provide short-term models for such parallel parent-child groups which shall guide the focus for the first part of this practicum.

Although few studies have evaluated the effectiveness of parents group for children who have been sexually abused, with the exception of Winton (1990), clinicians who have developed and used this model of parallel parent-child groups for sexual abuse have developed a great respect for this process and consider it critical to the success of any treatment for the child victims (Corder et al., 1990; Mandell & Damon, 1989). This model enables parents to be more involved and supportive in understanding the effects of this trauma on their child as it allows the mothers an opportunity to examine their own feelings and concerns about the abuse.

Mandell and Damon (1989) note the main goals of the parallel caregivers group include:

> 1) to emphasize the caregivers commitment to and support for their children; 2) to decrease the sense of isolation by providing a safe environment to share problems, ask questions and receive validation; 3) to assist caregivers in working through their responses to the sexual abuse; 4) to educate caregivers about the dynamics of child sexual abuse and to increase awareness of underlying motivation to their child's behaviour; 5) to help caregivers become more empathic of and nurturing towards their children; 6) to reinforce the parental role and responsibilities so as to provide adequate protection; and finally 7) to increase bonding and to improve communication between caregiver and daughter (p.20).

While the main goals of treatment for the children's group as cited by Damon and Waterman (1986) include:

> 1) To validate the expression of their feelings surrounding the sexual abuse 2) To help children think about the sexual abuse in ways that are less destructive to their self-image by assisting them to reduce their sense of responsibility and guilt, and to develop labels for their feelings and past experiences 3) To teach children to be more

> assertive in sexual, as well as nonsexual, situations 4) To set limits on children's sexualized responses and to help them explore appropriate ways of expressing their needs 5) To help children integrate their conflicted feelings towards the perpetrator. (p.247)

In a similar fashion Corder et al., (1990) emphasizes that children must develop coping skills with which to master the sexual abuse experience in order to progress developmentally. The child group work focuses on changes which will help the children avoid future victimization through teaching problem-solving skills, intellectual understanding of abuse, building self-esteem and training from seeking help from others in the environment (Corder et al., 1990).

To achieve the above stated objectives for mothers and their children, an effort is made to carry out the caregivers group in a parallel manner with the children's group. Mothers are informed of the children's agenda weekly and of the children's activities as well as other items in the mothers curriculum. As well, it is suggested that after each group and before each group, adult and child therapists meet in order to discuss reactions and progress and in order to coordinate treatment plans for each family (Damon & Waterman, 1986).

It is strongly recommended that individual and family therapy be offered as well for all group participants as this can further reinforce and consolidate the learning occurring within group. As well, this is necessary, as often these families present with a multitude of problems (e.g., post-disclosure adjustment, depression, financial strain) and supplementing group therapy would allow them to concentrate more fully on the group. Following, or simultaneous to group therapy and/or individual therapy, the sexual abuse treatment package should involve a dyadic therapy with the non-offending parent i.e., the mother and the daughter (child victim) in an effort to strengthen this critical relationship. According to Sgroi (1982) this dyadic therapy needs to address areas such as communication breakdown and role reversal. Mothers and daughters must be given an opportunity to share and resolve their hurt, anger and shame regarding the sexual abuse. The child needs reassurance from her mother that: she will be protected now from revictimization and that the sexual abuse was not her fault. It is essential that the mother empathize with her daughter in order to assist her daughter's recovery. Prior to engaging in such dyadic intervention clinicians should always assess the caregiver in order to ensure her ability to the child in an atmosphere of safety while accepting responsibility for her basic safety.

However, all therapies must be well coordinated both with the family and with the therapists involved as there exist a

tendency/risk for helpers to begin to mimic the family's dysfunctional interactions and or communication patterns (e.g., CFS, mental health worker and family becoming triangulated) (Barrett, 1986; Dale et al., 1986). To guard against such risks Barrett et al., (1986) suggests that: inter and intra-agency coordination of services is mandatory and that whenever possible the use of co-therapy teams or ongoing supervision is essential. This is also in part due to the emotionally charged nature of this problem which challenges us as clinicians to remain vigilant of our own attitudes, beliefs and biases.

GROUP TREATMENT FOR PRE-ADOLESCENT SEXUAL ABUSE VICTIMS

As previously described, a complex set of symptoms occur as sequelae of the sexual assault of children and adolescents ranging from short-term physical, psychological and behavioral consequences to long-term dysfunction (Kitchur & Bell, 1989). Clearly maturation alone has not shown to remediate the effects of sexual abuse (Corman, 1989). Tufts as cited in Kitchur & Bell (1989) found that in particular victims in the seven to thirteen year old age group exhibit greater psychopathology than any other age group, with forty percent scoring in the seriously disturbed age group. This sequelae of the sexual abuse presents a number of notable treatment themes for preadolescents who were sexually victimized.

Group therapy is known to offer particular advantages to clinicians in the treatment of child sexual abuse victims. As an example, "the most elusive yet persistent effect is the "differentness" from others" child sexual abuse victims feel (Berliner & Ernst, 1984, p.105). Berliner & Ernst (1984) contend that without a peer forum to resolve this sense of differentness a child's recovery may be hindered. A further rationale for group therapy with early adolescent victims, in particular, will be presented as this is the focus of the second group intervention featured in this practicum report. A summary of the literature groups for preadolescent sexual abuse victims will also be reviewed.

Clinicians observations indicate that group therapy more uniquely and effectively addresses the needs of adolescent victims of intrafamilial sexual abuse than does individual or family therapy (Berliner & Ernst, 1984; Knittle & Tuana, 1980). Although no significant treatment outcome studies exist that can corroborate this clinical intuition (i.e.advocating one treatment approach over another) (Corman, 1989; Kitchur et al., 1989). As previously described in this chapter, the impact of child sexual abuse is multi-dimensional, consequently treatment need also be multi-dimensional. Group treatment for adolescent victims is not intended as a panacea to substitute for other forms of intervention (i.e., family and individual therapy) but rather to complement such therapies. However, an exception to multi-

dimensional treatment may exist when a family has proven resistant and unengagable. In cases like this, group therapy for adolescent victims can prove to be a major source of treatment. Berman (1990) found in her work with resistant, multi-problem families that an adolescent group intervention was perceived as less intrusive than other interventions and was therefore one of the only interventions these family systems permitted. For some adolescents group becomes a primary support system which replaces but preferably enhances the child's basic support system, the family (Berliner & Ernst, 1984).

RATIONALE FOR GROUP THERAPY WITH ADOLESCENTS

In large part, group therapy with early adolescents is most efficacious because it is most consistent with their developmental needs (Corman, 1989). During this stage of development peer interactions become the major source for meeting the adolescents basic needs (Berliner & Ernst, 1984). Not being part of a peer group, not belonging or sharing are experienced as a major loss for an adolescent. Given the sexual abuse victims predisposition to a sense of isolation and alienation, forming peer connections may prove a difficult task. Other adolescent developmental tasks which appear to benefit from group therapy include: separation and individuation from parents, developing a sense of identity,

and developing life goals (Knittle et al., 1980). Corman (1989) adds to this list, the need for healthy, appropriate sexual education and development (including a sexual identity). This is especially important for the child whose sexual development has been distorted and violated by the sexual abuse experience.

CURATIVE EXPERIENCE IN GROUP

Berman (1990) in describing an insight-orientated, structured preteen group for sexual abuse victims connects her findings to Yalom's curative factors in group therapy. Berman (1990) found the curative experience for these girls had come from the following: "participants recognizing that others have had similar experiences, revealing personal experiences, gaining personal insight, and helping others gain insight" (p.248). Berman (1990) also stressed the need for the group therapists to assure safety within the group milieu.

PRIMARY OBJECTIVE AND GOALS FOR GROUP TREATMENT

The overall objective of group therapy appears to be to move a child or adolescent from the position of "victim" to that of a "survivor". This means, helping the child master the sexual abuse experience in such a way that the experience no longer negatively defines the child's sense of self. This

is particularly critical for the adolescent because her awareness of self-image is heightened in her struggle to form an identity (Rosenberg, 1965). In order to accomplish this objective (i.e., helping the adolescent gain mastery over the sexual abuse experience) Berliner & Ernst (1984) suggest preadolescent group therapy with the following goals: to break the child's sense of alienation through peer support and acceptance, to educate and correct distortions regarding child's sexual abuse and human sexuality, and finally to allow the expression of feelings and a better understanding of the experience. To this list, Knittle et al., (1980) add the following goals: the development of social skills, the meeting of dependency needs through peer approval, and assertiveness training in order to break with the helpless role of victim. This list of goals is completed by adding Berman (1990), agenda: to discuss rather than deny the abuse, to evaluate rather than feel victimized by the experience and to supportively confront each other rather than collaborate in denial.

More specifically, recurrent treatment themes cited in the literature include: frequent distrust and mistrust of adults and authority, a sense of betrayal, fear of intimacy, feelings of guilt, blame and shame with a need to the protect family, low self-esteem and a sense of being "damaged goods", pseudomaturity, and feelings of alienation and isolation (Finkelhor, 1986; Kitchur et al., 1989; Knittle et al., 1980).

Others such as Berliner & MacQuivey (1982) and Corman (1989) have used Finkelhor's four traumagenic effects as treatment themes to structure weekly group interventions. This list of goals is by no means mutually exclusive nor is it necessarily exhaustive.

THE THERAPIST'S APPROACH

Berliner & Ernst (1984) advocate that the therapist's approach should be one of providing ongoing support coupled with education and above all stress the need for the group experience to be pleasurable. Berman (1990) primarily defines the therapist's role as the that of facilitating and promoting insight (e.g., with regards to problem solving, coping skills). The literature quite consistently suggests the benefits of utilizing co-therapists in order to ensure group continuity and to facilitate group process. However, no definitive data exists with respect to the impact of therapist's gender on the group participants and on the group process (Kitchur et al., 1989). Kitchur et al., (1989) makes reference to literature which cites the benefits of having both a female and male therapist in providing essential role modelling regarding male female relationships. Regardless of gender, the responsibility of the therapists is to answer questions and to educate, to provide insight, to challenge distortions or misperceptions, to set limit sets, to model and

promote healthy communication, problem solving, coping skills, and appropriate exchange of affection (Berliner & Ernst, 1984; Corman, 1989; Knittle, 1980).

MEMBERSHIP, SELECTION CRITERIA

In selecting participants for group Berliner & Ernst (1984) suggest that: 1) therapist know the complete history and circumstances of the assault; 2) the someone (e.g., a Child and Family Services worker) be responsible to assure the ongoing safety of the child; 3) participants be able to communicate with their peers; and 4) all participants share significant factors (e.g., relationship to the offender, and that participants age range should only be within a 2 or 3-year span.)

GROUP STRUCTURE (CONTENT, SETTING)

According to Berliner & Ernst (1984) the adolescent group focus is on the peer context, calling for less structure and influence from the group therapists. Although the sexual abuse experience is the common group experience to be mastered within the group, it should not be the basis of all group interactions. Other individual concerns relevant to members are equally important to address e.g., family disintegration, foster placement. However, each group session should be

preplanned by therapists in order to cover a basic treatment theme as defined above. Privacy should be guaranteed unless the client system's safety is at risk.

The group should be time-limited with members knowing the number of sessions from the onset so as to facilitate closure of the sexual abuse experience and of group in general. As well, the closer to puberty age the members the more likely they will benefit from the same sex group members (i.e., the more easily and meaningfully they will relate with the same sex peers). The group should be no smaller than about 4 and no larger than 6 or 7 members (Berliner & Ernst, 1984). Adolescents, unlike younger children, benefit more from discussion versus activity as a primary means of communication. Regardless, members of all ages benefit from a varied modes of communication e.g., films, role playing and didactic presentations. Non-offending parents or caregivers should be kept informed of the group themes and general progress so they can encourage their child's ongoing participation and healing. Berman (1990) found "regular attendance to be a major factor group to be a major factor in determining high versus low group achievers" (p.251).

SYNOPSIS OF THE LITERATURE REVIEW

This review of the literature in the area of intrafamilial child sexual abuse further reinforces the

pervasive nature of this problem within our society and the damaging effects to both the child and the family. An ecological framework is proposed for conceptualizing the theoretical, etiological and therapeutic issues with regards to child sexual abuse. This framework allows clinicians, such as the author, to integrate aspects of both a feminist and family systems perspective to the problem.

This author's bias, as reflected in her beliefs and attitudes with regards to child sexual abuse shall guide this practicum report and can be summarized as follows. The offender alone is always responsible for the child sexual abuse and must ultimately be held responsible as the child who is abused is always an innocent victim. The offender must firstly, be held accountable for this sexual crime through the criminal justice system. This author shares the feminist contention that more child sexual abuse cases need to be successfully prosecuted without the cost of revictimizing the child, which the author believes presently reflects the current situation, as these offenders are likely to continue to proliferate without such an intervention (Armstrong, 1989). The feminists concerns for the need for political analysis of the problem, as but one more form of sexual violence against women and children are also shared by this author. However, in spite of this macro level concern, the author's unit of study and focus in this practicum report will be child and early adolescent aged victims and their non-offending

caregivers or mothers.

This author believes that the child's safety should always govern as a priority and that initially adult offenders should always be removed from the home (while cases of sibling incest might prove as an exception proved adequate supervision is available for the child victim and provided the family is in receipt of comprehensive therapy to all member). However, the author shares the family systems belief that stopping the sexual abuse alone, while essential, is insufficient and that underlying individual and family dynamics must also be addressed or the child victim continues to be "at risk" for further revictimization (Mrazek & Bentovim, 1981). Any form of treatment must work to change the structure of the family, reduce dysfunctional behavioral patterns which have contributed to the abuse and improve family communication patterns (as previously described by Maddock, 1989) so that family members developmental needs are more appropriately met (Barrett et al., 1986). As well, this author believes that from the onset of intervention there must be adequate communication and coordination amongst the various professionals and other systems involved in the life of the family so as to avoid mimicking the family's dysfunction e.g., chaos, rigidity (Trepper & Barrett, 1986).

CHAPTER THREE

THE PRACTICUM

SETTING

The setting for this practicum was the Community Resource Clinic (CRC), located at 301-321 McDermot Avenue, Winnipeg, Manitoba. The CRC is an innercity counselling clinic which operated under the sponsorship of the Psychological Services Centre and the School of Social Work at the University of Manitoba. It is primarily utilized as a training facility for clinical students of the School of Social Work and Department of Psychology, University of Manitoba, although there are also a number of therapists on staff. This facility was created to provide training to mental health professionals and to provide accessible counselling services to residents of the core area of Winnipeg. The facility with its gleaming hardwood floors is tastefully decorated in soothing pastel colours with colour coordinated area rugs, walls, chairs and a plant in each room. This facility is comprised of the following: three larger therapy rooms appropriate for family therapy or small groups; three smaller rooms for individual or couple sessions; a fully equipped play therapy room and a large open area conference room. All therapy rooms contain video equipment which allowed students an efficient means of

clinical supervision. As well one family therapy room and the play therapy room adjoin with a supervision room accessible by a one way mirror, allowing for live clinical supervision.

The same family therapy room was chosen for the non-offending caregivers group and for the early adolescent group, as both these groups operated on different weekdays. This room allowed for the comfortable seating of up to seven individuals and still allowed room for a white board when needed. Whereas the conference room was chosen as the setting for the majority of the children's group sessions and contained a variety of toys and art materials for play as well as a child size table and chairs. Half of the conference room is carpeted. The conference room has two doors on each half of the room and it is enclosed with frosted glass. A family therapy room (containing stuffed animals and art materials) was utilized for three of the children's group sessions.

PERSONNEL AND SUPERVISION

This practicum report covers the detailed efforts of its author who performed as one of the team members involved in a collaborative treatment approach to intrafamilial child sexual abuse. Team members included four Master of Social Work students and their respective committee members. The team co-operated with referrals, intake and screening, service delivery, peer consultation, and supervision.

The four students joined to provide a comprehensive, short term (i.e., 14 week) parallel group treatment program for sexually abused children and their non-offending caregivers. The primary treatment modalities employed involved both group therapy for the children/adolescents and their non-offending caregivers, and systemic interventions (e.g., dyadic or family focused practice). This practicum report specifically addresses the parallel treatment program for sexually abused, latency-age girls (with a primary focus on their caregivers' group) and early adolescent female group (with a primary focus on the adolescent victim's group) and their non-offending caregivers. Karen Gamey and Ron Kane acted as co-therapists for the latency group which ran on Tuesday evenings for fourteen consecutive weeks, meeting for one and one half hours per week while Kathy Anderson and Barb Gajdek acted as co-therapists for the parallel (latency) caregivers' group. Barb Gajdek and Ron Kane also served as co-therapists for the early adolescent group which ran for Wednesday afternoons for fifteen consecutive weeks, meeting for one and one half hours weekly. Kathy Anderson was the sole group therapist for the parallel non-offending caregivers' group for the adolescents but this group terminated after only five session due to a high number of "drop-outs".

One case manager was also assigned to each family system involved in the groups. This assignment of case managers

occurred within the second to third week of group. The role of the case manager was significant and covered everything from transportation arrangements, completion of clinical measures, crisis intervention, liaison with CFS and other agencies (as warranted), and the implementation of any family systems intervention. In accordance with this, this practicum report also includes the case study of two of the five family systems involved in the early adolescent group treatment program (i.e., systems I. and J.) as the author acted as "case manager" for these families.

The total number of treatment team contacts for the author was:

1. Dr. Barry Trute, 8 supervision sessions addressing family system interventions; each session one to one and half hours, included viewing videotapes of the family sessions, case consultation.
2. Professor Walter Driedger, 14 supervision sessions addressing the parallel latency caregivers' group, viewing of videotape for each group session for one and half to two hours and consultation.
3. Enid Britton, 8 supervision sessions addressing the early adolescent victims group, viewing of videotapes and consultation for two hours per supervision meeting.
4. Team Supervision (Kathy Anderson, Walter Driedger, Barb Gajdek, Karen Gamey, Les Jerome, Ron Kane,

Aaron Klein and Barry Trute), four larger case conference and planning sessions.

5. Weekly consultation and "de-briefing" sessions among the parallel group therapists; lasting approximately one half to one hour per group per week to review cases and co-ordinate interventions.

6. Weekly "de-briefing" sessions and preparation with the co-therapist for approximately two hours per group per week.

CLIENTS AND SELECTION CRITERIA

In keeping with the philosophy and mandate of CRC, that is: to serve innercity residents, this treatment program gave first priority to the Child and Family Services Agencies serving or bordering the inner city area of Winnipeg (i.e., Central, North West, and South Regions). Each of the agencies noted above were informed as to the intent of the parallel treatment and its selection criteria. This was done via a telephone conversation which was followed by a meeting with the respective abuse coordinators. As there were a shortage of appropriate referrals forthcoming within the first three weeks of the program's inception, referrals were opened up to the following agencies: other CFS agencies, Marymound Family Resource Centre, Child Protection Centre, and Child Guidance Clinic.

SELECTION CRITERIA

1. female intrafamilial sexual abuse victim (as defined earlier to include sexual abuse perpetrated by a trusted third party);
2. children currently, ages seven to nine (for latency group) and adolescents, ages eleven to thirteen (for early adolescent group);
3. the child/adolescent must currently reside in a stable and safe home (natural or foster family, with an emphasis on maintaining the present placement throughout treatment);
4. the child/adolescent should be in a stable, supportive relationship with at least one significant adult/caregiver who is capable of recognizing and meeting the child's needs (i.e., at minimum: the caregiver should be supportive of treatment, <u>the primary caregiver to participate in the parallel group,</u> be protective of the child, and must restrict offender's access);
6. the child must not be currently living with the offender; and
7. the child must be reasonably comfortable with and able to cope with the context and content of treatment (e.g., discussing sexual abuse issues, sharing their personal experiences, acknowledging

their sexual abuse).

Note: Two exceptions were made to the above criteria. In one family, (latency group) the older girl in a sibling unit was 10 years old but warranted therapy and was accepted. In the second family, (adolescent group) the mother adamantly refused to attend the parallel mother's group but wanted help for her daughter and agreed to a mother-daughter dyadic intervention.

CLIENTS

Refer to Appendix A for a table summarizing the intake data gathered during pre-group intake meetings for the latency children and their caregivers. All of the family systems participating were referred by a Child and Family Services Worker with the exception of one mother, who had called the CRC months earlier requesting therapy upon the suggestion of her CFS worker. Of the five caregivers two were foster parents, two were natural mothers and one was a maternal grandmother. One of the natural mothers had just recently had her children returned to her by CFS. Four of the five caregivers were single parents, three of whom were supported by provincial assistance. Three of the five families were of Native Canadian heritage (i.e., both natural mothers and the maternal grandmother). All of the caregivers denied any history of sexual abuse. Three of the seven child victims

were sexually abused by more than one offender. The ages at which the children were abused ranged from 2 to 9 years. Six of the seven child victims had at least one offender who was a family member. The nature of the sexual abuse ranged from exposure and fondling to penetration.

Refer to Appendix B for a table of the intake data gathered during pre-group intake meetings for the adolescents and their caregivers. Again, all but one of the family systems participating in the early adolescent parallel group, was also referred by CFS. The one exception here was also a mother who had made a self-referral to the CRC. Three of the four caregivers were natural mothers and one was a foster mother. All of the caregivers had been sexually abused themselves as children or adolescents. All of the four adolescents living with their natural mothers had recently (from 3 months to 2 years) been returned from the care of CFS or another substitute caregiver. All of the caregivers with the exception of the foster mother were single parents supported by provincial assistance although two also worked part-time to supplement their incomes. Two of the five adolescents had been sexually abused by more than one male offender. Two of the adolescents had been sexually abused by their grandfather while another two had been sexually abused by one of their mother's past boyfriends. The age at which the adolescents had been sexually abused ranged from 2-11 years. The nature of the sexual abuse ranged from fondling to

penetration.

Generally, the child was identified by the family as the identified patient, but the client system was perceived by the treatment team to include the non-offending caregiver, other significant members of the family system, and other significant systems (e.g., CFS).

The coding system utilized in this practicum was created to assure client anonymity and confidentiality and can be described as follows: Each family, that is all its members are identified by the same letter of the alphabet beginning their first names and then the same corresponding letter following a hyphen (-) after their name. The child/adolescent attending group will be identified by a lower case letter following the hyphen (-) while all other significant members in that family or system will be indicated by a capital letter following the hyphen (-).

The latency-age group members and their non-offending parallel caregivers group members were:

A: Fiona-a (eight years old) whose foster mother Fran-A, did not attend the caregivers group

B: Heidi-b (seven years old) and foster mother Helen-B

C: Cindy-c (eight years old) and maternal grandmother Carol-B

D: Lucy-d (10 years old) and her natural

sister Laura-d (eight years old) and their natural mother Lori-D

E: Ellen-e (10 years old) and her foster mother, Erica-E

F: Dee-f (nine years old) and her natural mother, Donna-F.

The early adolescent group members and their non-offending parallel caregivers group members were:

G: Rhonda-g (eleven years old) and her natural sister Ruth-g (twelve years old) and their natural mother Rose-G

H: Ann-h (twelve years old) and her foster mother Alice-H

I: Gail-i (thirteen years old) and her natural mother Gert-I who did not attend the caregivers group

J: Pam-j (thirteen years old) and her natural mother, Pat-J

Treatment Goals

This practicum focused primarily on parallel group therapy for intrafamilial child sexual abuse. As well, family systems therapy was encouraged and provided to two family systems participating the adolescent group. The

overall treatment goals for the children and adolescents and their family systems were as follows:

1. to ensure continuity between the child's treatment and that of the mother;
2. to create and facilitate an opportunity for peer support among both groups, i.e., sexual abuse victims and their caregivers;
3. to encourage and model appropriate, healthy communication and socialization amongst the children/adolescents and their caregivers especially with regards to the expression of feelings;
4. to educate children/adolescents and their caregivers with age appropriate information regarding sexual abuse dynamics, human sexuality and prevention strategies (e.g., personal privacy and sexual privacy boundaries, relationships, good and bad touch, personal safety);
5. to provide an opportunity to disclose, explore and liberate feelings with regards to abusive experiences, through various activities;
6. to introduce and encourage, improved coping skills which promote and enhance within the child a survivor versus victim mentality i.e., enhance the child's self-esteem and body image, sense of mastery and control versus powerlessness;

7. to role model healthy male-female and parent-child interactions and relationships;
8. to facilitate awareness of child sexual abuse dynamics and to facilitate preventative measures; and
9. to support the child within her family system (i.e., the caregiver-child dyad and other significant members of her system); to enhance improved communication and effective/nurturing interactions between the caregiver and her daughter.

Because these families were at the initial stages of therapeutic involvement and healing, the family systems interventions were designed to address primary relationships (most often with the caregiver) and the needs of the child/adolescent and her system. The priority for case managers was to encourage and facilitate attendance (e.g., tend to transportation and respond to frequent family crises), integrate treatment issues in terms of the parallel groups, facilitate awareness of sexual abuse, to support the child with significant caregiver and family members, and to foster open communication regarding sexual abuse and protection between the child/adolescent and her respective caregiver(s).

METHOD OF EVALUATION

As a method of evaluation for this practicum, the following clinical outcome measures were administered pre and post the application of the treatment interventions. The one exception was the Impact of Events Scale (IES) which was used primarily for intake and assessment purposes only, with no post-test administration. The following standardized self-report measures were utilized for the purpose of clinical evaluation: The Index of Parental Attitudes (IPA) (Concoran & Fisher, 1987), The Brief Scale of the Family Assessment Measure III (BF-FAM) (Skinner, Steinhauer & Santa-Barbara, 1984), The Brief form of the Beck Depression Inventory (BF-BDI) (Beck & Beck, 1972), The Self-Esteem Scale (SES) (Rosenberg, 1965). Two non-standardized measures (i.e., two separate group evaluation forms) were employed to elicit consumer feedback. One such form was administered to the latency caregiver group participants while the other was administered to the early-adolescent group participants. Refer to Appendix C for a copy of each group evaluation form. These two group evaluation forms were developed by Barb Gajdek and Kathy Anderson and by Barb Gajdek and Ron Kane respectively. Each evaluation form contains ten questions which are either open ended or scored on a three point Likert scale.

All latency caregiver group members completed the following measures both pre and post, group and or family intervention: IPA, BF-FAM, BF-BDI, and a group evaluation form upon the completion of group. All but one foster mother (Erica-E) completed all pre and post measures. Erica-E "dropped out" during the course of the group, therefore, she was the sole member to complete only pre measures. Group facilitators administered all pretest measures during pre-group meetings and the initial group while all post-test measures were completed primarily by individual case managers following the final group session.

With regards to the early-adolescent group, the following measures were administered both pre and post group, individual or family intervention: BF-FAM, BF-BDI, SES and the adolescent group evaluation form upon completion of the group. All pre and post-test measures were administered by the group facilitators. It is important to note that the pretest measures were actually completed within the second to fifth week of group due to new membership being accepted up until the fourth week of group. As well, two adolescents never completed certain pretest measures due to absenteeism and then due to a miscommunication amongst the group facilitators. All post test measures were completed by all members during the fifteenth and final group session.

All clinical measures of evaluation utilized in this practicum will be reviewed below with an emphasis on their

intended purpose, their strengths and limitations and the normative data (mean scores) used to guide in their interpretation.

Index of Parental Attitudes (IPA)

The Index of Parental Attitudes (IPA) was chosen to measure the latency mothers/caregivers attitudes and relationship problems with their daughters. As previously cited in the literature review, a mother's support for her daughter in cases of intrafamilial child sexual abuse serve as a mediating factor in the child's recovery (MacFarlane & Waterman, 1986). The IPA consists of 25 items designed to measure the extent, severity and magnitude of parent-child difficulties as reported by the parent (Concoran & Fisher, 1987).

The IPA is one of a nine scale Clinical Measures Package (Hudson,1982) which includes the Child's Attitude Towards Mother (CAM) and Father (CAF). The CAM and the CAF were utilized as pre and post measures to assess parent-child relationship problems from the latency children's perspective (Concoran & Fischer, 1987). The CAM and CAF measures correspond item by item with the caregivers' IPA, therefore the IPA measure was selected to assess the mother-child relationship. This enabled both group facilitators an item analysis and comparison between the child and their respective

caregiver. This information was then was used in the overall treatment planning for the families.

The IPA has superior group validity which meaningfully distinguishes between groups of clients designated by themselves and their therapists as having or not having relationship problems with their children (Concoran & Fisher, 1987). The mean alpha of .97 (Concoran & Fisher, 1987) indicates excellent internal consistency. Concoran and Fischer (1987) also report acceptable validity for these measures in terms of construct and predictive validity.

The IPA, like the CAM and the CAF has a cutoff score of 30 (SD=5). IPA scores above 30 indicate clinically significant difficulties in that parent-child relationship from the perspective of the respondent (i.e., the parent) (Concoran & Fischer, 1987).

The Brief Beck Depression Inventory (BF-BDI)

As a caregiver's ability to support her child (MacFarlane & Waterman, 1986) is crucial, assessment of the caregiver's own mental health was relevant to the treatment team. Also as depression is often correlated with self-esteem (Rosenberg, 1965) and because depression and low self-esteem are features associated with sexual abuse the Brief version of the Beck Depression Inventory (BF-BDI) (Beck & Beck, 1972) was chosen

as a measure for both the latency caregivers group and the adolescent survivors group.

The BDI is one of the most widely used screening measures for depression. Mental health professionals in a variety of settings benefit from its use (Steinhauer, 1985). The BDI was originally developed for adults and late adolescents although later research indicates it is even appropriate of use with younger adolescents, as young as twelve years (Strober, Green & Carlson, 1981).

The brief form of the BDI was chosen because it is a simple (13 item) questionnaire deduced from the revised 21 item test which contends to measure the presence and degree of depression in adolescents and adults (Steinhauer, 1985, p. 24). Each of the 13 BF-BDI items assess a depressive symptom that is: sadness, pessimism, sense of failure, dissatisfaction, guilt, self-dislike, self-harm, social withdrawal, indecisiveness, self-image change, work difficulty, fatigue, and anorexia (Beck & Beck, 1972). The BF-BDI is relatively easy to administer, the reading difficulty is quite low, statements are easy to comprehend, and directions are clear. The BF-BDI takes a total of about five minutes to complete and yet provides an accurate means of assessing a client's degree of depression.

The BF-BDI is highly correlated with the original, 21 item BDI. Beck and Beck (1972) report that the brief BDI has a correlation of 0.96 with the original BDI. Reliability and

validity studies of the original BDI showed a split half reliability of .93 and significant correlation with clinical ratings of depression, others depression scales, and objective behaviour measures of depression (Beck & Beck, 1972). Beck and Beck (1975) calculated a range of scores or cut-off points based on analysis of distribution of the short BDI. These score ranges estimate the degree of depression and can be summarized as: 0-4 none or minimal, 5-7 mild , 8-15 moderate and 16+ severe (Beck & Beck, 1972).

THE BRIEF SCALE OF THE FAMILY ASSESSMENT MEASURE (BF-FAM)

The Family Assessment Measure III (FAM III) is a self report instrument based on a process model of family functioning which attempts to define the process by which families operate. FAM III serves to measure a family's functioning by providing quantitative indices of family strengths and weaknesses. This measure is particularly useful as it provides a framework for integrating various approaches to family therapy and research (Skinner, Steinhauer, & Santa-Barbara, 1983).

The Brief Scale of The Family Assessment Measure III[1] (BF-FAM) is highly correlated with the FAM III. The BF-FAM

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1 Information regarding the FAM III Brief Scale is available from Dr. Harvey Skinner, Alcohol Research Foundation, Toronto, Ontario.

was selected to assist as a diagnostic tool in assessing family functioning and as a measure of therapeutic outcome in this practicum. The BF-FAM was created by choosing two of the original items most highly correlated with each of the seven basic dimensions of family functioning (for a total of fourteen items). The seven basic dimensions of family functioning that are measured include: communication, affective expression, affective involvement, control, and values and norms.

The BF-FAM was chosen for its short length (14 items), easy administration, and good normative data for both adults and adolescents in both normal and clinical families. BF-FAM scores range from 14 to 56 with a low score indicating family strengths and a high score indicating family problems and dysfunction. Norms for BF-FAM for clinical families are adults (30.4) and adolescents (31.5) (Skinner et al., 1984). FAM scales are quite reliable (general scale - adults = .93, children = .94), and serve to significantly differentiate between problem and non-problem families (Skinner et al., 1983).

SELF-ESTEEM SCALE (SES)

The Self-Esteem Scale (SES) is a self-report measure of self-esteem developed by Morris Rosenberg (1965). This scale was specifically developed for use with junior and senior high

school students. It was therefore appropriately chosen for use with the adolescent group. The SES serves to measure self-esteem, most particularly the self-acceptance aspect of self-esteem (i.e., the individual respects themselves for what they are but do not necessarily consider themselves superior to others) (Rosenberg, 1965).

Low self-esteem implies self-rejection and self-contempt and is often cited in the literature amongst sexually abused children (e.g., Finkelhor's (1986) "damaged goods" syndrome). As well, it was especially relevant to evaluate the self-esteem of the adolescents in group, as awareness of self-image is heightened during the adolescent phase of development. Therefore, due to the prevalence of low self-esteem amongst sexually abused children and due to the heightened awareness of self-esteem during adolescence, the SES proved the measure of choice. The SES was chosen both as a diagnostic tool and as a measure of therapeutic outcome for the adolescents. As previously noted with regards to the BDI, Rosenberg (1965) claims that depression is correlated with low self-esteem, therefore as the BF-BDI was utilized as an outcome measure for the adolescent participants, in combination, it appeared appropriate to utilize the SES.

The SES consists of ten simple items answered on a four point scale. All items revolve around liking and/or approving of the self (Robinson & Shaver, 1973). The scale is brief, easy to understand and easy to administer. SES scores range

from 10 to 40. A low score indicates low self-acceptance and a high score indicates high self-acceptance (i.e., the individual respects himself, and considers himself worthy) (Rosenberg, 1965). The main criticism of this scale is that there has been insufficient recent work has been insufficient and there is no central repository of information for potential users. As well, in general, as a Guttman scale, the SES is criticized for producing only gross, ordinal distinctions amongst individuals (Robinson & Shaver, 1973). Nevertheless, as a brief measure of self-esteem, particularly applicable to adolescents, the SES seemed fitting as a clinical outcome measure for the adolescent participants in this practicum.

IMPACT OF EVENTS SCALE (IES)

The Impact of Events Scale (IES) was administered more during the initial intake for the purpose of further contributing to the clinical assessment process. The IES measures the subjective level of distress associated with the sexual abuse experience and or disclosure for the clients. It was immediately apparent that foster mothers refused to complete the measure as they felt it was irrelevant and inappropriate for them.

The IES is a fifteen item scale assessing post-traumatic stress for any specific life event, as defined by the

administrators of the scale. The IES measures two categories of experience, that is: intrusion (characterized by unbidden thoughts and images, troubled dreams, strong pangs or feelings) and avoidance (characterized by denial of the meanings and consequences of the event, blunted sensation and ideational constriction) (Horowitz, Wilner & Alverez, 1979).

The total mean stress score was 39.5 (SD=17.2, range 0-69). The mean intrusive subscale score was 21.4 (SD=9.6, range 0-35) and the mean avoidance subscale score was 18.2 (SD=10.8, range 0-38) (Horowitz et al, 1979, p.213). The test retest reliability of the total scale score was high (r=.87), for the intrusion subscale .89 and .79 for the avoidance subscale (Horowitz et al., 1979). The IES is sensitive to change as demonstrated by significant changes to discrete life events of varying magnitude (Horowitz et al., 1979).

However, the concern for utilizing the IES as a clinical outcome measure in this practicum was because of the multi-problem nature of the families involved in this treatment program. Most of the families appeared to be suffering ongoing crises, beyond that of the sexual abuse, throughout the course of treatment. Therefore, it would have proved difficult to distinguish whether the responses given to the IES were solely based on the sexual abuse experience or whether they were based on other ongoing crises and trauma. For this reason, the IES was chosen only for the purpose of providing assessment information and was not utilized as a

clinical evaluation measure.

CHAPTER FOUR

GROUP INTERVENTIONS

THE EARLY ADOLESCENT VICTIMS' GROUP AND THE LATENCY NON-OFFENDING CAREGIVERS' GROUP

This chapter will contain detailed information, discussion and analysis on the above named groups. Firstly the intake and pre-screening procedures utilized for the two group will be reviewed. Then the major phases for each group will be outlined. Each phase of the groups will include a detailed description of the sessions i.e., the agenda, objectives, session summary and session themes.

INTAKE AND PRE-GROUP PROCEDURES

The purpose of conducting a pre-group intake meeting with each participant, their caregiver and CFS worker (where applicable) was to:

a) begin to join with the family

b) outline the treatment offered

c) indicate the screening criteria and assess whether the client system met the criteria

d) to elicit the support and joint participation of the child and caregiver (and CFS worker where

applicable)

e) to collect information (e.g., good history with regards to the history of sexual abuse utilizing Trute's intake information outline)

f) to begin a clinical assessment

g) (for the latency groups) to begin to administer pre-test clinical measures

It was requested that the child not attend the initial meeting in order to allow the caregiver and the CFS worker (where applicable i.e., where the CFS is actively involved with the family system) to attend the first meeting with the treatment team to acquire an understanding of the treatment offered. This approach was taken primarily with the latency age children with the one exception of an adolescent actively involved with a CFS worker. This approach was taken to avoid the possibility of disappointing the child and informing her she would not be accepted to participate in treatment. Once the system's involvement was indicated, two additional pre-group sessions were held with the latency aged children and their caregivers. Whereas with the adolescents group, it was difficult to secure more than one pre-group meeting with the adolescent and her caregiver (except for the one noted above) due to time constraints and the resistance of some families.

The pre-group sessions served to assess the parent-child relationship, to assure the family's comfort, and to openly

acknowledge the sexual abuse experience and the intent of treatment. The sessions provided an opportunity to join with the child and caregiver, to prepare them each for the groups content and the structure of treatment (e.g., use of videotaping), and to begin to complete a clinical assessment. Most of the pre-test clinical measures were administered to the latency age children and their caregivers during the course of these pre-group sessions. The clinical measures administered to participants of the latency non-offending caregivers' group included: Brief FAM III, BDI and IPA. Due to only one pre-group session for the adolescents and their caregivers no clinical measures were administered at this time. Instead, the adolescent group participants completed the following pre-test clinical measures by the third session: the BF-FAM, BF-BDI and the SES.

EARLY ADOLESCENT VICTIMS' GROUP

The following section of this chapter will include an outline of the five key phases of the early adolescent group. Each phase includes a number of succeeding sessions. Each of the individual sessions will be presented with a description of the session's: objectives, agenda, summary and themes. This section describing the early adolescent victims' group will end with an analysis of the clinical outcome measures implemented to evaluate this group.

EARLY ADOLESCENT VICTIMS' GROUP - PHASES AND SESSIONS

Phase I: Gathering and Setting the Stage

Session 1. Welcome

Session 2. Getting Acquainted and Making Friends

Phase II: Education and Mastery

Session 3. Exposure to Sexual Abuse Dynamics

Session 4. The Impact of the Sexual Abuse

Session 5. Christmas Celebration

Session 6. Breaking Free from the Role of Victim

Session 7. Mid-term Evaluation

Session 8. Facts Versus Misconceptions

Session 9. Continuation of #8.

Phase III: Release

Session 10. Preparation for Disclosure

Session 11. Body Education and Sexuality

Session 12. My Story of Sexual Abuse

Phase IV: Coping

Session 13. Sexuality, Dating and Coping Skills

Phase V: Continuation of Coping and Closure

Session 14. Closure, Safety and Social Support Networks

Session 15. Farewell Celebration

PHASE I - SETTING THE STAGE

SESSION #1: GATHERING AND WELCOME

OBJECTIVES:

1. To begin to establish a safe, supportive, and pleasurable atmosphere for all group members.
2. To allow members to begin to join with one another and with the group therapists.
3. To orientate members to the purpose of the group. To outline the structure of the group and group expectations.

AGENDA:

1. Snack served to the members by the group therapists.
2. Discussion: introductions of adolescents and therapists.

   a) clarify purpose of today's meeting as welcome and getting to know each other

   b) clarify purpose of the group: commonality of sexual victimization and group as part of the healing process

   c) clarify weekly group structure with snack, check-in activity/theme and closure (with use of the journals)

3. Joining Activity - "Name Game" using name tags and a ball, ask each member to progressively disclose more than their name (e.g., where they live and their family composition, hobbies)
4. Group rules - group therapists will lead in the creation of a set of group rules e.g., confidentiality and then to empower members input in order to complete a set of group rules.
5. Closure: a) group therapists will assign each member their own log or journal scribbler and discuss its intended purpose. b) group therapists will distribute friendship bracelets allowing each member to choose their own individual bracelet design (same bracelets but different designs) as a symbol of group membership and belonging, and for potential use as a transitional object upon termination of group.

SESSION SUMMARY:

Four of the five adolescents expected, attended this initial group.

All members appeared anxious and uncomfortable at the start of group. There was little interaction except through the group therapists. Member's anxiety was expressed partially through their quick and excessive indulgence in snack, despite most members having had lunch.

The joining process progressed with the start of the "Name Game" which was initiated by the therapists in a supportive, self-esteem building manner. That is, therapists assisted introductions by highlighting a strength or talent in every one of the girls (e.g., Ruth-g's talent as an artist, Pam-j's good sense of humour, etc.) as noted by the therapists during the pre-group meeting.

Group members were slow and cautious in connecting with each other and revealed only minimal personal information, e.g., grade level, pets, who resides at home, and family composition. Their initial anxiety may also in part have been due to the fact that group therapists had explained that new members (new composition) would still be allowed over the next two weeks, due to a small group number.

Group joining and cohesion became more spontaneous towards the end of session when members joined to create a set of group rules. All group rules were created by the members themselves with minimal guidance from the therapists. Ann-h assumed leadership by acting as the group secretary and writing the group rules on the white board. The rules created were: no fighting or swearing (probably an indication of members need for safety given their abuse histories), no looking in other members' journals (highlighting the need for boundaries and privacy), and what is said in the group stays in the group (confidentiality). Camaraderie was facilitated by the fact that two members (a sibling unit) and another

member identified some commonality, with both their sisters currently residing in the same residential treatment facility. Despite this commonality all members appeared equally uncomfortable commenting on their sexual abuse in any way or their reasons for involvement in treatment. Therapists respected this initial discomfort and recognized the need to place more effort into facilitating the joining process and building the level of safety and comfort within the group.

At closure, all members appeared to have enjoyed themselves despite their quiet apprehensions and all vowed to return. Overall, only positive feelings were expressed about the group. Members appeared particularly exhilarated by the therapists' distribution of friendship bracelets, symbolic of group membership and belonging. All members immediately donned their bracelets and wore them outside of the group.

SESSION THEMES:

1. The group achieved an initial degree of cohesion.
2. As a whole the group appeared anxious, uncomfortable, and somewhat hesitant to trust and disclose much about themselves. Most members appeared anxious for acceptance from their peers. All members appeared equally uncomfortable commenting on their sexual victimization or this content in any way.
3. The therapists validation of members and members

validation of each was significant in this initial stage of group process. For example, when therapists commented on members strengths during the "Name Game" activity this facilitated an increased comfort level amongst members and fostered more self-disclosure.

SESSION #2: GETTING ACQUAINTED AND MAKING FRIENDS

OBJECTIVES:

1. To establish group structure i.e., weekly group routine with: snack, check-in, an activity or discussion related to a theme and closure.
2. Further establish the group as a safe, supportive and comfortable environment.
3. To introduce the new group member and build on group joining, cohesion, and identity.
4. To foster mutual acceptance and trust amongst members and amongst therapists and members alike.

AGENDA:

1. Snack served by group therapists.
2. Check-in.
3. Ask for members participation in developing and prioritizing group themes with some guidance from therapists.

4. Identify ways in which to welcome and introduce oneself to the new member (starting later today).
5. Session theme - continue building camaraderie amongst group members. Activity : Pictionary game with two teams.
6. Check-out: including ten minutes allotted for individual work on journals.
7. Clinical measures administered.

SESSION SUMMARY:

Snack was again very well received this week. Members appear to feel nurtured by the snack especially with it being served to them by the therapists. In time, the therapists anticipate that through their modelling members will gradually begin to nurture each other by taking turns serving snack to each other. Members again appeared anxious at the start of group. This was indicated by their excessive laughter and giddiness which was normalized by therapists as part of the initial anxiety that accompanies the beginning of any adolescent group. Therapists had difficulty having members focus on any self-disclosure or expression of feelings during the check-in process. Instead they engaged in more general conversation talking about their friends. Gradually members began to talk about themselves, e.g., Ruth-g spoke about the discomfort she feels with her new braces.

Later Ann-h risked self-disclosure and revealed a strange

dream she had last week. She seemed to be testing the group by illustrating her feelings indirectly through use of the dream. Members offered interpretations and validation for her dream which seemed to enhance her sense of trust and acceptance. Ann-h went on at some length interacting with Pam-j who also appeared to be seeking the group's recognition and acceptance. The group's sibling unit initially kept more exclusively to themselves however, the eldest of the two, eventually reached out to participate with other group members also seeking validation and acceptance.

Group members candidly expressed their anxiety about the introduction of a new member later this session. Despite this continued trepidation with regards to expanding the group composition, there was distinct progress in group bonding as the session progressed, i.e., there were a number of self-initiated interactions amongst group members with much less communication through the therapists.

Group members spent some time preparing to introduce themselves and discussed how to welcome their new member. Noticeably the level of trust within the group was expanding as members used this task as another opportunity to ask each other more personal questions. As an example, one member asked the sibling unit what it was like for the two of them to be in a group together and both answered "fine". Both sisters appeared genuinely comforted by each others presence in these first two group sessions. These sisters proceeded to share

with the group their family composition. Ruth-g shared worries for her sister living in residential care (away from the family) because of sniffing and running behaviour. While her sister, Rhonda-g disclosed that they also had a brother who is in jail. Therapists attempted to subtly relate this issue of family separation and loss to the topic of sexual abuse. Therapists commented that often in families where there has been child sexual abused the family becomes separated like Ruth-g is now separated from her sister and brother and asked what that experience feels like. Ruth-g admitted worrying about her sister and wanting her to return home.

Again, members seemed too anxious and proved unable to sustain a serious focus on the topic of sexual abuse at all. Members instead returned to exchange stories about their most embarrassing experiences. This exchange seemed to be an expression of their need to return to socialization and bonding while also subtly testing their acceptance by specifically sharing their most, humiliating moments in life. Therapists, in vain, briefly attempted unsuccessfully, once more to have members address the purpose of the group by asking them to contribute ideas for weekly group themes. Therapists relinquished any further attempts to refocus on the sexual abuse as this was obviously premature. Therapists accepted the group's obvious need to continue to bond and test their composition. Therapists believed members could not

enter the working phase of the group until the introduction of the newest member and further testing of the new group composition. The latter proved to be especially true as increased self-disclosure occurred following the fun (game) activity.

When the newest member finally entered (half way through group) the other group members converged around helping her get acquainted by introducing themselves and explaining what had happened in group to date. They now self-disclosed more personal information about themselves then they had in the previous week. This newest member connected easily with the others in part due to her obvious social skills. In playing the pictionary game members displayed good co-operation, appropriate competitiveness and good social skills. They all displayed a sense of playfulness and truly seemed to enjoy themselves. The game successfully served the purpose of furthering group bonding and group cohesion.

During closure the therapist reiterated the purpose of the group i.e., healing from their sexual victimization. One of the group members offered to present the newest member, Gail-i with her own honourary group symbol, the friendship bracelet. This introduction of the friendship bracelets led to an enthusiastic exchange between the girls in which they each proudly displayed their bracelets to one another (surprisingly they all had worn them to group today, an indication of the bracelets significance to the girls). The

renewed excitement and the interest in the bracelets further indicated a growing sense of belonging and group identity. Journal were not completed today as group ended with the completion of clinical measures (pretests).

SESSION THEMES:

1. A common strain amongst members is deprivation, expressed in part by their excessive indulgence and need for the nurturance offered by the snack ritual.
2. Members also appear excessively needy of much recognition, approval and acceptance.
3. To date, members appear uncomfortable with any sexual abuse content.
4. Group process has not advanced yet to the working phase as member simply needed to test their new composition through a fun activity.

PHASE II - EDUCATION

SESSION #3: EXPOSURE TO SEXUAL ABUSE DYNAMICS AND RELATED FEELINGS

OBJECTIVES:

1. To desensitize the group's anxiety regarding the sexual abuse context.
2. To explore the issue of sexual abuse in general and the feelings commonly experienced by sexual abuse victims.
3. To validate and offer permission for members unique experiences and to reinforce acceptance that each member may be at a different stage in healing from their sexual abuse experience.
4. To encourage members to begin to share feelings and experiences related to their own sexual victimization.
5. To encourage an atmosphere of mutual support and empathy.

AGENDA:

1. Snack.
2. Check-in.
3. Activity: Therapist will read a true story in which an adult woman writes of her childhood sexual

abuse experience (incest by her father). Classical music will be played quietly in the background to create a relaxing environment.

4. Check-out: members will have ten minutes to reflect in their journals on what they heard about another woman's sexual abuse experience and how this relates to them.

SESSION SUMMARY:

Therapists imposed some limits on the amount of snack per person as members have quickly overindulged in snack the past few weeks. This lead to a discussion on the need for food and its connection to emotional needs and nurturance. Some members admitted to using food at times as a solution to feeling bad, e.g., feeling rejected. While therapists also suggested that members may also be using food as a means of dealing with their initial anxiety about group. This naturally led into an opportunity to briefly review various problem solving and coping techniques. Members supplied examples of coping methods they have used in the past. This discussion prompted a further understanding of how certain coping mechanisms are self-defeating and less effective than others. The need for and the importance of, a support system and friends was also highlighted. This session marked a significant development in group support, empathy and sharing.

One of the therapist's spilt the beverage while serving

snack. Interestingly this appeared to serve a purpose, i.e., it reassured the members that the therapists were not "perfect" people and this furthered a sense of acceptance between members and the therapists. This small gesture appeared to have gone a long way in immediately increasing the comfort level within group. Further to this, the therapist suggested that just as with the spilled Coke there was an solution to every problem in life and asked whether members agreed. This question served to organize the check-in process and led to some members acknowledging their disappointments and feelings of hopelessness regarding their current family problems and situations (e.g., foster care). Members made good use of the check-in by disclosing their feelings today. Clearly the group had now entered into its working phase. Ann-h and Pam-j shared angry feelings towards their mothers, spoke of feeling unfairly treated at home, and described current tensions and problems at home. Gail-i shared her history of serious acting out behaviour this past year and encouraged others to find better means of expressing their painful feelings and solving their problems. Gail-i presented as a good role model for others in group and had the makings of a potential group leader.

This week, members were captivated by the sexual abuse story read to them. This activity undoubtedly raised and sustained members attention and interest on the topic of sexual abuse. The tone of the group was appropriately serious

and reflective. Members also seemed very comforted and nurtured with the activity of the therapists reading to them (like young children being read to by their parents at bedtime). This story of incest, written from a survivor's perspective, prompted a further understanding of the dynamics and effects of intrafamilial sexual abuse. As well the story presented the girls with a vocabulary for the feelings often identified by girls who have been sexual abused. Overall, members acknowledged feeling comforted knowing they were not alone in that someone as well known as the author of a story had also shared their experience. More importantly they easily related to the many feelings associated with sexual victimization as expressed by the author. This activity marked a point of a transition in the group in that it solidified the group identity as sexual abuse survivors.

Closure proved difficult for all of the girls today as they expressed a desire to continue to listen to more of the story. Because the girls truly seemed to feel safe, connected and supported today it was difficult for them to part at the end of group. The compromise reached was that they worked on their journals for the last ten minutes while the therapist continued to read on in the story. Therapists validated members for their receptivity to this week's activity and commended them for their interest and desire to continue to work today. The therapist assured members of the continuation of group for another twelve weeks and suggested the

continuation of this theme next week through another media, the use of a film. All members seemed somewhat disappointed with group needing to end today and had difficulty leaving.

SESSION THEMES:

1. There was a major progression in group today. Members were feeling safer, more trusting and more self-disclosing. There was the beginning of mutual support and empathy.
2. Group members shared feelings and experiences related to family problems and foster care.
3. Another major development in group, was the increased level of comfort and the members desire to start to deal with the topic of sexual abuse.
4. Members experienced difficulty leaving group today because they were feeling supported and nurtured. Given the girls' histories of neglect and deprivation this was not surprising.

SESSION #4: THE IMPACT OF SEXUAL ABUSE ON THE VICTIM

OBJECTIVES:

1. To continue to destigmatize and validate the girls sexual abuse experiences and feelings and to break their sense of isolation by relating stories of other preadolescents who have been sexually

victimized.

2. To continue to educate members regarding feelings, reactions and dynamics related to sexual abuse.
3. To encourage members to explore their feelings related to the sexual abuse experience.
4. To clarify and underscore that the responsibility for the sexual abuse belongs to the offender alone, not to the victim (i.e., to cognitively challenge members who feel to blame for their own victimization.)

AGENDA:

1. Snack.
2. Check-in.
3. Activity: To view the film No More Secrets, 1982, National Film Board of Canada.
4. Post film discussion and debrief.
5 Plan Next Week's Christmas celebration.
6. Check-out and ten minutes to complete journals.

SESSION SUMMARY:

This week the snack ritual progressed to the point where members assisted therapists and began to serve one another snack. This was a sign of their growing ability to care for one another and perhaps a sign of their maturing social skills. Check-in remained fairly brief today. Members

pursued one of last week's check-in themes (i.e., feeling unfairly treated at home). Gail-i, the emerging group leader, shared her frustration with being a parentified child, and described some of her responsibilities for her younger siblings. She expressed frustration with her parentified role interfering with her ability to maintain her own age appropriate peer group and activities. Ann-h and Pam-j empathized with her situation. They also spoke of feeling burdened by their own responsibilities and chores around the home.

Members moved to express some curiosity about sex-roles. They asked whether the male therapist fit the stereotype of a traditional male (i.e., whether he engaged in house cleaning). The group appeared very surprised and yet pleased to learn that he, like they, did perform household chores. Therapists explored what male role models members had been exposed to in their families. They all described having been exposed to strict, traditional sex role stereotypes of men and women. Therapists effortlessly challenged the girls view on traditional male, female roles. The girls easily welcomed the view of more equality amongst the sexes. However members returned to venting their frustrations about feeling exploited within their own families. The sibling unit shared their experiences with living in a residential alcohol treatment facility with their mother for two years until she was rehabilitated. They instilled hope in other members by

describing how well their mother now nurtures them.

As therapists described this week agenda i.e., a continuation of last week's theme and began to introduce today's film, Gail-i asked whether either of the therapists had ever been sexually abused. This question seemed to infer "how would you know how we feel?" Therapists explained their employment and educational qualifications and informed the group that although neither had been sexually abused, the way in which group members had been, they had in some way been sexually victimized. The male therapists described how he had suffered sexually obscene phone calls. The female therapist disclosed that she had witnessed a man at the university library masturbating in public. Therapists also explained the high prevalence rates of sexual abuse in the general population and members appeared somewhat surprised. This discussion appeared to further break the groups sense of isolation and alienation regarding their own sexual victimization (i.e., it challenged their sense of being "different" or somehow set apart from others in the general population).

Therapists presented the film No More Secrets which depicts four preadolescent girls discussing their experiences of intrafamilial sexual abuse. The girls in the film candidly disclose their sexual abuse experiences, the feelings they had, the subsequent events in their lives and the process of treatment. Themes stressed in the film included: the

offender's responsibility for the abuse, the importance of disclosure, and methods of preventing revictimization. Overall group members were attentive to the film. However, Rhonda-g presented as especially uneasy and anxious. She closed her eyes choosing simply to listen to the film and later went for a bathroom break. This may be because she is the youngest (the only member the very same age as the girls portrayed in the film) and also the most shy member in group.

Following the film, therapists provided group members with an opportunity to discuss the film. The tone of the group had become solemn. In attempting to elicit feedback on the film, members explained how, in general, the film had served to revive memories surrounding their own abuse. Members initially appeared stifled and hesitant to share these thoughts and personal experiences in any detail with the group. Gradually members moved to share how they like the girls in the film had felt powerless about stopping their abuse. They also related feelings of guilt about not having disclosed their abuse sooner and spoke of how shameful and "dirty" the abuse made them feel. Despite this, members appeared easily comforted by the therapists speculations regarding what had made it difficult for the girls to have disclosed their abuse sooner. They unanimously verbally acknowledged knowing that they were not responsible for their sexual abuse. Some group members were quick to point out that unlike the film, their offenders have not taken any

responsibility for the sexual abuse.

Time had run out too quickly again this week in group, as members appeared to want to continue to talk. Members spent the last few minutes of group planning a Christmas party for next week. They voted to use next week simply to socialize and celebrate Christmas with each other. They decided to exchange cards and view a video of their choice. Interestingly, the video they choose was titled "Problem Child" which may represent a projection of their own continued sense of feeling like "damaged goods". The last five minutes of group were spent working on journals. Comments included: " the film brought back a lot of bad memories ...... but I felt good to know that these other girls in the film have been through sex abuse too".

SESSION THEMES:

1. There appeared to be another positive transition point within the group i.e., members launched into offering support, care and empathy for one another.
2. There was a decreased sense of "differentness" and isolation, communicated at three levels i.e., amongst members, amongst members and therapists (via discussion) and amongst members and the general population (via the film).
3. Curiosity regarding male and female sex role stereotypes surfaced.

SESSION #5: CHRISTMAS CELEBRATION

NOTE: The female co-therapist, this author, was absent from today's group due to illness. Therefore the written account of this group session will be brief and was provided by co-therapist, Ron Kane. One of the group members was absent today.

OBJECTIVES:

1. To provide an opportunity for the group to share in the celebration of the upcoming Christmas holiday, in an effort to reinforce the nurturing, pleasurable aspect of the group and to further the group's sense of cohesion.

AGENDA:

1. Snack (extra special goodies for this Christmas party).
2. Check-in.
3. Activity: Group's choice of video "Problem Child" to be viewed.
4. Check-out: Exchange of cards, discussion of the meaning of Christmas for each member and plans for the holidays.

SESSION SUMMARY:

The most significant issue which dominated the check-in discussion was Pam-j's physical assault by her mother. Pam-j appeared in group with significant bruising on the right side of her face and explained that her mother had hit her during an argument and had caused the injury. Some members supported Pam-j and revealed that their own mothers had physically assaulted them in the past. Pam-j minimized the incident and expressed anger at CFS for removing her from the home and placing her at her grandmother's home.

SESSION THEMES:

1. The importance of operating the group with a co-therapist was highlighted today. With the absence of one therapist the other ensured the group's continuity which is critical for the girls as their lives have historically been and continue to be somewhat chaotic and unpredictable.
2. To continue to validate the girls for breaking the cycle of secrecy within their family systems by facilitating disclosure of sexual abuse and or family violence.

SESSION #6: BREAKING FREE FROM THE ROLE OF VICTIM

OBJECTIVES:

1. To regroup (i.e., renew group cohesion) following the two week Christmas break.
2. To provide members experiencing recent life crises with an opportunity to debrief and address their crises in a planned way, so as to reduce the risk of this interfering with the therapeutic process.
3. To decrease the members sense of victimization, hopelessness and powerlessness especially related to recent personal crises.
4. To empower members to problem solve and to learn more effective means of coping.

AGENDA:

1. Snack.
2. Check-in with therapists explaining the absence of the sibling unit due to their tragic house fire and asking members to debrief their own Christmas holidays.
3. Activity: to create a collage or mural by cutting pictures from the magazines provided. The purpose of the collage is for members to create and project (via this art project) their personal goals for the New Year.

4. To further debrief any aspects or questions arising from group sessions prior to Christmas e.g., the film.

SESSION SUMMARY:

A combination of events: the two week Christmas break, individual members crises and having only three members in group today, seemed to have adversely affected the group process and group's ability to stay focused on the intended agenda. Regular bathroom breaks and verbal interruptions reflected the high degree of anxiety during this session. Nonetheless the resulting check-in proved relevant and members were most supportive to each other. An emerging group identity seemed evident with members expressing concerns about the absent members.

At the start of group, two of the girls (Pam-j and Gail-i) who live in the same geographic area travelled to group together. This served to build camaraderie and a strong alliance between them. Their dyadic alliance was quickly evident and interfered with the group process today as it served to exclude the only remaining member, Ann-h. This was problematic as Ann-h is socially immature and the member most needy of peer acceptance and peer relations. Therapists initially unsuccessfully attempted to include and engage the excluded, Ann-h.

Initially the two allied members presented as verbose and

anxious and had difficulty staying attentive or focused on any personal issues. They instead deferred to humouring the group at some length. They attempted to humour the group by sharing "dumb blonde jokes" which they explained as being popular amongst their peer group. Therapists challenged the group to recognize how these jokes are both exploitive and degrading of women. Pam-j expressed a great deal delirious laughter today and initially deferred from discussing her pre-Christmas family crises and its aftermath (her relocation to live with her grandmother). While Gail-i seemed to act to protect Pam-j from talking about her family crisis.

Eventually members moved to discuss their disgust with the city's recent domestic murder and the group discussion shifted to the topic of familial and societal violence. Gail-i revealed her sense of hopelessness with the comment "the world's falling apart". This discussion led Pam-j into further revealing the extent of violence within her family. Pam-j elaborated on the extent of chaos and physical violence exhibited by all three generations of her family over the holidays (i.e., her mother and grandmother fighting; her and her siblings fighting; her grandmother verbally assaulting her). Given this opportunity, she went on about her uneasiness with visiting her mother over Christmas. She minimized the pain she felt about her mother blaming her for the physical abuse and described how her mother denied her a Christmas gift as punishment. The excluded member, Ann-h who

had proved incredibly patient throughout the group, entered the discussion and connected with Pam-j regarding intrafamilial violence and ambivalent feelings toward abusive mothers. Ann-h described horrendous historical incidents of violence within her own family of origin. She empathized with Pam-j and presented problem solving suggestions (i.e., she encouraged Pam-j to consider foster care). The girls also then proceeded to romanticize the option of living with their (historically distant, neglectful, and alcoholic) biological fathers.

Members commented on how quickly group had passed today. They again expressed the need for longer group sessions or more group sessions then the designated fourteen weeks. This comment was an indication to therapists that although little of the proposed agenda had been accomplished today members benefitted from the themes that naturally surfaced (e.g., intrafamilial violence) and in general had felt supported by the group process. Therapists suggested that if members desired group could be extended for one extra week as the female group therapist had been absent last week and as the sibling unit missed group today. Members were quick to commit to this one week extension and expressed a desire for an even further extension of the group.

SESSION THEMES:

1. The group explored feelings of separation and loss

related to members recent crises (separations from family and living in foster care). This allowed members an opportunity to begin to master negative experiences and life crises.

2. Members eagerness and desire to extend each group session is a further indication of their neediness and deprivation and the group's ability to help meet some of these needs for nurturance and support.

SESSION #7: MID-TERM EVALUATION

OBJECTIVES:

1. As all members were present today, for the first time in three weeks, it was important for members to "catch-up" and reinstate group cohesion and identity. To decrease last week's high level of anxiety by creating a slightly lighter atmosphere.
2. As most members have limited support systems and have recently experienced personal crises, the group should provide empathy and support to members with regards to their crises.
3. To redirect the group back to the sexual abuse context in the latter half of the group. As this is mid-point of group, to elicit feedback from members regarding any new priorities for group

themes.

AGENDA:

1. Snack, pizza ordered in.
2. An extended check-in period to permit updates from each member and to provide an opportunity for members to debrief recent crises with each other (e.g., the sibling units house fire and another members recent move to an alternative caregiver).
3. Activity: conduct an informal mid-term group evaluation. Ask members for input as to their experience of group to date. Ask for members input on remaining themes or topics to cover over the next half of group.
4. Closure: return to use of journals.

SESSION SUMMARY:

As three members had recently experienced more loss and deprivation in their lives it was especially fitting that the therapists nurture the girls this week with a special snack, pizza. The sibling unit were welcomed back to group this week after having missed the last week following their house fire subsequent relocation. At the start of check-in each sibling recounted details of the fire and their heroic rescue. Some members indicated they had been concerned as they had followed the family's tragedy through the local paper. Members were

also genuinely sensitive and careful not to overwhelm the girls with any detailed questions about the fire as they had experienced feeling overwhelmed when having made their initial sexual abuse disclosure (e.g., to police or CFS). One member thoughtfully declared that overall the group was simply relieved that the entire family was safe. The two sisters appeared excited by the group's support and exclaimed they were happy to be back in group.

Pam-j expressed feeling both amazed and impressed at how well this family was coping with their crisis. She complimented them on the caring nature of their family "your mom really knows how to make a house a home" in referring to their new residence. Pam-j expressed how, on the contrary, her own mother was now so totally rejecting of her removal from the home by CFS. She spoke of having "no hope" of things working out in her family. Pam-j appeared to be reality testing her family's world view and asked if either sibling had received "a spanking" from their mother for the fire as their mother had not been home at the time. The sisters quickly responded "no" and appeared surprised by the question. This naturally led into a discussion on parenting. Therapists asked members for their views on physical discipline and what they considered constituted the physical abuse of children. Members were asked to share how they had been parented. This provided a natural opportunity for members to disclose their histories of physical abuse and the feelings that surrounding

this abuse. Most all members openly recalled being painfully physically abused by their mothers, mother's common-law or both. Gail-i also disclosed how physically violent her offender, her mother's boyfriend, had been to her.

Members unanimously agreed that the physical discipline of children benefits neither child nor parent and came to the revelation that what their parents had justified as parental discipline was often violence and physical abuse. The girls proved fruitful in problem solving other disciplinary actions such as grounding and other consequences. This group discussion also raised the issue of parental responsibility. Therapists advised the girls that parents, as adults own the responsibility to control their own anger (as do adolescent group members) and reinforced that child physical abuse is a parental problem and not the child's responsibility, just as sexual abuse is never the child's responsibility.

After check-in was completed by each of the five members, therapists initiated an informal mid-term evaluation. Gail-i once again assumed a leadership role and approached the board to record the group's recommendations. Members clearly enjoyed and appreciated being asked for their opinions. Members stressed the need for check-in to be more structured and time limited so as to accommodate the intended agenda and theme. Members unanimously agreed that it would be beneficial for them to share their personal disclosures at some point in the group with each other. As well, they requested more

readings about sexual abuse as an activity. Members also asked that time be structured to allow for them to work on their journals regularly at the close of group. The journals seem to serve to relax, relieve tension and unwind members at the close of group. The journal also seems to provide members with a non-verbal means of releasing their feelings. For example one member consistently draws in her journal as she is an artist and this proves to be a more natural means for her of expressing her affect. Members had difficulty specifying themes or topics to address in group and agreed to entrust this duty to the therapists.

At the close of group today members spontaneously acknowledged feeling they had "fooled around" too much in group and had been too silly the last few groups. The girls themselves adamantly expressed the need "to do more serious work in group ..... to get down to business with less fooling around". Members vowed to encourage each other to work harder each week in group to cover the intended agenda and theme. Therapists assured members that as per their request (today), following group sessions would be more structured. Group ended with members working on their journals for ten minutes.

SESSION THEMES:

1. Group members clearly expressed a need for more structure and progressed to the point of initiating

and requesting more sexual abuse orientated content themselves.

2. Clearly with full attendance (five members) back in group today, group cohesion and identity were reinstated. Members utilized the group process and proved to be appropriately supportive of each other.
3. Group members discussed a variety of experiences and feelings surrounding familial violence and physical abuse by parents.

SESSION #8: SEXUAL ABUSE - FACTS AND MISCONCEPTIONS

OBJECTIVES:

1. To provide educational information regarding the definition of sexual abuse and other forms of sexual victimization with a focus on dynamics of power, coercion, manipulation and secrecy.
2. To further educate members by distinguishing myths from facts regarding sexual violence towards women in society (i.e., incest, rape, sexual assault and sexual abuse).
3. To continue to increase the members comfort level in an effort to continue to encourage members to share examples from their own sexual abuse experiences.

AGENDA:

1. Snack.
2. Check-in.
3. Guide members to compose a definition of sexual abuse by requesting group participation in identifying a range of examples.
4. Activity: Discussion sheet handed with questions regarding sexual violence towards women.
5. Closure: Journals.

SESSION SUMMARY:

Three of five members came early to group and keenly offered to prepare today's snack. This was a growing indication of their eagerness to attend group and their desire to display their own competence. In helping prepare snack the girls also received an opportunity to feel special. However due to the girl's own apparent neediness for food most of the snack they had prepared they had also quickly consumed before group even began. Check-in remained brief today and focused on members' age appropriate worry about their appearance e.g., braces and cold sores. Members helped raise each other's self-esteem by complimenting each other. They also challenged each other's self-criticism.

Gail-i who is pseudomature and familiar with the role of being a caretaker has surfaced as the group leader. This

appears to be sanctioned by the group as a whole. She naturally assumed her role as leader today and proceeded to record on the board all the definitions of sexual abuse provided and she encouraged her fellow members to participate in providing various examples. The initial definition of sexual abuse composed by the group stressed the immaturity and inability or lack of mutual consent on the part of the victim. The girls, with some prompting from the therapists, easily expanded their definition to include the concept of the abuse of power i.e., the abuser is in a position of power which he misuses over the victim as in the case of a family member, teacher, priest or minister and so forth. Members offered examples from their personal experiences which ranged from someone exposing their genitals, touching your private parts or making you feel, touch or rub their (offenders') private parts, someone coming into your bed naked, to someone having sex or oral sex with you (even if they are your boyfriend). Surprisingly, given the opportunity, members openly disclosed knowing individuals involved in a variety of deviant sexual behaviours (i.e., everything from bestiality to acts of public masturbation). Sexual harassment and obscene sexual phone calls were also examined as forms of sexual victimization.

Therapists were impressed by members' attentiveness, interest and by their all-encompassing range of examples. Members exhibited increased maturity, expressing little anxiety or giddiness this week with the subject matter. This

was an indication of their growing comfort with the sexual abuse content of the group. The group has clearly made a transition into the working phase of the sexual abuse content. A further indication of this transition was that members identified the following feelings as resulting from their sexual victimization: shame, embarrassment, hurt, and disgust. These feelings verify the internalized negative self opinion (i.e., "damaged goods syndrome") of victims, commonly cited amongst in the literature (Finkelhor, 1986). Therapists also reiterated the pervasive nature of sexual abuse both intergenerationally within families and within society as a whole. Therapists attempted to further reduce the members stigma, alienation, and isolation by educating members that sexual abuse pervades across all ethno-cultural and socioeconomic backgrounds.

As an activity, members were given a discussion sheet handout. Each member answered all seven questions independently, indicating true or false and then the group discussed each question. Each question stimulated a great deal of spontaneous discussion coupled with some controversy therefore only seven of the twenty-one questions were prioritized and completed today. Members illustrated an interest in this activity however therapists discovered that some questions proved to be too abstract and too difficult for certain members. Members are clearly at different levels of cognitive development (from concrete to more abstract) and

certain members have difficulty reading. Regardless, members have been encouraging and supportive of each other. Members assertively challenged the therapists answers to some questions and convinced therapists to amend some of their answers. This proved to increase the group's sense of ownership and control over the group. As well, the exercise exposed members to the proper terms for sexual acts thereby providing a common language for all group members.

During this activity, one member revealed that her uncle had married his half sister thereby creating an incestuous union. This naturally provided therapists with the opportunity to describe the historical rationale and purpose for the incest taboo. In discussing other questions, members demonstrated a sensitivity to inferring any "mother blaming" with regards to their own sexual abuse. The girls were unanimously adamant that this was most unjust. However, it was also obvious that some girls remained confused with regards to holding the offender completely responsible for the sexual abuse and they seemed to accept excuses e.g., if father and mother had a normal sex life father would not commit incest. It was important to have re-raised the issue of accountability so as to provide yet another opportunity to cognitively challenge misconceptions and to reinforce the offenders responsibility for the abuse.

By way of closure, therapists structured the journal writing exercise and asked members to answer one question

i.e., "what I learned most about sexual abuse today is?" Answers reflected that members had integrated the fact that regardless of the offenders creative excuses or rationalizations he (offender) not she (victim), is at fault and is responsible for the sexual abuse.

SESSION THEMES:

1. Members displayed increased comfort with discussing sexual abuse particularly within the context of their own experiences. This reflected a major progression into the working phase of the group.
2. Members pervasive "damaged goods" feelings again resurfaced. This self image seems well entrenched (like a deep battle scar of the sexual abuse experience), and appears connected to the girl's lingering sense of responsibility or blame for the sexual abuse. This negative self-image requires ongoing repeated challenging and cognitive restructuring.

SESSION #9: CONTINUATION OF #8

OBJECTIVES:

1. To continue to educate members with factual information regarding sexual abuse in order to dissipate their myths and misconceptions.

2. To continue to assist members to disclose and examine their own sexual victimization within a context of mastery. To encourage mutual support and trust amongst members in this endeavour.
3. To reinforce the knowledge base members have already acquired over the past weeks in an effort to work towards mastery and prevention from future revictimization.

AGENDA:

1. Snack.
2. Check-in.
3. Activity: a) to complete the remaining discussion question from the previous session and b) to play a ball game created by the therapists with question and facts cards regarding sexual abuse.
4. Work on journals.
5. Check-out and closure.

SESSION SUMMARY:

There was increasingly more mutual trust and empathy amongst members as reflected by the overall degree of sharing and caring. The extreme neediness of members, as previously expressed through their quick and excessive consumption of snack, appears to have subsided as snack now lasts throughout most of the session. However, two members whose personal

situations are near crisis proportions, with alternate placement pending, slightly interrupted the group process with their behaviour at the start of group. Pam-j quietly withdrew for most of the group. While Ann-h provoked therapists with her obnoxious attention seeking behaviours e.g., shutting the lights out and banging the windows. Therapists quickly placed limits on this behaviour. Today the longstanding alliance between the group leader, Gail-i and Pam-j appeared severed. These members appear to have individuated from one another acting more independently and coming to group separately. This action proved advantageous to the group process.

Despite her anxiety, Ann-h disclosed some of the details surrounding her own sexual abuse during the activity (completion of the discussion questions). She explained how she had attempted to protect her brother from also being abused. Members responded with empathy and support but challenged her to consider that perhaps despite her efforts to protect her brother, he may also have been abused. Nevertheless, as a child, members stressed it was not her responsibility but her mother's to protect her and her siblings. The group leader was also moved to disclose some of the details surrounding her own abuse by her mother's ex-boyfriend. She also took some initiative in sustaining members in discussing their own abuse experiences. Again there was interest and full participation for each discussion

question and a consensus was reached regarding all the answers. Gail-i also expressed feeling confused and ambivalent regarding the incestuous relationship her uncle has with his half sister because her own family have never perceived this relationship as abnormal or aberrant. This led to a brief discussion on secrecy and family loyalties, and the intergenerational transmission of sexual abuse.

The second planned agenda activity was dispensed with as members expressed an intense interest and curiosity in learning more about human sexuality this week. They asked a number of age appropriate questions. This provided a natural lead in for therapists to inform the group that they had arranged for a speaker to come and address the group on this very topic two weeks from today. Therapists normalized members sexual curiosity and attempted to answer some of their questions today. The sibling unit brought with them to group today a book that their mother (an incest survivor herself who felt she could not talk with them about their sexuality) had bought them a book about asking about sex and growing up. Members implored therapists to allow them to read chapters from this book as a means of satisfying some of their curiosity today. Therapist perused the book and agreed as it appeared to be age-appropriate. Members competed for who would read from the book as each wanted to occupy this special status. The chapters read from (as prioritized by members themselves) covered the topics of masturbation and sexual

intercourse. There was some discussion following the readings with the focus on normalizing human sexuality. The group showed a good level of maturity (perhaps pseudo-maturity) and comfort. They expressed little embarrassment or discomfort in discussing human sexuality and various forms of healthy touching. Members turned to the therapists for guidance regarding sexual development and appropriate sexual behaviour e.g., "Is it okay or is it sick to masturbate?" The focus of today's discussion, unlike the previous weeks, was not on deviant sexual behaviour but instead on normal sexuality.

SESSION THEMES:

1. The member's level of comfort with the sexual abuse content and their mutual trust is such that they are prepared to share their own disclosures.
2. Members desperately expressed the desire and need for sexual education. They also appeared to be seeking validation and normalization of their age appropriate sexual curiosity.

PHASE IV - RELEASE AND MASTERY

SESSION #10: PREPARATION FOR DISCLOSURE

OBJECTIVES:

1. Facilitate and support members verbal and written expression of their sexual abuse experiences; validating feelings thereby reducing stigmatization, alienation and isolation.
2. Discuss the offender, and related feeling (e.g., anger, rage and confusion or ambivalence), typical in the cases of intrafamilial sexual abuse. Reiterate the need for personal safety and a safety plan.
3. Validate the girls for being "survivors" and reinforce their mastery over the sexual victimization and their ability to cope.

AGENDA:

1. Snack.
2. Extended Check-in.
3. Activity: a) ball game (question and fact statement cards regarding sexual abuse) carried over from last week, b) sentence completion (Refer

to Appendix D) handed for individual members to complete describing their history of sexual victimization and their related feelings.

4. Closure: no time for journals today.

SESSION SUMMARY:

Check-in carried on for an extended period of time today as members shared various recent personal experiences which were relevant issues and themes (e.g., personal boundaries, safety and violence within society, and racial discrimination). To begin, two members shared the story of their travel to group today and raised some safety concerns regarding "strange" people approaching them. Others joined in and shared similar stories. Members helped devise methods for the girls to assure their safety in these situations (e.g., travelling in pairs, approaching the bus driver for assistance.)

A new form of commonality was discovered today in group which served to only further secure the group's identity. As one member shared the hurt and pain she recently experienced from discriminatory racial comments directed at her Native Canadian heritage, it was discovered (for the first time) that actually all five group members shared some degree of Native Canadian heritage. This heterogeneity served to only further bond members as "survivors" of various sorts of hurts and suffering and further served to build empathy and support

amongst members. As well, therapists used this discovery of group homogeneity regarding Native Canadian heritage as an opportunity to further promote self-esteem and pride.

One member re-raised the increasing amount of violence in our society, and described a recent shooting in a local city bar. This theme of violence led a discussion on member's feelings towards their offenders. As one member shared her fantasy of how she desired that her offender die a violent death at her hands. Therapists normalized member's intense anger, rage and violent fantasies of punishing the offender, as feelings experienced by many victims. However, therapists also acknowledged that intrafamilial abuse, victims may feel conflicted or ambivalent feelings towards their offender as he is a family member. Members were also asked whether they were currently having any contact with their sexual offenders. Given the intrafamilial nature of the sexual abuse, this was not completely unlikely. Three members identified having recently seen their offenders. One of the sibling unit admitted having mixed feelings toward her offender, her grandfather as she continues to love him and wants to visit with him. Other members accepted her feelings and her having forgiven her offender despite his denial of the offense, but they challenged her to be "on guard" so as to assure her continued safety from any revictimization. The sibling unit

also talked about a violent aunt who was threatening to break into their home. They expressed their ongoing fears regarding these threats. Members also went on to share stories about the dangers of abuse occurring even within foster homes. All these fears regarding personal safety from sexual offenders and from other forms of violence, prompted therapists to led a discussion on methods for ensuring safety e.g., safety planning.

After this extended check-in period, members continued the activity with a good level of participation and genuine enthusiasm in the questions and facts game. Some of the questions and facts provided included: Name three feelings a sexual abuse victim experiences? What is the most important thing an offender needs to know about how the victim feels? What should happen to the offender when he is caught? What might victims do when they are feeling bad? What would you do if your friend tells you she has been sexually abused by a relative? Fact: No matter how hard you tried to stop the abuse or no matter what you think, it is up to the offender not to behave this way (i.e., sexually offend). Members became very anxious (probably in anticipation of the disclosure release exercise to follow) with the question "Ask anybody in group a question about their sexual abuse?"

Due to the extended but productive check-in process, little time remained therefore therapists concluded with members privately completing their sentence completion

exercise (i.e., their disclosures of sexual abuse). All members completed the exercise and left group on a quiet note with the understanding that they would be asked to share their disclosures in two weeks.

SESSION THEMES:

1. Group members shared feelings and experiences related to racial prejudice, violence in society, and violence with their families.
2. Feelings expressed towards their offenders displayed a range from rage filled aggressive fantasies to hurt and ambivalence.
3. Members experienced the initial stages of mastery over their victimization.

SESSION #11: BODY AND HUMAN SEXUALITY

OBJECTIVES:

1. To provide educational information on human sexuality with an emphasis on: puberty and the onset of secondary sex characteristics for girls and boys, pregnancy and the female anatomy, contraception, A.I.D.s, and various sexually transmitted diseases.
2. To foster a more positive female body self-image, further diminishing any sense of shame.

3. To validate members for their sentence completion exercises completed during the previous week, stressing that although this is not good timing the disclosure exercises will be processed next week (as speaker could only attend today).

AGENDA:

1. Snack.
2. Brief check-in with some time spent preparing questions for the guest speaker.
3. Introduction of guest speaker, her presentation and discussion.
4. Debriefing.
5. Special thanks to speaker and check-out.

SESSION SUMMARY:

Again a few members came early to group but due to the unavailability of therapists' supervision, a conflict arose amongst two members (who have both experienced stressful changes in their living arrangements) which then carried on in group. During check-in, therapists normalized conflict amongst peers and some members showed initiative to resolve the conflict and one girl offered an apology. The group was supportive and offered the member who seemed most hurt/offended by the conflict (the one who portrayed the role of the victim) the special status and honour of thanking the

guest speaker today. Therapists successfully intervened to also help diffuse and mediate the conflict.

Members choose not to prepare a list of questions for the guest speaker but instead felt comfortable offering questions spontaneously throughout the course of the presentation and discussion. The girls displayed an age appropriate degree of embarrassment and giddiness (impressively, no pseudomaturity) with the introduction of the speaker and the topic of sexual education. However, the speaker proved especially skilful at creating a comfortable atmosphere and also at sustaining the girls interest throughout the session. The speaker directed ownership over the focus of the presentation to the girls, not the therapist, giving the girls control over the topics discussed during her presentation. She emphasized that her agenda was to meet the girls agenda i.e., answer all their questions and was able to successfully promote much discussion. Topics covered included: menstruation, secondary sex characteristics in both sexes, female reproductive system (health care), myths regarding sexuality, contraception, sexually transmitted diseases and AIDS. The speaker presented the information in a sensitive yet straightforward manner with an emphasis on reinforcing a positive body image amongst the girls. In return the girls themselves were forthright with most of their own questions and curiosities. All except one group member surprisingly demonstrated accurate age appropriate sexual knowledge as evidenced by their questions

and discussion while the remaining member revealed many sexual misconceptions she was taught within her family of origin.

SESSION THEMES:

1. Members expanded their sexual knowledge base (especially regarding the female body and health care) in an atmosphere of building a positive body image. Most members surprisingly displayed an age appropriate level of sexual knowledge with minor distortions or misconceptions.

SESSION #12: MY STORY OF SEXUAL ABUSE

OBJECTIVES:

1. To facilitate and support members to share with each other the verbal expression of their sexual abuse experiences. To process their sexual abuse stories/experiences reinforcing a sense of surviving and mastery.
2. To facilitate the expression of feelings related to their sexual abuse experiences and related to the role of their family (especially mother) in relation to these experiences.
3. To assist members to understand some of their past behaviours (e.g., acting out behaviour) in reaction to or in the context of their sexual victimization.

4. To again clarify roles and responsibilities related to the protection of children in their families.

AGENDA:

1. Snack.
2. Check-in: a) therapists to follow-up on answering any remaining questions from last week's presentation (can be submitted privately in the journals); b) therapists to raise the issue of group closure in an effort to begin to prepare for this phase.
3. Exchange and process each member's sexual abuse story.
4. Check-out and closure most important today given this intimate exchange of information (disclosures) today.

SESSION SUMMARY:

Check-in remained brief and focused on the forthcoming closure of group. Members displayed a great deal of anxiety about group ending in four weeks. The group's difficulty with the upcoming conclusion of group was likely compounded by their own recent experiences of loss e.g., house fire, change in caregivers. Members collectively verbalized their disappointment and anger about the ending of group stating that group had been too short. Some of the girls openly

acknowledged the significant role the group has played as welcomed support in their lives and their fears of this support coming to an end. Therapist used this talk of termination as an opening to validate members for their interest and participation to date. The group members creatively strategized possible means to assure the group's continuation.

The majority of the group today focused on members sharing their sexual abuse disclosures visa-vis the sentence completion exercise. Group expressed concern about the absent member missing this crucial group session. This was again a sign of the group's cohesion and identity and also a sign of their growing concern for one another. Overall members proved most "ready", that is, comfortable and confident to complete the activity. The group consensus was to read each others stories out loud and allow for a question period to follow each disclosure.

In general all members, with the exception of one (who seemed very concealed as to the extent of her abuse) were minimally defensiveness as they revealed and released their stories of abuse. The tone of the group was appropriately serious and the girls responses appeared authentic and sincere. Members also displayed appropriate empathy and sensitivity when questioning one another but yet also felt comfortable enough to supportively challenged one another. For example, when the two sisters described their ambivalent

feelings (of hurt and yet love) for their offender, their grandfather, fellow members adamantly stressed the girls need to continue to be vigilant about their safety and cautioned them about revictimization by grandfather.

Overall, group members defended their mothers' role in the abuse and were adamant that their mothers were unaware of the abuse until the time of disclosure. Members were protective with regards to their mothers' role. They denied that their mothers played any role in the abuse and were reluctant to be critical of their mothers' post disclosure support or protection. They were averse to acknowledge any reasons why they may have been unwilling to approach their mothers (at all in some cases) any sooner with their abuse disclosures. This reluctance on the part of the girls to be at all judgemental or faultfinding of their mothers is not surprising given the extreme extent of family loyalty operating within these families.

In general, members impressed therapists with their ability to integrate the facts and knowledge they acquired over the past weeks in group with their personal experiences of sexual abuse. As a means of closure today members proposed the use of a check-out question to focus on how members had experienced the release of their stories. The question was "how do you feel now that you've shared your story of sexual abuse?". Responses were all positive, i.e., "good, relieved, better, and it improved my self-esteem. Their complete

release and disclosure of their sexual abuse experiences amongst all their fellow group members today appeared to contribute significantly to their sense of mastery.

SESSION THEMES:

1. Members expressed difficulty with the pending closure of group and acknowledged the importance of group as a significant support in their lives.
2. Unanimously members appeared well prepared to release their disclosures. The release of their disclosures reinforced their ability to cope as a "survivor".

PHASE V: COPING AND FURTHER MASTERY

SESSION #13: SEXUALITY, DATING AND COPING SKILLS

OBJECTIVES:

1. To "debrief" last week's disclosure session.
2. To facilitate a discussion around morals, values, and dating practices which enhance self-esteem.
3. To begin to address coping skills while distinguishing adaptive from maladaptive skills.
4. To further prepare group for termination.

AGENDA:

1. Snack.
2. Check-in: to discuss concerns regarding one member's absence now for two consecutive weeks and to "debrief" disclosures.
3. Guided discussion regarding coping skills asking members to participate in providing examples.
4. Activity: exercise on dating and sexual behaviour with use of a story.
5. Closure: journals.

SESSION SUMMARY:

From the onset, group members were distressed observing Pam-j's flash a pre-group appearance in the waiting room where she announced she was on "the run" from her family. Members unanimously expressed worry for Pam-j's current safety while on "the run" and suggested possible means of continuing to support Pam-j outside of the group. Therapists used this concern as a natural opening to discuss methods of coping with problems. Members disclosed stories of their own attempts at running away from their problems and or their family. They also provided other examples of coping methods they had employed, those which proved "harder" and those that proved "easier" e.g., physical aggression versus reaching out for support from friends, family, counsellors. Members, with guidance from the therapists, brainstormed more adaptive

methods of coping, with an emphasis on the importance of maintaining a trusted support system.

Today's exercise on dating and sexual behaviour proved very timely as a member shared a recent incident in which her friend was violated by a group of boys at school. Some discussion ensued as to whether this girl had indeed provoked or precipitated the boys behaviour and was therefore somehow responsible. This discussion re-raised the issue of responsibility for sexual victimization. It repeatedly appears that members have a well engrained cognitive misperception of blaming the victim and of perceiving women as being responsible for a man's behaviour. In an effort to continue to confront this misconception therapists shared with members a brief vignette, about an adolescent girl who feels continually coerced by her boyfriend to have sex and reflects and the girls were asked to reflect on how they would handle this situation. The story precipitated thoughtful ideas from the girls regarding their own unreadiness for sexual relations. The girls also demonstrated an informed understanding about the responsibility and consequences of sexual behaviour. As well members generated qualities indicative of an abusive relationship (controlling, possessive) versus a more positive relationship (respect, honesty, responsibility, compassion, trust). Group ended on a positive note with members integrating of moral and values within the context of sexual behaviour.

SESSION THEMES:

1. Member shared experiences and feelings related to various coping methods they have used e.g., running away and strategized more adaptive alternatives.
2. Members were encouraged to both recognize and practice their ability to set boundaries and limits with respect to dating and sexual behaviour.
3. Members pervasive tendency to blame the victims resurfaced briefly during today's exercise regarding dating and sexual behaviour.

PHASE VI - PREPARING FOR CLOSURE

SESSION #14: SAFETY AND SUPPORT SYSTEMS

OBJECTIVES:

1. To further prepare for and process group closure.
2. To problem solve potential methods of coping in "high risk" situations where there is the potential for any combination of physical, sexual and psychological abuse. To provide personal safety information.
3. To highlight the importance of social support networks and to assist members in identifying their own support systems.

AGENDA:

1. Snack.
2. Check-in: update the previously absent member as to the group's progress and to ensure members are aware that this is the last "working" group session.
3. Safety planning.
4. Activity: engage members in completing a support network list.
5. Planning of next week's closing party and celebration.
6. Closure: discuss termination.

SESSION SUMMARY:

At the start of group Ann-h approached the therapists with a letter she had drafted (with the help of her case manager) to the director of the CRC requesting that the group continue beyond next week. Therapists congratulated the member on her creative problem solving skills and her assertiveness. Therapists directed her to attempt to elicit the support of her fellow members by having them sign the letter which would act as a petition. Members unanimously supported the letter and jumped to offer their signatures in an effort to sustain and preserve the continuation of their group. With the therapists guidance the group requested that the therapists deliver the letter to the director of the CRC for his verdict. Members were aware that the current therapists would not be the group therapists should the

extension of group be granted.

Members were also excited and relieved with the safe return of the Pam-j, the absent member who had been "on the run". She was easily reintegrated into group this week, another indication of the members mutual support. One member's comment "we're reunited at last", again signified the solid group identity and cohesion that had been established within the group. Given the significance of the disclosure exercise (as expressed by members) this previously absent member was invited to share her story of sexual abuse (which she had already written weeks ago) with the group. As this proceeded members again displayed the same interest and enthusiasm, asking questions as they had when they originally completed their stories two weeks ago. This contributed all the more to Pam-j, feeling accepted and supported by the group following her recent running behaviour. However, therapists were concerned with timing and the fact that Pam-j was not adequately prepared for group closure.

During the safety planning exercise, the group's anxiety resurfaced and therapists identified this as partially due to members anxiety regarding the closure of group next week. For the most part, members jointly participated in creating a generic safety plan or options for safety. Then the group proceeded with the social support network inventory. Members quickly and easily seemed to identify their current social support networks, however, therapists were concerned that some

members identified very few supports and another member identified only persons who recently entered her life (i.e., group therapists and new foster family). Given this, therapists assisted members in devising methods for expanding their social support systems.

Members displayed leadership and increased maturity in indicating the need for closure and "good byes". However despite this declaration members presented as very anxious and had difficulty verbalizing their feelings regarding closure. They also had difficult remaining focused on planning next week's farewell party. Members remained adamant that they did not want group to terminate and were hopeful there would be approval to continue with the group. Regardless, therapists encouraged the need to bring closure to this specific group experience.

SESSION THEMES:

1. Reviewed safety plans briefly and the importance of a social support network.
2. Members avoidance regarding the need to process the closure of this group and their related feelings. They appear to have placed all their energies into the hope and optimism that group will continue.

SESSION #15: FAREWELL CELEBRATION

OBJECTIVES:

1. To provide an elaborate celebration party as a ritual marking the closure of group treatment and as a means of rewarding members.
2. To facilitate a review of group content, achievements and gains. To validate each members contribution and accomplishments.
3. Closing comments, distribution of good-bye packages and good-byes.

AGENDA:

1. To complete all post-test measures (members were asked to arrive early to accomplish this task).
2. Snack, cake and ice cream, music (tapes provided by members) played in the background.
3. Introduction of CRC director, Professor Walter Driedger to respond to the girls petition requesting the continuation of group.
4. Party game: Pictionary.
5. Closure processed (also validating members for their accomplishment and reviewing the group content).
6. Distribution of individual envelopes containing: CRC business card with appointment for a follow-up reunion meeting in six months, outline for a safety plan,

personalized good-bye progress cards from each therapist, a graduation certificate.

7. Members exchanged good-bye cards and some brought gifts. The girls jointly (under the direction of the group leader) contributed to purchase a thank-you cake for the therapists and the group.
8. Good-byes, hugs, and well wishes exchanged.

SESSION SUMMARY:

Members had a difficult time attending to the completion of post-test measures as they were anxious to begin their party. In retrospect, measures should not be completed during the final group. The celebration started immediately with much excitement. There proved to be much competition for the special status of cake cutter of the cake presented by the member to the therapists as a farewell, thank-you gift. Not surprisingly, the group leader who had purchased the cake with the help of her mother, assumed the role of official cake cutter. The girls engaged in an excessive indulgence in the two cakes and snack which again appeared to reflect their anxiety surrounding the closure of group today. The celebration was temporarily interrupted and the group moved to a more serious tone as the CRC director entered to personally respond to the group's request. The director also commended the group on the ingenuity of their letter. He clarified the possibilities for a continuation of group, e.g., a guided

self-help group facilitated by another CRC therapist but he could not offer a firm commitment to the girls at this point.

Members engaged in a fun game of Pictionary, reminisced and related how symbolic it was that this was the same game they had played at the start of group as a means of getting acquainted. Therapists ended the game to assure adequate time for exchange good-byes messages, envelopes, and cards. Members spent a great deal of time focusing on the group's reunion (meeting) six months from now as a means of deterring from discussing today's closure. The group seemed to have less difficulty bidding the therapists a good-bye and closing out with them but avoided saying good-bye to each other. Perhaps this occurred as members remained eternally optimistic that the group would continue and therefore they did not need to say good-bye. As members departed the female therapist offered the girls good-bye hugs which the girls easily accepted while the male therapist offered a warm hand shake.

EARLY ADOLESCENT VICTIMS' GROUP

OVERALL GROUP SYNOPSIS:

The primary focus of the early adolescent group was to provide support and education to girls who had experienced intrafamilial child sexual abuse. The support focused on promoting the girls release from, and mastery over, the sexual

abuse experience and the associated feelings. The sessions had an educational focus intended to amend distorted learning. Educational themes or topics included: the impact and dynamics of sexual abuse, human sexuality and body education, dating and sexual behaviour, personal safety, coping skills, social support networks and general preventative measures. The two most pervasive cognitive distortions, which proved reoccurring and difficult to challenge were: a tendency towards "blaming the victim" (not holding the offender responsible) and the girls sense of feeling like "damaged goods".

The group provided a safe and structured environment which was primarily used by members for support, validation, socialization and problem solving. Although the main purpose of the group was for the girls to deal with their sexual victimization, other important life crises were also dealt with, which included themes of: family violence, personal safety concerns, separation and loss, and self-defeating coping mechanisms.

Members craved structure within group and they themselves highlighted the need for this when the therapists relaxed this for two consecutive weeks. An essential part of the group's structure proved to be the snack ritual, at the start of each session and the journal exercise at the end of each session. The snack ritual provided essential nurturing, while at times its excessive consumption appeared to reflect the girls'

efforts to feed their emotional deprivation and neediness. Emotional deprivation and neediness proved common amongst all group members.

The initial stage of gathering and start of group cohesion was extended into week two, due to the acceptance of a new member. Yet by week three and four the group was forming an initial group identity. At this point members were already beginning to break with their sense of alienation and isolation and began to experience the support of the group. In week four there was also the beginning emergence of a group leader. The Christmas group party in week five, provided members with another key opportunity for socialization. The socialization opportunity provided by the group appeared to be an important aspect of the group for many of the girls as most girls had few peers outside of group. The group provided a natural opportunity for the girls to improve their social skills.

Then with the two-week post Christmas break and the subsequent absence of two group members group's development was somewhat impeded. Group process was very limited with but three members and two therapists. By the seventh week, (mid-point in group) full membership resumed. However as almost all members were in crises at this time, two group sessions were monopolized by these issues while other group themes and structure were relaxed. During this time, therapists prioritized directing the group process so as to primarily

support members in dealing with their individual crises/events.

Then in week eight, after dealing with their personal crises, members expressed a desire to launch the group into the working phase, specifically with regards to the sexual abuse context. Members began to disclose more freely and began to integrate their own experiences of sexual abuse with the education information provided. At this time, members presented as very motivated and committed to the sexual abuse content. The girls displayed a real sense of ownership in the group, pursuing all activities with vigour. Members continued with intensive education on sexual abuse related topics until the release phase of group in week ten. Members appeared most prepared for the release phase by week ten and anxiously awaited the opportunity to disclose their personal stories of sexual abuse to each other.

During the closure phase of group, the girls refused to process the closing of group at any length. Instead they choose to invest their energies into creatively and assertively problem solving how they could get the group to continue, as they unanimously agreed that they wanted the group to continue. This action seemed indicative of both the significance of the group experience for them and their improved problem solving, their assertiveness and their increased sense of confidence. Moreover, this gesture (i.e., composing and submitting a petition for the group's

continuance to the CRC director) signified their mastery over the victim role.

All of the girls in group had achieved certain gains in group despite some of the frustrating realities which proved to be crises in their lives (e.g., two girls had their house burn down; two girls changed caregivers during the course of group; one of these girls had also been physically assaulted by her mother). Given the multi-problem, dysfunctional nature of the family systems these girls came from and given the resistance, on the part of all but one family, (to commit to family intervention), group proved to be an essential and beneficial treatment alternative/modality for these adolescent girls.

EARLY ADOLESCENT GROUP - CLINICAL EVALUATION

The following section of this chapter will focus on a clinical evaluation of the adolescent group (i.e., an analysis of the clinical outcome measures chosen for the adolescent group). Refer to Appendix E for a list of the pre and post test scores for all the clinical outcome measures administered to the adolescent group members.

GROUP FEEDBACK FORM

As indicated in the group feedback form, (Refer to

Appendix F) all members unanimously found group to be helpful. They indicated that it provided them with the opportunity to talk about their problems, express their feelings, deal with the pain of their abuse, and helped build their self-esteem and confidence. The most important thing members felt they had learned, varied from: to talk about my problems, how to solve problems, no one can touch me unless I say they can, to the abuse was not my fault. It was important that all members had felt safe talking about their feelings in group as this had been an important objective of the group therapists.

In protecting themselves from future abuse, most members believed they would be able to much better able to protect themselves now. This was also an important finding given prevention from revictimization was an critical group objective. Three of five members felt it was easy or very easy to talk to the group therapists while the two remaining members indicated it was only somewhat easy to talk with the therapists. It was not surprising that most members did not find it very easy to talk to the therapists, given that the girls family systems were predominantly closed and distrustful of any outside helpers. All except one group member felt there should have been more group sessions. Overall, members general comments about the group indicated they had enjoyed the group, wanted it to continue and believed the therapists had done a good job.

THE BRIEF FORM OF THE FAM III (BF-FAM)

Refer to Appendix E.

With regards to the clinical outcome measure of family functioning, as measured by the BF-FAM scores, two members' scores remained relatively unchanged. One member, Pam-j noted a high degree of family problems and dysfunction both pre and post treatment. This was probably due to the fact that the treatment team was unable to engage the family in any therapy throughout the duration of the girl's group treatment program despite the family's numerous crises (e.g., physical assaults, placement outside the home in foster care). The other member, Gail-i's score which remained very low probably reflected continued high social desirability effect, as the low score was not congruent with the clinical observations and the clinical family assessment which indicated dysfunction and family problems.

While the remaining three group members, Rhonda-g, her sister Ruth-g and Ann-h noted a substantial decrease in family dysfunction and family problems after the conclusion of treatment. These findings are congruent with clinical observations of the case managers. Rose-G the mother of the Rhonda-g and Ruth-g had been very committed to the entire treatment program particularly to a family intervention. Therefore seemingly despite the many crises (e.g., house fire) this family endured throughout the treatment program they were

able to benefit from the therapy offered and improved their family functioning in the face of such crises. In the case of Ann-h one of her case manager's interventions was precipitating Ann-h's move to a more stable foster home placement during the course of treatment. Therefore, Ann-h's perception of high family functioning and few problems reflects her more positive perception of her new foster placement.

BRIEF BECK DEPRESSION INVENTORY

Refer to Appendix E.

The BDI, used to identify probable depression amongst the adolescents was only administered to three of the five members pre and post treatment One of the three members, Pam-j showed a obvious increase in depression from a moderate depression pre treatment to a severe depression rating post treatment. This score was consistent with the therapists clinical observations of her depressed mood or her more recent serious acting out behaviour (which is indicative of depression in adolescents). There are a number of reasons that account for Pam-j's severe depression rating at the end of treatment. These reasons include : the longstanding history of severe family dysfunction coupled with the most recent crises in which mother, Pat-J's physical assaulted Pam-j during the course of treatment, the subsequent refusal of both Pam-j and

her family to engage in any individual and family interventions offered and Pam-j resulting placement foster care near the conclusion of treatment. The remaining two members showed a marked decrease in their depression rating post treatment. Ann-h moved from a severe rating of depression to minimal, almost non-existent degree of depression. Again this was probably in part due to her change into a more stable foster placement and due to her motivation (e.g., perfect attendance) and her ability to benefit from group. While Gail-i moved down from a moderate rating of depression to only a mild rating. For Gail-i this was probably more a reflection of her ability to benefit from the group intervention than the family intervention because as a family they appeared unmotivated to commit to work on any family interventions. Gail-i specifically cited in her group feedback form (See Appendix F) that the group had helped her with the pain of her abuse and to learn the abuse was not her fault. While the remaining two siblings, Rhonda-g and Ruth-g, who had only completed the post-test BDI (due to absenteeism) scored no depression and a moderate rating of depression respectively. The mother, Rose-G had presented upon intake as especially concerned for Ruth-g and wanted mental health intervention for her much more so then for her other daughter Rhonda-g. It is difficult to determine if perhaps Ruth-g's depression rating, although seemingly high at the conclusion of treatment, may still have actually decreased. This is

possible given the mother's initial impressions and concerns for her daughter upon intake and given the daughter's initial clinical presentation which was one of a very withdrawn and despondent adolescent.

SELF-ESTEEM SCALE

Refer to Appendix E.

The clinical outcome measure of self-esteem, the SES indicated that of the four members who completed pre and post clinical measures, two members self-esteem improved significantly while the other two members ratings of self-esteem remained relatively stable i.e., high and moderate respectively. Rhonda-g and Ann-h were the two members whose self-esteem apparently increased significantly. These findings are congruent with the therapists clinical observations as both girls seemed to mature significantly, especially in the area of social skills, during the course of group. Rhonda-g had initially presented at the point of intake as very shy and introverted. She was also the youngest member of group and part of a sibling dyad. Given all of these factors in combination it was most significant that Rhonda-g developed into an equal group participant, and was liked by all. Whereas Ann-h had initially presented at intake with few social skills, few peers and was very inappropriately attention seeking. Therefore, she most benefitted from a

group intervention in that she was accepted and supported by the group and she further developed her own social skills.

The two members whose SES scores remained stable were Gail-i and Pam-j. For Gail-i, the group leader the fact that her SES scored remained relatively high was not so unexpected as she presented good leadership and social skills right from the start of group. Interestingly in the group feedback form she identified that the group had helped her most by building her self-esteem and confidence. This is not surprising as she easily attained and sustained the role of group leader and was well liked and respected by all the group members. Pam-j's SES score also remained stable but at a moderate to low moderate level of self-esteem. It appears that Pam-j was somehow able to sustain her original moderate degree of self-acceptance despite her family crises and her subsequent mother's rejection of her. However, this is difficult to believe and somewhat surprising as this moderate self-esteem score does not appear to correlate much with her very severe depressions rating. This previously noted under the discussion of measures, according to the Rosenberg (1965), the author of the SES depression and self-esteem are presumably correlated.

SUMMARY OF ADOLESCENT GROUP EVALUATION

Refer to Appendix E.

From a subjective, consumer feedback point of view, all members unanimously agreed that they had benefitted from group and actively advocated for the group to continue. Overall, the clinical outcome measures indicated that Rhonda-g's self esteem improved during treatment which was consistent with clinical observations e.g., her increased participation in group. While, as the younger sister, her view of family functioning remained positive. Her sister, Ruth-g however perceived slightly more family dysfunction (within the mean for clinical families) which could still probably be interpreted as somewhat of a gain, given the numerous losses and crises the family experienced throughout the duration of treatment. The differences in these two sisters BF-FAM, are consistent with therapists clinical observations as Ruth-g, the older of the two adolescents, has a more longstanding history of rebelliousness (e.g., running from home) and the mother initially presented at intake as being most concerned for Ruth-g. For Ann-h, all three outcome measures (family functioning, depression and self-esteem) indicated a significant improvement. This improvement occurred in the face of a crisis which resulted in a change in her foster placement. This therapeutic intervention (a change in foster placement which was precipitated by her individual case

manager) only proved to be therapeutic for Ann-h. The group appeared to assist Ann-h in improving her social skills which probably contributed to her increased sense of confidence. The group experience primarily helped Ann-h conquer her sense of social isolation as it naturally provided her with a social support network. Given how the group experience appeared to meet a number of needs for Ann-h one can better understand her dependence on the group and her assertive efforts at insisting on the group's continuation. Ann-h's experience reflects the experience of most of the girls i.e, the group decreased their sense of isolation and met their dire need for socialization and social support. For Pam-j, who experienced the most instability (i.e., further physical abuse, family crises and a subsequent placement breakdown) during the course of group, her scores not surprisingly reflected this chaos she was experiencing in her life. She rated herself as having become severely depressed while her (seemingly accurate) perception her family's dysfunction and problems remained high, as did her low moderate level of self-esteem. Although the group experience appeared to benefit Pam-j to some degree, alone as the sole treatment modality accepted by Pam-j and her family, it proved insufficient in treating the extent of her current problems and pain. While Gail-i continued to maintain a high degree of denial regarding her family, she also maintained a relatively high self-esteem rating and her level of depression showed improvement i.e, it decreased. As the group leader,

her high self-esteem rating was congruent with therapists clinical observations of her many individual strengths, which she herself recognized (i.e., her intelligence, her maturity, her good leadership and social skills). While her perception of high family functioning and strengths proved totally incongruent with the clinical observations of both the therapists and the CFS worker. Her BF-FAM scores probably reflected a high social desirability effect, which would not have been surprising, given the family's well entrenched distrust of outside systems.

LATENCY AGED CHILDREN'S NON-OFFENDING CAREGIVERS' GROUP

The following section of this chapter contains the major phases of the above named group. Each phase will include a description of each session in the phase i.e., the session's objectives, agenda, summary and themes. This section describing the non-offending caregivers' group will end with an analysis of the clinical measures implemented to evaluate this group.

LATENCY NON-OFFENDING CAREGIVERS' GROUP - PHASES AND SESSIONS

Phase I: Introduction
- Session 1. Welcome
- Session 2. Making Friends and Introducing Sexual Abuse Dynamics

Phase II: Education
- Session 3. Feelings Regarding Sexual Abuse, Definitions and Facts
- Session 4. Human Sexuality
- Session 5. Providing Sexual Education to Your Children
- Session 6. Secrecy and More About Child Sexual Abuse

Phase III: Release, Coping, and Working Towards Prevention
- Session 7. My Daughter's Story of Sexual Abuse and Her Disclosure
- Session 8. Indicators of Abuse
- Session 9. Feelings and Behaviors
- Session 10. The Caregivers' Letters to their Daughters
- Session 11. Boundaries: Physical and Sexual

Phase IV: Closure
- Session 12. Preparing for Closure: Answering Remaining Questions
- Session 13. Closure: Social Networks and Other Resources
- Session 14. Farewell Celebration

Phase I: Introduction

SESSION #1: Welcome

SESSION OBJECTIVES:

1. To begin the joining process.

AGENDA:

1. Introductions and exchange of names.
2. Purpose and philosophy of group.
3. Group goals - support, education, parenting.
4. Goals of children's group.
5. Group rules.
6. Group member's agenda/situation - discussion.
7. Completion of pre-test clinical measures.

SESSION SUMMARY:

The facilitators provided members with information on the group (i.e. time, number of sessions, purpose). All members expressed that the children had been looking forward to group. Helen-B raised the concern that her child feared a male co-facilitating the children's group. The facilitators addressed this concern while raising the benefits of the girls observing a positive male role.

Each member was then given the opportunity to give some information about themselves and their families. In

discussing who was in their family, Erica-E and Lori-D discovered that their children went to the same school and knew each other. This commonality appeared to add to the comfort level of group members. As well, by way of building commonality and group cohesion, it was pointed out to the members that, while they had different relationships to the children (e.g. Lori-D and Donna-F, natural mothers; Carol-C natural grandmother; and Helen-B and Erica-E, foster mothers), they were all the primary caregivers of the children in group. Further towards building commonality and group cohesion, facilitators also noted that all of the group members, with the exception of one, were single parents.

Group members were quick to ask the facilitators if they had children and what their qualifications were to run such a group. Facilitators interpreted this as the members asking how could you possibly understand us. Both facilitators gave information that they either had children or experience with them, as well as having specific experience in working with children who have been sexually abused.

This led into a more detailed discussion regarding the purpose of the parallel groups. Members were told that the facilitators were there to answer questions and share information, but that they as members also had valuable experiences and information to share with each other i.e., to validate their own sense of worth. Group members were validated for the support they provide their children by

attending group themselves. The goals of the caregivers' group were formulated as supporting their children, learning more about sexual abuse, and working towards prevention of any further abuse. The goals of the children's group were reviewed and it was pointed out that most of the issues they covered would be parallel in the parent's group. Parents were informed they would be regularly offered feedback with regards to the children's group so that they could be better prepared to deal with their children's reactions, and so they could understand the dynamics of the sexual abuse in relation to their own family. Group members were then given information on some of the topics that would be covered by the facilitators. Members were also invited to bring forth any issues they wished to discussed in group so they might feel some ownership of the group.

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

Facilitators asked group members to decide on group rules as a means of giving them some sense of group ownership. The group rules established included: regular attendance,

confidentiality, and smoking only at breaks. Most members expressed that their children had not yet discussed their abuse with them. Each member was given the opportunity to disclose what had happened to her child, only to the extent that they felt comfortable. This discussion was difficult for Donna-F, as it was her son, Derek-F who had sexually abused her daughter, Dee-f. Donna-F stated that she was very angry with her own sister who abused Derek-F. It was noticed that Lori-D had one of her daughter's offenders names tattooed on a visible part of her body. Most of the mothers were genuinely unaware of the details of their children's abuse and appeared indifferent to obtaining this information.

The facilitators needed to assist Lori-D and Carol-C in completing the clinical measures due to difficulties in reading and/or understanding the questions. It was evident in this group that the facilitators needed to be aware of their use of language and to be more concrete in general.

SESSION THEMES:

1. All of the mothers presented as very anxious, slow to trust and disclosed a minimal amount during this initial group. They were also leery of the facilitators ability to understand and empathize with them and their situations.
2. Most mothers stressed that they were here for their daughters i.e., so their daughters could attend the

children's group. They came with no agenda or expectations for themselves but gradually acknowledged wanting to learn how to better help their daughters heal from their sexual victimization.

3. Initially there was some tension between one foster mother and the natural mothers, as this foster mother presented herself like a co-facilitator, setting herself apart from the other mothers in a somewhat intimidating manner. The facilitators reframed the foster mothers' comments and attempted to mediate the situation by highlighting aspects of commonality amongst all members, in an effort to promote more mutual acceptance.

4. All of the natural mothers had some difficulty comprehending some of the clinical measures questions, facilitators suspected one of the mother's might be illiterate. Regardless, facilitators recognized the need to mind their use of language in group i.e., to stay concrete and not use professional jargon.

SESSION #2: Making Friends and Introducing Sexual Abuse Dynamics

SESSION OBJECTIVES:

1. To further work at the group's JOINING process, to further build a foundation for peer support and trust between facilitators and members and between members

themselves. To foster more mutual ACCEPTANCE amongst members.

2. To desensitize the mothers difficulty in talking about their child's sexual abuse and their own related feelings.

AGENDA:

1. Review children's group agenda: to build foundation for peer support and trust between therapists and children, to emphasize acceptance, believability regarding their sexual abuse and to allow for expression of feelings.
2. Myths regarding sexual abuse, an exercise for all to participate.
3. Definition and examples of sexual abuse, for all to participate.
4. Facilitators to present incidence statistics of sexual abuse within the general population.
5. Film - Finding Out: Incest and Family Sexual Abuse, 1984, National Film Board of Canada.
6. Facilitators to reveal the assignment of a case manager to each family to explain their function.

SESSION SUMMARY:

During today's check-in, facilitators asked Lori-D how she had resolved her concern regarding a boy in Lucy-d's school inappropriately touching her chest. Lori-D stressed

that she was pleased that Lucy B. had told her about the incident and explained to the group that she had involved the principal in confronting the boy and that this had resolved the problem. Facilitators and other group members validated Lori-D for her quick response in protecting her daughter. Erica-E raised concerns about her own children's safety with regards to her foster daughter Ellen-e. She wondered what she could do to educate and protect her natural children regarding sexual abuse. Facilitators advised members that this topic was crucial and would be discussed in more detail in an upcoming group meeting. As well, facilitators advised Erica-E to arrange a meeting as soon as possible with her case manager to explore her specific concerns in more detail.

Donna-F proceeded to dominate much of this week's session expressing both her anger and ambivalence in regards to her daughter's sexual abuse by her son. Donna-F who is receiving counselling from another agency also expressed confusion between attending both counselling services. Donna-F expressed little hope of her son being rehabilitated. She emphasized her own need to hear him verbally acknowledge responsibility and then for him to apologize for the sexual abuse. Donna-F also spoke of having "bad nerves" and self-medicating with aspirin in the evenings. Lori-D and Carol-C also acknowledged self-medicating with aspirin, as an identified means of coping. This was concerning to facilitators and the need to promote alternative methods of

coping was obvious.

Facilitators and group members proceeded to listen attentively to Donna-F's outpouring of confusion and anger towards her son. Members patiently listened, to her apparent neediness. While facilitators utilized Donna-F's situation as an opportunity to illustrate some of the dynamics of sexual abuse (e.g., intergenerational transmission of sexual abuse, how often an offender himself has a history of childhood sexual victimization)

Group members supported Donna-F's expectation that her son, Derek-F accept responsibility for his sexual abuse. Facilitators explained that there are no guarantees in regards to offenders not sexually re-offending. Again, facilitators suggested Donna-F meet with her case manager to begin to address her specific concerns regarding: Derek-F's progress, as well as the family's overall treatment plan. In keeping with good team communication and by way of supporting Donna-F, facilitators also raised her issues with her assigned case manager.

After the smoking break the mothers were shown "Finding Out: Sexual Abuse" and they watched attentively. After the film, facilitators validated the mothers for being supportive, as were the mothers in the film, of her daughter's disclosures. Due to a shortage of time, their was little debrief of the film. Note: As a result of Donna F's extended check-in most of the intended agenda was not covered.

<u>SESSION THEMES:</u>

1. One of the natural mother's presented as very needy and dominated much of the group discussing her son's sexual offending against her daughter. Facilitators used this as a natural opportunity to illustrate certain sexual abuse issues and dynamics e.g., betrayal, family loyalty, treatment modes and issues, and adolescent offenders (histories of their own previous sexual victimization.)
2. Facilitators nurtured the mothers by providing a snack and coffee which seemed to positively enhance a more relaxed atmosphere and was well received by all the mothers. This will be a regular part of group, offering mothers an opportunity to be nurtured and to provide for socialization.
3. Facilitators validated the mothers for supporting their daughters by attending group, this praise appeared to be well received by these mothers who appear sensitive to any perceived criticism and most of whom present with limited confidence.

Phase II: Education

SESSION #3: Feelings Regarding Sexual Abuse, Definitions and Facts

SESSION OBJECTIVES:

1. To encourage the mothers to identify their own feelings and reactions regarding their child's sexual abuse.
2. To promote the mothers understanding of their child's feelings and behavioral reactions regarding the sexual abuse.
3. To discuss methods of encouraging their children to communicate (verbalization of feelings) and to encourage mothers to express empathy for their children.

AGENDA:

1. Check-in with each group member.
2. Review children's progress from last week and their group agenda for today.
3. Discuss myth regarding sexual abuse - having members respond true or false to list of questions.
4. Provide definition of sexual abuse and put together list of examples with group input.
5. Discuss the incidence of sexual abuse.
6. Debrief the film from last week and promote discussion in regards to mothers feelings regarding the sexual abuse.

SESSION SUMMARY:

During check-in, Lori-D told the group that her ex-husband, who had offended against her two daughters, had recently been arrested for sexually abusing yet another child. She admitted that she had found it hard to believe when her daughters sexual abuse by their father was first disclosed. This recent disclosure of yet another child victim appeared to eliminate any of her remaining denial and served to confirm for her, that indeed her own children had been abused by her ex-common law partner, even though he had never officially been charged. Group discussed the possible reactions the girls may experience when she informs them that their father has been arrested for the sexual abuse of another child (i.e., confused, hurt, angry, scared). Helen-B queried how children's reactions are different when they have been sexually abused by a family member. The feelings of betrayal, confusion, and loyalty were highlighted as major differences.

In an effort to parallel the children's group facilitators, asked members how they felt about their children having been sexually abused. Members responses showed a limited range as they generally stated feeling "angry" or "mad" that their children had been abused. Members were informed that often their children's feelings are expressed by behaviours and facilitators reinforced the need for mothers to understand the meaning of such behaviour and to encourage

their children to identify and label their feelings. Helen-B raised concerns about Heidi-b's as sexualized behaviour with men. Facilitators talked briefly about the need to both establish and reinforce appropriate boundaries. Erica-E discussed concerns in regarding to Ellen-e's behaviour, e.g. tantrums, acting out, and swearing. She also disclosed that Ellen-e had threatened to hurt herself. Two other parents, Helen-B and Lori-D stated that their children, at some point, had also wanted to hurt themselves. Group then discussed the meaning of such behaviour, specifically, the dynamic of self-blame. Facilitators reinforced the importance of children being reassured that they are not to blame and of placing the responsibility for the abuse with the sexual offender.

Facilitators reinforced the need to de-emphasize behaviour and focus on the children's feelings. Each member was asked to identify feelings they thought their child had when describing certain behaviours. Feelings described included distrust, fear, anger and hurt. Helen-B and Erica-E the two foster mothers, in particular, demonstrated more insight into their children's behaviour than the natural mothers. Mothers described their children's aggression or "magical thinking" as a means of coping. Lori-D talked about her children, Laura-d and Lucy-d constantly seeking her attention. Facilitators reinforced the need for mothers to display affection and to appropriately validate and provide

positive mirroring for their children. Group members were asked to think about how they might spend time with their children and how they might reinforce the children's sense of being important. Lori-D responded to this by saying that Lucy-d sleeps with her nightly. This led to further discussion regarding some of the children's reactions to the abuse such as fear (e.g. fear of the dark, wanting to not be left alone at night, needing to have a night light on). Both foster mothers described their foster children as children who were "parentified" in their families of origin. This led group to discuss the dynamics of pseudomaturity and parentification.

During the group exercise on myths regarding sexual abuse. It was apparent that this group as a whole knew little about the facts of sexual abuse. Group members expressed great curiosity regarding offenders and why they sexual abuse. Members were told there would be an entire session devoted to this at a later date, at the members request.

Facilitators and group members participated in an exercise in which they created a list of examples of various forms of sexual abuse. Most members had a difficult time even listening to some of the examples without pointing out their disgust. It was highlighted that if they as caregivers had a hard time even listening to such words, they could begin to imagine how their children must feel having experienced these forms of sexual victimization. This exercise proved helpful

in both desensitizing the mothers to talking about sexual abuse and in helping them empathize with their daughter exploitation.

The facilitators then provided the group with information regarding the incidence of sexual abuse. All members were surprised at how many children are abused. Group members again discussed intergenerational sexual abuse and the role of denial and secrecy in perpetuating the problem. Treatment was defined as a starting point in breaking the perpetuation of the problem. It was pointed out that sexual abuse happens in all cultures and at all socio-economic levels, as one of the foster mother's asked if there was only a specific group of people who experience this problem as she had not heard of this problem in her neighbourhood. This information appeared to serve to further break down the barriers between foster and natural parents.

SESSION THEMES:

1. Another natural mother's dominated the check-in process today with her need to discuss her ex-partner's current sexual abuse against more children. This mother's sharing of her own initial reactions to her girls sexual abuse e.g., anger, betrayal naturally led to the other mothers disclosing their initial reactions.
2. Facilitators reinforced the concept of the offender as being responsible for the abuse and stressed the child's

tendency towards self blame and the mother's need to empathize with her daughter.

3. Facilitators educated the mothers with regards to common behavioral reactions to sexual abuse, a definition of sexual abuse and various acts and forms of sexual abuse.
4. Facilitators also educated mothers regarding the prevalence of child sexual abuse and described the tendency for the intergenerational transmission. The child sexual abuse incident rates appeared to further decrease the mothers sense of isolation and alienation, beyond that provided by the group experience itself.

SESSION #4: Human Sexuality

SESSION OBJECTIVES:

1. To appropriately sexually educate mothers regarding human sexuality with an emphasis on sharing developmentally age appropriate information with their children.

AGENDA:

1. Check-in: review mother's feedback with regards to last week's session.
2. Review the children's group agenda for this week: to provide girls with labels for private parts and to facilitate comfort in discussing body parts, sexuality, touching and sexual abuse. Hand out copies of the body

parts booklet distributed to the children.

3. Introduce this week's theme of sexual education by asking mothers what they themselves were taught or told as children about human sexuality and by whom. To ask the mothers what terms their children currently use for their private parts and attempt to teach the use of common, proper terms.
4. To ask mothers to watch, discuss, screen, and provide their feedback on the appropriateness of having their children view the film called "Where Do I Come From". This film will be shown next week in children's group (if acceptable today to all the mothers), as a tool to educate the children regarding human sexuality in an age appropriate way.
5. To begin to discuss and educate mothers about teaching and talking about human sexuality with their children. Sol Gordon's Askability Questionnaire will be distributed and discussed. Also a chapter on age appropriate answers for children regarding sexuality will be distributed from the book: Why? Children's Questions (Formanek & Gurian, 1980, p.24-32).
6. To suggest a Christmas celebration or party for next week and to plan this with ideas and input from the mothers.

SESSION SUMMARY:

Although Donna-F who had also been absent from last

week's group, arrived late today group members expressed having missed her last week. This gesture appeared of the growing group identity.

During check-in Helen-B began by stating that Heidi-b had given police a report this week with regards to her sexual assaults. Helen-B expressed concern for how hard the court process will be for Heidi-b who will have to face her perpetrators in court. Donna-F said her family had finished with the court process and the outcome had been institutionalized foster treatment for her son, the offender. Facilitators discussed some of the inadequacies of the legal system's prosecution of sexual offenders however highlighted the importance of charging the offender with the crime. Regardless of the legal outcome, facilitators stressed the importance of mothers believing their children's sexual abuse disclosures and validated them again for having done so.

Facilitators stressed the importance of human sexuality education (this week's topic) as being particularly important due to the children's distorted and deviant sexual knowledge resulting from their histories of sexual victimization. Facilitators attempted to empower the mothers by asking them to screen the appropriateness of the film "Where Do I Come From?" prior to the children (potentially) viewing the film next week. By previewing the film, mothers would have an opportunity to discuss the film with their girls or to answer any of their resulting questions. Lori-D spoke of how

inappropriately her girls touch her sometimes. The group validated Lori-D for quickly eradicating this inappropriate touching. Helen-B said Heidi-b had inappropriately touched a boy's genitals at school. This lead Helen-B to appropriately model for the group how she had discussed "good and bad touches" with her foster daughter. This lead to a general discussion on good and bad touches with the mothers providing examples.

After enjoying viewing the film themselves, all the mothers mutually agreed to the benefits and the appropriateness of showing it to their daughters. Facilitators stressed the need for children to be advised of their upcoming bodily changes in puberty. Facilitators educated mothers that some sexually abused children feel very shameful of their bodies and normal pubertal changes. As well, sexual curiosity was defined as normal, when age appropriate, and facilitators provided examples. Facilitators explained how sexual curiosity is often heightened in children who have been sexually victimized.

At the conclusion of the session facilitators encouraged mothers to be open to answering their children's sexual questions. The facilitators expressed an understanding of how difficult a job this might prove to be for some of the mothers depending on their level of comfort and knowledge. Facilitators went around the room asking each group member how they themselves had learned about sex. All group members were

forthcoming in disclosing that they had had a lack of sexual education from their own caregivers/families or origin. Lori-D said she had grown up in foster homes and a girls home, so no one had ever talked to her about sex. Carol-C said she was raised in the residential school system where any talk of sex was taboo. Donna-F said she was afraid when she started menstruation as no one had ever talked to her about her own sexuality. Helen-B, one of the foster mothers, said she, like the natural mothers, had never been taught anything about sex and was surprised when her first baby had not come out of her belly button. This group discussion helped all the mothers to see that despite their apparent difference, they had some commonality with respect to their upbringing. This seemed to serve as the turning point in establishing group cohesion and group identity.

<u>SESSION THEMES:</u>

1. During the check-in mothers raised the issue of the court process on the children and vented their anger regarding its inadequacies and the lack of supports for child victims.
2. One of the natural mothers raised a parenting concern which naturally led facilitators into another opportunity to discuss the need for privacy and sexual boundaries.
3. The animated film <u>Where Do I Come From</u> proved to break the formalness of the group atmosphere and the mother's

seemed much more relaxed and informal this session. They all laughed and thoroughly enjoyed themselves while watching the film. The film also proved to successfully further desensitize the mothers ability to discuss normal human sexuality.

4. Facilitators attempted to empower the mothers by having them preview the film as to its acceptability for their daughters and to create the opportunity for them to talk with their girls about the film.

5. This week proved to be a turning point in the group's cohesion and a more common group identity was beginning to form as the gap of mutual acceptance amongst foster mothers and natural mothers was bridged with their discovery of further commonality regarding their own lack of sexual education within their families of origin.

SESSION #5: Providing Sexual Education to Our Children

SESSION OBJECTIVES:

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

AGENDA:

1. Check-in.
2. Review the children's group agenda for this week (i.e., the film Where Do I Come From, Walsh, F. and New World Video (1985). Review holiday homework assignment for parents.
3. Discuss the importance of connecting values to any sex education. To further define both good and bad touches with examples provided by the caregivers.
4. Review the Askability quiz. Refer to the question and answer handout from last week as a resource to help mothers answer their children's questions regarding sexuality.
5. Review and prioritize themes that caregivers want to cover in the upcoming sessions (e.g., boundaries, prevention, coping).
6. Brief discussion on the meaning of the Christmas holidays for each family system.

SESSION SUMMARY:

Coming to group late appears to be a pattern for Donna-F alternating with her absenteeism. Facilitators raised this concern with her case manager. Both Donna-F and Carol-C remained attentive but quiet throughout most of group today. Carol-C's participation in group has generally tended to be more non-verbal, which may be due to the distinct age gap

between her (she is the only grandmother, caregiver) and the other members, however, her verbal participation appears to increase with fewer members in group.

Group began with check-in, at which point Lori-D disclosed that she had been dating a man who had stayed overnight. She also expressed fears of her girls possibly being reabused. She explained how she had found Laura-d under her bed one night while she and her male friend were in bed together. Group members offered their insights into why her daughters may have been hiding there (e.g., sexual curiosity, concern for their mother's safety). Group facilitators, raised the importance of setting and enforcing appropriate sexual privacy boundaries with all family members. Lori-D interjected saying she had already set a privacy boundary with the girls as a result of this incident. Facilitators noticed a pattern emerging with Lori-D. She would often raises problematic situations regarding her daughters, seemingly request the guidance and support of the group but then she would quickly retract, stating that she had already done and said all that other members might suggest. It is the facilitators hypothesis that this is the result of Lori-D's own ambivalence about revealing her vulnerability (her parental deficits) and yet constantly needing the approval and validation from the group, the validation which was probably unavailable to her in her own childhood.

When facilitators gently probed Lori-D to explain how she

had come to decide that this current male friend was safe with regards to her daughters, she deferred the responsibility to her daughters. She responded that the girls themselves had requested his presence, "so they must feel safe with him". She then diverted from the issue of her daughters' safety and moved to the issue of the violence she had experienced with the girl's primary abuser. In an effort to diffuse Lori-D's defensiveness, facilitators engaged other members in discussing their own experiences in relationships with men. It was apparent that for most mothers, emotional abuse was not perceived as abuse. The only married group member, one of the foster mother's in the group expressed having a supportive husband. In bringing closure to this extended check-in, facilitators stressed that all women and children are entitled to and need the assurance of basic safety in all of their relationships. Facilitators, however, stressed that this did not equate, with mothers needing to be without a partner, as the only means of assuring safety. Facilitators educated members regarding characteristics indicative of an abusive relationship. Facilitators stressed the importance of giving this topic more serious consideration at a later date, and members agreed.

After returning to today's topic of sexual education and values, some members indicated they had pursued other resources to use in order to educate their children about sex and shared this information. Helen-B modelled what she might

tell her children by way of discussing last week's film, framing sex as one means adults have of expressing love and warmth for each other. Most mothers agreed that this would be a good way to preface any discussion about sex with their children. They also stressed the need to inform children that sex should only occur between two mutually consenting adults, but preferably should be exclusive to adults in a committed relationship.

Facilitators initiated the exercise of going through the Askability Questionnaire inviting members to take turns answering the questions. Mothers were asked to answer these questions in accordance with their children's development level and comprehension. Facilitators were surprised how much discussion the questionnaire generated and felt this was in part a result of the growing level of comfort amongst the caregivers regarding the topic of sexuality. Facilitators were also impressed with the overall degree of comfort amongst members which seemed indicative of the growing group cohesion.

Group concluded with a discussion on the significance of the upcoming Christmas holidays, reflecting, with interest and appreciation, on individual cultural differences and yet similarities amongst members. Carol-C spoke of her plans to take her family to the local church mission for Christmas dinner but noted no other significance in this holiday. Lori-D agreed with Carol-C as they share the same culture, that Christmas for them was not deemed a big celebration or

event. In closing, facilitators presented each caregiver with a small Christmas gift. This was in an effort to nurture and model nurturance to the mothers. This was a gesture paralleled in the children' group. Caregivers appeared surprised but yet delighted that they as adults were also being nurtured, as most of the mothers have histories of extensive childhood deprivation and neglect themselves.

SESSION THEMES:

1. Again one of the seemingly neediest mothers, raised her own generalized fear about her powerlessness, that her daughters may become revictimized, as there is now a new boyfriend in her life. After clarifying that her fears were not based on any present behaviours or concerns, facilitators supported this mother in identifying and operationalizing means (empowering her) to assure their girls safety (e.g., limiting access to their children by others like a new boyfriend, enforcing stricter sexual privacy boundaries and limits). Women and children's rights to basic safety in their homes was stressed.
2. This led facilitators noted that other members are quick to be supportive, validate and offer parenting support mainly to the two seemingly neediest mothers, while the other mothers remain cautious in disclosing any of their own concerns, or appearing vulnerable, especially a pattern for the foster mothers.

3. Again this week demonstrated a growing level of comfort amongst group members as reflected by their increased ability to candidly discuss sexuality.
4. Therapists nurtured the mothers and validated their own sense of self-worth and esteem by hosting a special Christmas party for them with small gifts of appreciation given to each mother. This gesture was well received by all the mothers who seemed to feel "special". This neediness for the natural mothers to have their self-worth reinforced is not surprising given their own histories of deprivation.

SESSION #6: Secrecy and More About Child Sexual Abuse

SESSION OBJECTIVES:

1. Discuss the mothers' feelings in regards to the abuse of their children, particularly with regards to the offender.
2. To help mothers empathize with and understand why their children kept the sexual abuse secret.

AGENDA:

1. Check-in (review how Christmas was for each family system).
2. Explanation for the drop-out of one foster mother.
3. Review goals of children's group for this week.

4. Discuss caregiver's feelings around the abuse of their children and their feelings towards their children since the abuse.
5. Discuss feelings towards offenders.
6. Discuss their experience (both positive and negative) with the different helping systems they have had to deal with regarding the abuse (e.g., hospital, CFS).
7. Explore how they express and cope with painful feelings.
8. Discussion of why some children keep the sexual abuse a secret.

SESSION SUMMARY:

For the second consecutive week now Donna-F was absent. Group facilitators informed the group that Erica-E would not be returning to group as Ellen-e's foster placement in her home had broken down. It was explained that Ellen-e had been moved to a new foster home because Erica-E had been concerned about the safety of her own two young children due to physical threats by Ellen-e. Group member's initial reaction was one of concern for the child moving to yet another foster home. However, mothers empathized with this foster mother's fears. Mothers also acknowledged the difficulty in fostering sexually abused children. The remaining foster mother was validated by the natural mothers for her work.

Lori-D monopolized check-in and commented on the many problems she had with her girls over the holidays. She said

that the girls had been physically aggressive towards her and that she had dealt with this by threatening them that she would go "drinking". Members gently challenged her use of threats as a means to discipline children. The members balanced this with empathy and support for her job as a single parent and suggested that she perhaps needed a break. This naturally led to a general discussion on the difficulties of being a single parent and the mothers need for a good social support network. Carol-C, who is normally the quietest member, talked a fair amount today. She stated that her daughter, Connie-C had come to live with her before Christmas. Connie-C is expecting her fifth child and Carol-C said that she wanted her to keep this child, as her previous four children have been placed in the care of other family members (three of them with Carol-C). Members asked Carol-C if her grandchildren overwhelm her but she laughed instead and reframed it as "they just keep me busy."

Group facilitators informed caregivers that the children were being prepared to share their stories of sexual abuse this week in group and that they were also talking about secrets. In discussing the issue of why children keep the abuse a secret, group members demonstrated a great deal of insight. The main reasons offered by the mothers included: the children didn't know what happened was abuse or necessarily wrong; their was little or no communication within the family; the kids or their families were threatened; nobody

asked the kids; and bribes were used. Group members identified the reasons which applied to their own situations, in an effort to begin to understand the dynamic of secrecy.

Members also discussed how <u>they</u> felt about their children having been abused. Helen-B stated that she was <u>angry</u> and yet felt <u>powerless</u>. She said "You can teach your children safety but you can't be there 24 hours a day to protect them." Helen-B also raised the issue of the power differential between the child and the offender and emphasized that the child is never to blame. Lori-D expressed feeling blamed by her own family for the abuse of her daughters, but wrote this off as hypocritical as her own mother was alcoholic and had never parented her. Lori-D expressed both guilt and anger for being blamed by her mother as her children had been in her mother's care during the time of their second sexual victimization.

Helen-B disclosed her difficulties in fostering Heidi-b. She stated her frustration in that Heidi-b had presented with many of the symptoms indicative of sexual abuse but had not yet disclosed. Helen-B stated that it was a hard decision for her to decide to foster an abused child because of the commitment required. Helen B's story seemed to only further the natural mother's growing empathy towards foster parents.

The group discussed the issues of assertiveness, particularly the difficulty in saying "no" to family. Carol-C said she herself was a parentified child in that she looked

after her siblings since the age of 14, as her own mother had been crippled but continued having babies. She stated that she was prepared to finally say "no" this time in regards to raising Connie-C's most recent baby. Members reinforced her need to set limits, without feeling guilty, so as to assure her own self-preservation.

In discussing how members felt about their children's offenders, they generally expressed that they were "angry" and felt like "shooting" them. Members again expressed frustration with the legal system, feeling, more adamantly then before, that offenders should be punished but are not. Lori-D stated that she was "pissed off" that her children's offenders were not charged and she was confused as to why they had not been (she was directed to discuss this with her case manager and CFS). Members mutually agreed that when legal charges are laid, this helps give a clear message to the children regarding who is responsible for the abuse.

After the break, Lori-D talked a lot about the pain she feels from her childhood and her family of origin and her sense of powerlessness in not being able to correct past hurts. She appeared to be more comfortable self-disclosing and exposing her vulnerability this week. Group discussed means of self-forgiveness and forgiveness of others and moving beyond a sense of hopelessness. Lori-D told group that the turning point in her life was when she went back to school and became involved with the "elders" in her spiritual circle.

Helen-B was very supportive and validating of Lori-D during her self-disclosure today, which further "broke the ice" between natural parents and the sole remaining foster parent.

SESSION THEMES:

1. As one of the foster mother has left group as she is no longer fostering and as another member has been absent on alternating weeks, group process has become difficult with but three members i.e., it has more like individual therapy with members relating more through the facilitators.
2. There was a break through in group towards more mutual acceptance and trust amongst the members in that one natural mothers validated the only remaining foster mother for her parenting abilities and her dedication to her foster daughter. There appears to be a growing sense of mutual trust amongst the mothers.
3. Again, one of the neediest natural mothers dominated the group time with her parenting problems and her personal pain. More discussion and disclosure occurred around family of origin, as a source of more pain and hurt versus support. This led to a discussion on the difficulty mothers have setting boundaries with their families of origin.
4. Mothers further revealed their feelings about their child's victimization today e.g., anger, self-blame,

powerlessness. Most of the mothers showed a good understanding of the secrecy dynamic. Facilitators emphasized the need to break this dynamic within their families so as to reduce the likelihood of their children's sexual revictimization.

Phase III: Release, Coping and Mastery and Working Towards Prevention

SESSION #7: The Story of My Daughter's Sexual Abuse and Her Disclosure

SESSION OBJECTIVES:

1. To further facilitate better communication between mothers and their children in regards to their feelings about the sexual abuse.
2. To further encourage mothers to verbalize and manage their own feelings regarding the sexual abuse.

AGENDA:

1. Check-in.
2. A review of children's group agenda (i.e., completing their sexual abuse disclosures and beginning to discuss their feelings towards their offenders).
3. This week's activity: letter writing exercise (See Appendix G). Facilitators will provide a sentence

completion sheet as a tool to direct and guide mothers on critical topics to address with their daughters regarding the abuse.

4. Mid point evaluation: asking members to offer feedback and input regarding future themes.

SESSION SUMMARY:

At the start of group, Lori-D stated her daughters were missing and apparently had not come home after school. Facilitators quickly agreed to use this crisis as a natural opportunity to illustrate the importance of safety and protection planning with the mothers. Due to concerns for the children's safety, one of the facilitators left group with Lori-D in an effort to assist her in locating the girls. Group members expressed their hope that the girls would soon be found due to the -30°C weather. This session highlighted the need for a co-facilitator i.e., to maintain consistency due to the need for flexibility during such crises or in the absence of a group facilitator.

The remaining facilitator proceeded with group. Helen-B updated Donna-F with regards to what she had missed last week. Members expressed that their girls continued to feel excited about attending group. Donna-F noted that Dee-f was having trouble in school and that the school was therefore offering additional counselling. She said she was unclear as to whether to accept the involvement of yet another helping

system. The facilitator redirected her to consult with her case manager on this matter. Members commented that their daughters had also experienced trouble concentrating in school as a result of the sexual abuse.

Helen-B spoke of how Heidi-b had not revealed her sexual abuse any earlier because she had feared blame from her natural family. It was not until after coming into foster care that she began to feel safe enough and disclosed. Helen-B described how her CFS-B worker was supportive in giving her guidance on how to talk with Heidi-b. Facilitators validated Helen-B for all the good work she has done with Heidi-b to date. It appeared much more significant that natural mother, Donna-F, further reinforced Helen-B.

Mothers were asked in a round-the-circle discussion to describe how they eventually learned of the sexual abuse and how they had responded at the time. Donna-F responded Dee-f had not told her as she was afraid she would be blamed. Derek-F had used physical aggression to restrain his sister and had threatened to beat her up if she told. The facilitator proceeded to educate mothers on such factors such as physical aggression which influence or mediate the impact of the sexual abuse on a child. Donna-F said that her youngest son, who had on occasion witnessed the sibling abuse, eventually disclosed. Donna-F said when she learned about the abuse, she confronted Derek-F, but he denied it. She was

enraged and thought she might hurt Derek-F so she called CFS-F and Derek-F was placed outside the home.

Since that time, Donna-F claimed she felt very protective and wondered if she was now overprotective of her children. The group validated the safety protection plan Donna-F described. Facilitators reinforced the notion that most often children are abused by family members or by a trusted third party, and that any safety plan should include precautions against trusted people. Donna-F appeared less condemning of Derek-F this week as she framed the sexual abuse as a "family problem" that the whole family needs to continue to treat in therapy, she appears to have integrated learning from her dyadic sessions with her son. She commented that this is not an easy process for her nor for her family. All group members supported her, empathizing with how difficult this would be, given that both victim and offender are her children.

Carol-C divulged that Cindy-c first disclosed the abuse last summer to her older cousin. Carol-C said she had noticed Cindy-c's vaginal area was extremely red and sore, however, accepted Cindy-c's explanation that this occurred as a result of falling down on the monkey bars at school. Carol-C stated that upon Cindy-c's disclosure to a community volunteer, she was seen at the Child Protection Centre and that CFS became involved. Carol-C displayed some insight into the effects of sexual abuse (e.g., fear of men). Helen-B reinforced the need to not force children into being affectionate, touching, or

going near anyone they feel uncomfortable with. Carol-C also revealed insight into the need for safety.

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

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

After break, the mothers came together to discuss how the crisis had been resolved. Facilitators raised the need for mothers to have a safety plan for their children. Lori-D stated that she was angry with her girls. Group members, particularly Carol-C, empathized with Lori-D, however, reframed her feeling as fear. Facilitators then proceeded to ask each member to share whether they had a safety plan and to

share what their plan was with fellow members.

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

SESSION THEMES:

1. As a crisis naturally presented at the start of group i.e., one natural mother could not locate her daughters ages 7 and 9 and was concerned for their safety as the girls had been locked out of their home in this -30 degree weather. This session highlighted the need for co-therapists as one therapist left group to help this mother locate her children while the other ran the group. This crisis was debriefed and the issue of safety planning and protection planning was discussed within the group. Each mother created or shared her current safety plan for such situations. The need for parental

responsibility of children's safety was also underscored in a non-blaming manner.

2. Mothers discussed how each one of them had learned of their child's sexual abuse through someone else, further pointing to the need to improve the parent-child communication and relationship, in general.
3. Facilitators initiated a mid-term evaluation asking for the mothers input into topics they wish to address. The group appeared fairly passive with their lack of response, with the exception of their advocating for a guest speaker on the topic of offender and/or the court system.

SESSION #8: Indicators of Abuse

SESSION OBJECTIVES:

1. To enhance the mothers abilities to protect their children.
2. To further facilitate communication between mother and child.

AGENDA:

1. Check-in and discuss the children's anxiety levels around disclosures given last week, and share feedback regarding the disclosures.
2. Review children's group agenda for this week.

3. Group exercise regarding behavioral and physical indicators of sexual abuse. Group provided with a handout.
4. Group member's to list the indicators they had observed in their children, what they had done at the time, and what they would differently if anything in retrospect.
5. Group exercise - assist mothers in writing letters to their children, expressing their feelings around the abuse, what they would have like to have done differently, and their feelings towards the offenders. Have letters written with a vocabulary the children can comprehend. Describe upcoming process of sharing of the letters with their daughters in a session with their case managers.

SESSION SUMMARY:

The group facilitators informed members that Ellen-e was moved once again into yet another foster home. Facilitators also explained that they had made a decision against Ellen-e's newest foster mother joining group due to the issues around late introduction into group (i.e., as concern for the effects on group process such as level of trust). (Note: Facilitators unilaterally made this decision also based on confidential concerns in regards to the appropriateness and longevity of this latest foster placement). All group members expressed concern for Ellen-e having to move yet again but also informed

the facilitators that they would have been agreeable to the inclusion of the newest foster mother. Members expressed that group would have been beneficial for her, as it has been for them.

Facilitators talked to members about the limited number of weeks remaining and asked members to make a decision as to which of two desired speaker topics they wished to prioritize (i.e., offenders or the legal system). The decision was to have a speaker come in to talk about offenders.

Check-in time was fairly balanced for all members this week. Carol-C informed the group that Connie-C would live with her until after she has her baby. She tried to encourage Connie-C to come to group but had not been successful. Donna-F continued to express her confidence that the counselling was helpful. She stated that she was even "beginning to enjoy group" and other members agreed. During check-in, members were asked how the children had been, following their disclosures in last week's group. Donna-F was concerned that Dee-f "never says anything to anybody" and keeps everything inside. Lori-D was unsure if her children recalled their abuse as they had been quite young the first time they were sexually abused.

Group members then discussed issues regarding how to talk with children about pubertal development and feminine hygiene. This was initiated by Lori-D whose children were asking her these questions. Members talked about the difficulty they

felt in discussing this topic. The facilitator normalized their discomfort but emphasized the importance of disseminating appropriate information to their children. Facilitators discussed issues around menstruation and hygiene which may reflect children's sense of shame around their sexuality, resulting from their abuse (e.g., hiding sanitary napkins).

The group then began the exercise of reviewing signs and symptoms of abuse. The facilitators had charted symptoms for the group to see and reviewed each symptom (using simplified langauge), and asking group members which symptoms they had observed with their children. The charts were broken down into three areas: 1) typical indicators of abuse and/or trauma; 2) signs specific to sexual abuse; and 3) physical signs of sexual abuse.

Symptoms observed by members were recorded and it was apparent that most of the children had had many symptoms or indicators of sexual abuse but that their caregivers had generally been either uninformed that these were indicators of sexual abuse and or were operating in denial. The group members were therefore provided with a handout of indicators to take home for future reference.

Following this exercise, Lori-D talked about feeling that her girls are angry for her absence in their younger years due to her alcohol abuse and incarceration. This was a progressive development for Lori-D as she had become more

genuine and self-disclosing and was attempting to integrate insight she had gained from her individual/family sessions. Group members attempted to support her stating that while children may feel angry they were not protected, they continue to want their parents love and approval and continue to need them to parent them effectively now.

Group then began to discuss what they had done when they had recognized any of these indicators of abuse. Helen-B modelled ways that she talked to Heidi-b, which seemed helpful for others to hear. However, this topic was held over until the following week due to a time shortage. The final message facilitators left members with, was that it was a caregiver's responsibility to protect her children and if signs of abuse are indicated, the caregiver should act to pursue the support of some outside intervention (i.e., Child Protection Centre, police, CFS, etc.).

SESSION THEMES:

1. Facilitators directed mothers to take more ownership of the group (e.g., asked that they select the topic for a guest speaker).
2. Mothers spontaneously offered their feedback about group. They talked about enjoying the socialization and support offered to them in group, this was further supported by the fact that families have started to come early to group. Mother talked about their social isolation and

this as being a positive new experience for them.

3. Facilitators were somewhat surprised with the mothers complete lack of knowledge with respect to indicators of child sexual abuse (during this exercise in group). It became readily apparent from the mothers disclosures that most of their children had displayed a variety of physical, behavioral and psychological indicators prior to their disclosures mothers had either denied or truly had not understood the meaning until now.
4. One of the natural mothers genuinely disclosed some of her insights gained from her family sessions with her case manager which appears to reveal the growing sense of trust experienced amongst some members of the group.

SESSION #9: Feelings and Behaviours

OBJECTIVES:

1. To further reinforce the caregivers awareness of physical, psychological, and behavioral indicators/symptoms of abuse for the purpose of prevention.
2. To begin to discuss the importance of social supports. To increase the caregiver's awareness of social and professional helping resources and supports in their community.
3. To carry over last week's objective #2 and further

facilitate communication between the caregivers and their daughter.

AGENDA:

1. A brief check-in with a review of the children's agenda.
2. Review physical, behavioral, psychological indicators from last week with caregivers, focusing on what they might do differently now to help protect their children from revictimization.
3. To complete the letter writing exercise to their daughters. Refer to Appendix G.

SESSION SUMMARY:

Check-in was intended to be brief, but group digressed as Donna-F returned to group this week, eager to discuss her individual issues. Fellow group members accommodated her need to vent and receive support, as they appeared empathize with her struggle. Members also appeared to respect her willingness to display vulnerability and her general level of trust within the group. Donna-F utilized group to "debrief" her feelings and insights resulting from her dyadic counselling with Derek-F this week. Donna-F's feelings focused on the theme of divided loyalties, including her anger, hurt, and ambivalence as to whether her family could ever bring the sexual abuse to a close. Members empathized with her struggle regarding divided loyalties (i.e., between

her daughter and her son, and between her sister and her son), but challenged Donna-F again to consider the truth of Derek-F's allegations that his maternal aunt had previously sexually abused him, as she vacillates over this allegation.

At one point in the discussion, Helen-B asked Donna-F if she had ever discussed sexual abuse or sexuality with her son, implying this may have averted the abuse of her daughter. Donna-F, felt blamed by this foster mother, and defended herself saying "he was brought up well". The facilitators interjected to mediate the interaction, clarifying that Donna-F had done her best as a parent and was not to blame nor was she responsible for her son's behaviour. The dynamic of Helen-B seemingly blaming or criticizing a natural mother, which had been an issue in an earlier session, had again resurfaced. The natural mothers, each at some point, have also tended to react defensively to any hint of blame or responsibility for their child's abuse. This dynamic may in part, be a reaction to their own internalized sense of guilt which to date has only minimally been expressed by one member in the group. Facilitators then engaged members in a discussion on how they each had dealt with the indicators of abuse that they had noticed in their children.

Donna-F expressed frustration in that she had indeed attempted, without any success, to get Derek-F help for his anger and acting out behaviour. She had not understood the exact meaning of this behaviour, but knew intuitively that

something was terribly wrong. Donna-F explained that a year and a half prior to the disclosure, she had sought help for her son through both with CFS and the school system, and was simply told "not to worry ... he'll outgrow this behaviour". She said, ironically, the disclosure of sexual abuse then suddenly resulted in her family's access to an abundance of counsellors and resources. Facilitators commended and validated Donna-F for her past attempts to seek help (through the appropriate channels). Facilitators commented on how often such behavioral indicators indicate some sort of trauma or abuse but how even many professionals still cannot identify sexual abuse victims and offenders. It was also pointed out that often victims need to be supported in a safe environment in order to disclose sexual abuse. Also discussed was how the identification of the root of problematic behaviour becomes even more paradoxical when the victim is also an offender.

Facilitators also attempted to expand the caregivers' knowledge of resources available in regards to issues of safety, prevention, and child abuse. It was noted that in reality, such resources are limited, and therefore, concerned caregivers were encouraged to be <u>aggressive</u> in pursuing help for their children as this is their right and their responsibility as parents. Caregivers were also encouraged to remain attentive to marked changes in their children's behaviour and mood as a means of further protecting their children. Above all, the importance of caregivers maintaining

open communication with children was stressed, as well as relating to their children in a "non-blaming" manner. Donna-F stated that all her children now know how to prevent any further abuse. Helen-B came close to tears as she expressed that she had wanted to do as much as she could to help prevent Heidi-b from any future revictimization (which was part of her motivation for attending this parents group). Helen-B, who seemingly restrained herself from tears, moved the group to laughter instead of exposing her own vulnerability. Members were supportive of Helen-B in how difficult it must be for her to now "let go" of Heidi-b and return her to her natural family.

During the break, some caregivers expressed concern in regards to Lori-D's absence. Facilitators noted that group process was again somewhat more limited by the absence of a member, as group is now down to a total of four members. Again with a member missing today, the group often became more individually focused.

After break, one of the facilitators began the group exercise of the mother's letter writing to their children. The sentence completion format was displayed on the board and caregivers were asked to begin to think about how they wanted to answer these questions. This exercise will be completed next week due a lack of time remaining in today's session. See Appendix G for a copy of the sentence completion exercise.

In preliminary discussion of the exercise, Carol-C, in

responding to what she would do differently now, said if Cindy-c came to her complaining of pain in her genital area, said she would try to "get it out of her and explain it is not her fault". She also indicated that she was now "used to talking to Child and Family Services". The facilitators believe that caregivers have expanded their trust in outside helpers due to their positive experience post-disclosure and due to their present experiences in this treatment program.

Facilitators in commenting on children's group agenda today explained how the children have completed their disclosures and are completing their "release" phase of group, which has probably been the most trying and difficult for them. Facilitators normalized how as a result of this parents may likely experience some escalation in their children's behaviour (e.g., Heidi-b refused to leave after group last week). Parents were informed that the children will slow down this week and work more on learning to connect their feelings with their behaviour.

Note: Following this session, children's and parents' group facilitators discussed today's concerns regarding Lori-D and her childrens absence from group today. There was a growing concern due to the previous crisis of the children missing in week 7, as reported by Lori-D. Therefore, two of the facilitators went to Lori-D's home where they found her two children who had been unattended for an extended period of

time. Facilitators contacted CFS, who made the decision to place the children in emergency foster care overnight. The children seemed relieved to have secured safety, however, they appeared anxious about being placed in foster care once again.

* Although initially the children attempted to protect Lori-D, they eventually disclosed that she had been out on a "drinking". This exemplifies clearly the paradox presented to children in such families with regards to their desire to be loyal and protective of family members, and yet their need to secure their own personal safety.

SESSION THEMES:

1. Another one of the neediest natural mothers dominated most of the check-in with her individual agenda i.e., her apparent need to integrate issues and deal with her feelings stemming from her dyadic counselling sessions with her son, the offender. Again with only three member in attendance, the group has even more of a tendency to become individually focused versus focused on group process.
2. The foster mother expressed some degree of need and personal vulnerability for the first time in group. She expressed her anticipatory grief regarding her foster daughter's pending departure back to her natural family and was supported by her fellow group members.
3. Mothers discussed in hindsight what some of them would do

differently now to protect their children e.g., respond immediately to seeking outside help upon discovery of indicator of abuse. Facilitators increased the mothers awareness regarding community resources and helping agencies.

SESSION #10: Caregivers' Letters to their Daughters

OBJECTIVES:

1. Communication - To facilitate the caregiver's ability to express and share their feelings in regards to the abuse with their children.
2. Safety - To integrate learning from previous group sessions in regards to assuring their children's future safety.

AGENDA:

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

SESSION SUMMARY:

Facilitators began group by talking about the letter writing exercise. Members were shown an outline (see Appendix G) to guide the expression of their own thoughts and feelings. One of the facilitators acted as a "secretary" and wrote down what caregivers wanted to say to their children. The facilitators structured the exercise procedure as a means of:

1. providing an equal opportunity to members who had difficulty reading and writing; and
2. as a means of promoting the sharing of these thoughts and feelings openly amongst fellow group members.

Members were asked to use language that their children would understand.

Prior to beginning the letter writing exercise, facilitators instructed group that check-in would be time-limited. Members were asked to provide some general feedback (i.e., were they finding group helpful or not). Helen-B stated that Heidi-b has been more stable since coming to group and has been able to talk more about her feelings. Yet she expressed a continued desire for Heidi-b to have therapy sessions with her natural grandmother, who will soon become her primary caregiver. The other two members said that their children do not talk to them about group or their abuse, although Carol-C stated that Cindy-c does talk to her older sister, Cheryl-C, about the group experience. Donna-F said that Dee-f does not talk to her about group except to express

her desire to attend.

Group members were informed that the children would parallel the letter writing today by writing letters to their caregivers/mothers. There was then some discussion regarding the purpose of these letters (i.e., a means for facilitating communication of feelings and so as to begin having the parent and child talk with each other about the abuse). Members were told that there would be a mother/daughter sharing of letters in a dyadic session, facilitated through their case managers, towards the completion of groups.

Donna-F had more of a difficult time in completing her letter than other members, probably again as it was her son who had abused her daughter. Overall, the letter writing exercise was quickly completed as the group had been well prepared over previous weeks in regards to the purpose and structure of this exercise. The facilitators felt that the extended preparation for this exercise resulted in both the mother's thoughtfulness and comfort in sharing their feelings. The member's responses also reflected their supportiveness for their daughters and also an integration of the issues addressed in the mother's group to date.

After the letter were written, members were told that they could add anything they wanted to their letters during either this session or during a latter time. This led into a discussion around what the caregivers/ mothers would have done in retrospect if they had known their child was either being

abused or what they might do to increase the likelihood of preventing any future abuse. Donna-F stated that she would not have done anything different except but that she would be more aggressive in her pursuit of outside help in the future. The natural mothers in the group (with the exception of Donna-F) revealed their distrust of CFS by stating that her children would probably have been taken away if they had reported the abuse. Donna-F remained adamant that she trusted that the system would help her and said she would again firstly choose to report the abuse to CFS. Facilitators validated her for her willingness to break the secrecy, as had her children broken the secrecy by telling her, and for taking appropriate action to protect her children. Facilitators clarified the mandate of CFS (i.e., that children are not removed from their homes just because they have been sexually abuse, but are removed if parents do not act to protect their children). Members eventually conceded that it was better to tell CFS based on their own positive post disclosure experiences with CFS.

It was noted that none of the members signed "Love ____" to their letters but generally closed with "Mom". Facilitators hypothesized two possible explanations. Firstly, that this was either simply due to the fact that mothers were not doing the actual writing themselves. Secondly, that this perhaps reflected the difficulty the mothers have in communicating affectionately with their children, which is a

common concern in sexually abusing families. Based on the latter assumption, facilitators planned a joint Valentines party for the purpose of modelling and encouraging an appropriate exchange of affection.

SESSION THEMES:

1. Mothers continued to express their concern that their daughters do not discuss with them their past sexual abuse experience therefore today's parallel letter writing exercise was offered as a means of beginning to bridge this communication gap.
2. The mothers letters indicated that the mothers had integrated themes from the previous sessions (e.g., not blaming their child for the abuse and holding the offender responsible, empathizing with the pain of the experience on the child). However given that the mothers did not sign their letters affectionately e.g., love mom, this may be an indication of their difficulty expressing affection to their daughters.
3. A turning point in the group today was the growing level of trust amongst both the members themselves and amongst the members and the facilitators. This was exemplified by two of the natural mothers joining with one another to vent their distrust of CFS. Facilitators had previously been unable to challenge the natural mothers distrust of CFS, as they had not previously disclosed this

perception.

SESSION #11 : Boundaries: Physical and Sexual Boundaries

OBJECTIVES:

1. To both educate and reinforce the need for boundaries, for the purpose of clarifying appropriate roles as further means to preventing revictimization.
2. To encourage an appropriate exchange of affection between caregivers and their daughters, initiated by caregivers.

AGENDA:

1. Check-in time limited. Review this week's children's group agenda.
2. Review of last weeks letters from the caregivers to the children providing yet another opportunity for the mothers to add any final comments.
3. Discussion on privacy and boundaries through the use of examples.
4. A joint Valentine's party/celebration hosted by the caregivers for their children.
5. Review of the basic needs of children, i.e. security, safety, self-esteem, nurturance and affection.

SESSION SUMMARY:

Facilitators explained that overall, the behaviour of the

children had escalated over the last few weeks probably due to their group's concentrated focus on discussing their sexual abuse experience and sexual safety. As well, facilitators felt that the children were reacting to major changes going on in their lives (e.g., moving from one caregiver to another as in the case of two children). Therefore caregivers were advised that one group facilitator might excuse herself to assist the children' group leaders. Caregivers were informed that the groups would conclude today with a joint Valentines party hosted by the mothers. Members were very excited and supportive, commenting "you ladies think of everything don't you". Facilitators attempted to shift more ownership for the running of the party over to the mothers e.g., cutting the cake, filling out Valentine cards to their children, arranging the room.

Facilitators proceeded with check-in and Lori-D began by complaining about suffering headaches due to her children not listening, an indication of her tendency to inappropriately blame her children for her behaviour. Facilitators stressed the benefits of setting limits and consequences on children's behaviour, both for parents and for children. Further to this, group members offered other parenting suggestions to Lori-D.

Lori-D, dominated much of this week's session, explaining that she had not wanted to miss group last week but that she had been "stuck babysitting" for a friend who had unbeknownst

to Lori-D, decided to stay out all night. Members empathized with Lori-D on how difficult it is to be assertive with a friend. Mothers acknowledged this as a common problem for them all and for women in general. Lori-D was quick to say she would never "fink to Child and Family Services on her friend", saying "how do you think her kids would feel?" This statement appeared to be a projection of her own anger over last week's incident when her own children were apprehended by CFS as our treatment team had found the children had been unsupervised for hours. Facilitators, knowing that Lori-D had since debriefed the incident with her own case manger earlier in the week, waited to see if she felt comfortable enough to disclose her children's apprehension in group so as to further process this issue, however, she declined.

Lori-D informed the group that she had renewed a relationship with an old boyfriend and then went on to discuss how helpful he was being to her in parenting the girls and how much the girls themselves were requesting his presence. Facilitators again addressed Lori-D's blurring of the parent/child boundary by stressing the importance of her making her own relationship decisions without allowing her daughters so much decision making responsibility. Carol-C informed the group that her daughter, Connie-C, just had her baby and would be staying with her until she found her own accommodation. Carol-C continued to express wishful thinking, hoping that Connie-C would finally decide to settle down and

raise this baby herself. However, Carol-C remained quite doubtful given Connie-C's history of instability and alcohol abuse.

Caregivers were informed as to the children's parallel agenda of prevention and self-protection with discussions on good touch, bad touch, and how to say "no" as reinforced in their theme song "My Body, Nobody's Body But Mine". Facilitators discussed how the caregivers' theme for this week reinforces the children's learning as the mothers' activity is to judge and respond to various examples of physical and sexual privacy (e.g., is it okay for the children to bathe with others, if so with whom, and until what age?) Group members discussed what the rules or limits should exist for these kinds of situations and how to communicate these rules clearly to their children and others living and/or visiting in the home. Facilitators accentuated the need for caregivers of sexually abused children, to be especially vigilant to teaching, role modelling, and enforcing these boundaries, with a view to preventing revictimization. As well, it was stressed that because these children had been prematurely sexualized, they are at some risk to themselves to go on to victimize other children. Earlier in group session, Helen-B said Heidi-b had once touched a boy's penis at school. This was used as an example of how children are "at risk" to be reoffend or to be sexually inappropriate with other children. Lori-D was quick to say she has a rule with the girls about

one person in the bathroom at a time. Lori-D spoke of being especially careful in setting privacy rules when her boyfriend stays overnight. Helen-B spoke of Heidi-b's peculiar habit (e.g., her careful avoidance of looking at other people's body at the swimming pool). Carol-C said that her girls go to the bathroom alone but do continue to bathe together and sleep together. For Carol-C these sleeping arrangements reflect, in part, her economic and living conditions. Nevertheless facilitators stressed and challenged Carol-C to think about alternatives as to who could safely sleep with whom, and encouraged the girls to bathe separately as they are growing older. Facilitators reinforced the need for consistent boundaries regardless of the rationalizations presented by anyone. Members also discussed rules caregivers might enforce around nudity. Facilitators stressed that the children are learning that their bodies are private but that most importantly, they need this modelled and reinforced within their own homes.

At break, one of the facilitators was asked to assist in the children's group. The other facilitator proceeded with the remainder of group. The remaining facilitator balanced the preceding discussion on restrictions by raising the importance of mothers providing children with nurturance and affection. Members were asked how affection was expressed and what models they had from their own families of origin. Helen-B said she spends individual time with her children and

values the importance of being openly affectionate (e.g., with hugs and kisses). She said her family was very large and she did not "get a lot" from her parents. All members identified with Helen-B and said they, like her, came from large families where they did not " get a lot". Lori-D who was raised in foster care as a youth never felt she had received much in the way of nurturing in either her natural home nor in her foster home environments. She said she now shows affection by spoiling her kids with material gifts and affection. Lori-D was also self-disclosing in regards to her extreme anger towards her natural mother. Carol-C said Cindy-c always asks for hugs and kisses and that she responds in kind. Carol-C shared her experience of being raised in the residential school system for Native Canadians children. She says there was no affection shown towards her in either the residential school system nor within her natural family. Carol-C was therefore praised for her ability to do what she had never experienced herself (i.e., display openly her affection and warmth for her children).

The facilitators invited the mothers to prepare their Valentines cards for their children and to set up the party room. The children then joined the parents group with their Valentines cards in hand and both cards and affection were mutually exchanged. Children appeared very excited and yet very settled by the presence of their caregivers.

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

SESSION THEMES:

1. A reoccurring theme (emphasized by facilitators) is the need for mothers to better differentiate parent-child boundaries, assuming their appropriate parental responsibilities. Further to this facilitators educated mothers regarding the need for physical and sexual privacy boundaries to be enforced within the family unit.
2. The mothers supported each other on their growing need to be more assertive, especially with family and friends.
3. There was more discussion regarding the mothers own families or origin and most mothers admitted to having experienced much deprivation and little nurturance in their own families or from their alternative caregivers e.g., foster care, residential school system.
4. The Valentine Day party effectively reinforced and modelled nurturance and affection but again the mothers

assumed little ownership for this event.

Phase IV: Closure

SESSION #12: Answering Remaining Questions

OBJECTIVES:

1. To educate and to increase awareness with regards to offenders and the issue of family violence in general.

AGENDA:

1. Brief check-in.
2. Review of children's group agenda for today.
3. Discussion of follow up counselling available (e.g., family/ individual may be available through CRC) upon termination of group.
4. Formulation of questions regarding sexual offenders and family violence.
5. Guest speaker - Aaron Klein, M.S.W.

SESSION SUMMARY:

The need for co-facilitators was again reinforced this week as one of the facilitators was unable to join session until later due to a crisis in one of her family systems. Check-in was actually brief today. The remaining facilitator noted that case managers will be discussing with members the

termination of groups and the follow-up treatment options available. Lori-D was quick to share that she had already secured a helping agency for follow-up services which she felt was more culturally syntonic with her belief. Carol-C talked about Connie-C continuing to live with relatives due to her inability to find housing. Facilitators became concerned with the safety and wellbeing of Connie-C's newborn baby, due to knowledge of neglect and instability (as previously provided by Carol-C), and shared this with the case manager.

Members were asked to identify their questions for the speaker in advance of his arrival today so as to reduce their anxieties and to ensure that all their questions would be answered. Members were quick in coming up with their questions and required no assistance from the facilitators. It appeared that members had had these questions unanswered in their minds for some time and were anxious to finally have them answered. The questions generated were comprehensive and thoughtful:

1. Why do offenders sexually abuse? Is it because it was done to them in their families?
2. Are offenders actually helped when they get out of jail, or through the criminal justice system, or do they just go on to reoffend?
3. How do offenders feel about having sexually abuse children?
4. Can offenders ever really be cured?

5. Do offenders live in a certain geographic area? Are they of a certain race or culture or socio-economic status?
6. Does the sexual abuse of children occur mainly within families?
7. Do offenders feel suicidal after they sexually abuse?
8. Are offenders afraid of the consequences when they sexually abuse?
9. How do offenders get access to victims?
10. After counselling/therapy, do offenders ever apologize to victims?

The guest speaker commended members on the depth and scope of their questions. He then proceeded to answer all questions, while also inviting further discussion and participation from members. The speaker identified behavioral, social, and psychological indicators of a sexual offender. He emphasized the danger of secrets and social isolation with regards to any form of family violence. He also described the cycle of violence and the almost "addictive" behaviour of sexual offenders. Lori-D disclosed her history as a wife abuse victim and identified with the speaker's examples. The speaker shared his opinion on the need to balance both the consequences/punishment with treatment for offenders. He stressed problems with regards to limited treatment resources for offenders, and spoke of the offenders' needed to be genuinely motivated in order to change. The focus of discussion was on intrafamilial child

sexual abuse as more prevalent and more relevant to this group. He stressed that offenders inappropriately cross boundaries and use power and manipulation over their victims for their own gratification.

In closing, one member asked, if an offender knows her daughters have completed treatment for their sexual abuse, would her girls then be safe from any future offender. The speaker concluded by stressing that the education provided in the groups is helpful but provides no guarantees in preventing future revictimization. He stressed the role of the caregivers i.e., that overall, children need to be able to feel safe, to come and talk with their caregivers, and know that their caregivers will adequately protect them. It was apparent throughout this session, that members were extremely attentive to and comfortable with the speaker. Based on feedback from the members, the use of a guest speaker proved to be an effective means of providing education while enhancing and stimulating discussion.

Due to the success of last week's joint parent-child party, group concluded again this week with the children reuniting with their caregivers for a joint snack. There was also some initial discussion about group closure and both groups jointly discussed the planning of a farewell celebration.

SESSION THEMES:

1. The need for co-facilitators was again reinforced today with one facilitator needing to tend to a crisis phone call from one of the family systems.
2. Mothers appeared most attentive and welcomed having their questions regarding offenders answered as this may have contributed in some way to decreasing their own sense of self-blame for the abuse.
3. Again the danger of the secrecy dynamic perpetuating various forms of family violence was reinforced as was the danger of social isolation reiterated.
4. The concept of "magical thinking" reemerged when one of the natural mother's asked if her daughters attendance at these groups would prevent them from any future revictimization.
5. The joint parent-child snack at the close of groups again proved to be a positive, comforting gesture for both mothers and children.

SESSION #13: Closure: Social Networks and Other Resources

OBJECTIVES:

1. To educate mothers regarding support systems and coping - i.e., distinguish more positive means of coping and highlight the need for a social support network.

2. To help mothers to both identifying their child's needs and how to meet these needs.

AGENDA:

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

for next week.

SESSION SUMMARY:

It is important to note that this is the first week since the mid point of group that all four members have attended group. Operating the group with only three members has clearly limited the group process. This week was the last "working" session prior to the "graduation" party next week.

Check-in was very lengthy this session as two of the members had recently experienced many changes in their lives and were again presenting as needy of individual time in group. Their recurring neediness was likely due to this being the last working group members and/or missed meetings with their individual case managers. Lori-D stated that CFS-D was not her worker any more and that frankly she did not need CFS. She gave mixed messages in regards to her being sick of them bothering her, yet at the same time, stated she was proud that they were proud of her. The facilitators felt that her ability to reveal her mistrust of CFS further indicated her level of trust within the group. Lori-D informed group that her boyfriend had moved out. She spoke of feeling lonely and disclosed her urge to go out and get drunk but then thought of her children so she went and spent her money instead. This was defined as an improvement on past coping methods for Lori-D. Helen-B offered verbal support as Lori-D. continued to discuss the loss and the break-up.

Group members were asked about their own experiences coping with the ending of a relationship which nicely tied in to the theme of the group's pending closure. At this point, Donna-F who appeared very distressed informed group that she and her boyfriend had also just broken up and that he had also moved out. Donna-F was very open in sharing with group that she had been avoiding meetings for the past two weeks as she had been having arguments with her boyfriend and was coping by withdrawing and isolating herself. She expressed a lot of insight into feeling very misused by her boyfriend. She also talked at length and utilized the group regarding her pervasive anger and anxiety felt with regards to her son's sexual abuse of her daughter. She disclosed that she had vowed not to miss group today or to push helpers away in the near future, although she knows this will prove to be a challenge for her. Donna-F said that she recognized her need for support and said she felt guilty about her daughter missing group due to her isolation and withdrawal. Donna-F was given a lot of verbal support from the group for making the decision that she did in coming to group at all.

Carol-C told the group that she had asked Connie-C to move to her sister's as CFS was "calling and asking a lot of questions" about the children she herself was raising for Connie-C. She said that she didn't want CFS bothering her and revealed her own mistrust of CFS. Lori-D suggested that maybe CFS "wanted the baby" and said "they are bad for that". It

was reframed by facilitators that maybe CFS could offer the support that Connie-C needed so that the baby would be safe and could stay with Connie-C. Carol-C talked further about Connie-C wanting to give her baby to other extended family instead of keeping it, which Carol-C preferred rather than the baby going into care with CFS.

The discussion in group around relationships and loneliness led naturally into this week's exercise of making lists of coping methods while distinguishing between adaptive and maladaptive ways of coping. Group members used examples given earlier in the discussion and added to the list. The issue of coping with loneliness was discussed at some length as it was pertinent to group members at this time as identified during check-in.

Following the exercise on coping, the topic of social support was discussed. Network sheets were handed out to each group member and each category, (i.e., practical support, emotional support, crisis, safety and trust) was defined by facilitators. Group members were each asked to fill out the sheets listing people they had for support(s) in each category. Facilitators then assisted each member in filling out their network sheets.

Facilitators pointed out that it was important to have at least one person the mothers could count on for each kind of support, i.e., who is safe and who can be trusted. All members were able to identify one of more supports in each

category. See Appendix H for a compiled list of the results. The importance of broadening current supports was also discussed.

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

Facilitators provided members with positive feedback and validation for their accomplishments, i.e., coming to group and showing support for and a commitment to their children. Group members generally stated that they felt better having attended group and had learned a lot about sexual abuse, something they knew little about before. They stated that they learned something about safety plans and how to talk with

their children.

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

SESSION THEMES:

1. Two of the natural mothers admitted to struggling with alcohol abuse, depression, and social withdrawal as a means of coping with their painful feelings e.g., loneliness. The mothers dependence on men and their fears of independence surfaced.
2. The natural mothers fears of CFS resurfaced. They stressed their preference for keeping their children with extended family if possible.
3. It was evident from the exercise on identifying the mothers social support networks that the mothers are generally lacking sufficient supports and require more assistance in expanding their networks.
4. In preforming an informal group evaluation, mothers again expressed their main criticism as being too short a group duration and their having not yet having talked with their girls directly about the sexual abuse.

SESSION #14: Farewell Celebration

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

OBJECTIVES:

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

AGENDA:

1. Welcome to group members and significant others.
2. A Magic Show.
3. Organized games.
4. Snacks and prizes.
5. Free play and socializing time.
6. Graduation ceremony for children.
7. Congratulations cake.
8. Closing comments.
9. Resource table.

SESSION SUMMARY:

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

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

The graduation ceremony was headed by the children's group facilitators. They presented each child with a graduation certificate and made a brief comment in regards to the positive change and progress observed for each child. The mothers were also commended in general for their efforts in

participating in group and supporting their children throughout. Both the children and the mothers appeared very proud as did their significant others. The ceremony was closed by the children singing "My Body is My Own" and the serving of the "congratulations" cake.

All participants appeared comfortable and relaxed throughout the closing session. Closing comments included information with regards to the availability of the CRC for service and a "resource information" table was also set up for the parents and guests.

SESSION THEMES:

1. This "graduation" party proved to serve as a significant ritualized means of celebrating both the children's and mothers' accomplishments in the parallel groups.

LATENCY NON-OFFENDING CAREGIVERS/MOTHERS

GROUP SYNOPSIS

The caregiver's group primarily focused on providing education and social support to the children's mothers. The primary objective, which paralleled the children's group, was to assist the mothers in healing from their child's past sexual abuse experiences and above all to work to prevent any revictimization. To this end, mothers received education on a variety of topics which included: dynamics related to

sexual abuse; (third party, intrafamilial and specifically sibling incest, as this was the case for one mother) indicators (behavioral, psychological and physical) of abuse; human sexuality and talk with your child about this; sexual and physical privacy boundaries, protection and safety planning for the family; offenders (including indicators of) and cycle of violence in abusive relationships; methods of coping and the importance of social support networks; and professional resources available in community for future reference.

Mothers were supported to express their feelings regarding the abuse and to were encouraged, through various activities (i.e., joint exercises and homework, role modelling and the letter writing), to further and upgrade their communication with their children. In order to facilitate communication and to promote the mothers nurturing and affectionate exchange towards their daughters, therapists from both groups created joint time near the conclusion of the later sessions. This joint time between mothers and their daughters proved most beneficial. It proved reassuring and comforting to the children and it fostered the exchange of nurturance and affection (e.g., the joint Valentine's day party).

The social support and socialization that the mothers received through participation in the group (as well as nurturance from the therapists) appeared to meet many of their

basic needs and was self-reinforcing. This was evidenced by the good group attendance by most members during the dreaded winter months. However, due to the extreme emotional neediness of two of the mothers (half the group) who often presented as distressed and in crisis, the check-in period was most often dominated by these two mothers. One of these members, however was also a poor attender which further impeded the group process. Facilitators attempted to deal with these members crises in a planned way, by redirecting to them to their case managers, in an effort to limit their interference with the therapeutic group process. However, due to a lack of follow through with mothers keeping regular sessions with case managers and simply due to the extent of their neediness, this continued. This monopolization of group time by certain members impeded group process to some extent (particularly during sessions with only three members in attendance). Despite this, facilitators used their material, to highlight relevant group themes (e.g., protection, safety planning, coping methods) and dynamics related to sexual abuse and promote further discussion. Overall, other group members were empathic and offered ongoing support to these mothers in areas such as parenting and problem solving.

The mixing of natural mothers and foster mothers initially also proved challenging to the therapeutic process. The effect of this distinction in group somewhat dissipated after the one of the two foster mothers "dropped out" of

group. Initially, the foster mother assumed the ongoing job of role modelling in an educational fashion to the natural mothers. Some of her content proved very useful as she obviously had good parenting skills but her air of superiority needed to be challenged, as it left the natural mother feeling guarded and inadequate. Facilitators did this by modelling and reframing her initial comments to be less judgemental. As this foster mother began to discover more commonality with the natural mothers she felt less "different" from them and was subsequently more genuinely supportive, respectful and less judgemental. This discovery of this increasing commonality amongst members, occurred as they revealed aspects of their family of origin, and this proved to be the transition in group to creating more cohesion and an emerging group identity.

The final turning point in the group process occurred during the latter stage of group when members increased group cohesion, mutual trust and empathy were such that members risked increasingly more intimate self-disclosure. This may also have been due to the fact that group was coming to a close and therefore members felt safer in exposing their vulnerability. The foster exposed her emotional vulnerability and indicated her difficulty separating from her foster daughter (who was being returned to her natural family) upon completion of the group. The natural mothers proved supportive of her and validated her commitment to the

difficult job of fostering a child which appeared to also signify the natural mothers increased confidence. As well, some of the natural mothers, near the end of group confessed their distrust and misgivings about CFS in group. This could only be challenged and processed in a circumscribed manner due to the shortage of time remaining.

Based on the facilitators clinical observations and based on the mothers subjective feedback, in general, the group appeared to prove beneficial. It solidified the mother's support, commitment and progress towards mother-daughter's healing from the sexual abuse, it proved them with a positive experience of outside helping resources, it broke their sense of alienation and isolation, advanced their knowledge base regarding sexual abuse, family violence, and parenting in general and expanded their problem solving and coping repertoire.

GROUP EVALUATION:

In the interpretation of the clinical outcome measures (all self-report) and the group feedback forms clinical observations and findings will also be taken into account. Because facilitators administered the outcome data, it may be that clients answered in a way designed to please the facilitators.

GROUP FEEDBACK FORM:

Refer to Appendix I. Members unanimously found group to be helpful, which was consistent with their verbalizations in group. They felt group provided them with a greater understanding of sexual abuse and made them better able to protect their children. As well, they felt better able to communicate with their children which had been one of the group's primary objectives. In keeping with the theme of parallel groups, the mothers noted that they were aware of what their children were learning and doing each week. Members reported that they had specifically found the decreased isolation and alienation, and the opportunity to discuss their problems helpful. All mothers felt that they had a better understanding of sexual abuse, and that their ability to protect their children was now greater.

Only one mother, the sole foster mother, found anything "least helpful" about group and that, not surprisingly, (as indicated above in the group synopsis) was the check-in. With regards to mixing natural mothers and foster mothers in one group, all four mothers indicated this was either fine or actually good. However, one of the natural mothers, had approached a facilitator privately and said that on the contrary she genuinely felt that the mixing the mothers had not been helpful and she would not recommend it. Most members indicated that they had found it easy to talk with the group

facilitators and that they were always abreast of what their children were doing weekly in group. The group was divided with regards to the number of session, half felt the number had been adequate while the other half indicated the need for more sessions.

CLINICAL OUTCOME MEASURES - OVERALL GROUP EVALUATION

Refer to Appendix J.

FAMILY FUNCTIONING (BF-FAM)

The clinical outcome measures for family functioning, as measured by the BF-FAM III, are fairly consistent with the treatment team's clinical observations. For three family systems (Lori-D, Carol-C, and Helen-B) the pre and post scores remained fairly consistent (Refer to Appendix J). That is, Lori-D's score remained high within the comparison mean for clinical families which was consistent with the clinical observations of this family's highly dysfunctional nature and frequent crises.

For Carol-C and Helen-B (Refer to Appendix J), their scores increased only slightly, placing them within the comparison mean for normal adults. This finding appears appropriate for Helen-B, given that she was a foster mother who had demonstrated good parenting skills throughout the group. However, for Carol-C, her score appears somewhat low

and inconsistent with clinical observations. For example, in the area of role assignment, there was obvious confusion expressed, and yet not reflected by her score. She deferred responsibilities (e.g., any issues regarding sexuality) to her unstable, alcoholic daughter, (the girl's natural mother) when it was clear the natural mother could not fulfil any parenting role. As well, her score may have reflected her denial and or her desire to please the group facilitators.

Donna-F's score changed the most significantly out of all the mothers, with a major increase moving her into the comparison mean score for clinical adults (Refer to Appendix J). Although her pre-test score was very low, indicating little family dysfunction, this was totally contradictory with the treatment team's initial assessment of the family and was probably indicative of her initial distrust of the treatment team. While her post-test measure appeared most consistent with the team's clinical observations and indicated a highly problematic, dysfunctional family system. Perhaps as Donna-F became engaged in therapy, her own denial decreased and she became more aware of the family's deficits. As a result, their ongoing and perhaps increased degree of family dysfunction, this family was prioritized for ongoing follow-up at the CRC.

PARENTAL DEGREE OF DEPRESSION (BDI)

Refer to Appendix J.

Lori-D, again remained most consistent, showing little change in her scores. She continued to indicate symptoms of mild depression. Given that Lori-D's life continued to be in crisis throughout most of the group but given that she appears to externalize her feelings e.g., blaming others like her children for her problems, her BDI score is, therefore not indicative of a greater degree of depression. Both Carol-C's and Donna-F's level of depression apparently decreased. Carol-C experienced the most significant decrease moving from a previously moderate level of depression to no sign of depression, upon completion of the treatment program. Despite, Carol-C's quiet manner in group, given her commitment to group as evidenced by her perfect attendance, it appears that she may have benefitted from the intervention package. It is possible that Carol-C initially internalized blame and guilt for the sexual abuse, due to her shy, nature. However, despite her limited verbalizations in group, the entire group was perhaps experienced as supportive and confidence building in helping her work through her feelings regarding the sexual abuse. Donna-F's level of depression also decreased, just slightly, and remained in the moderate range. Again this score is fairly consistent with her ongoing presentation of having "bad nerves" and feeling "eaten up inside" by the

sexual abuse experience. This score is also consistent with her BF-FAM, in indicating that further follow-up is warranted. Finally, Helen-B's level of depression increased slightly from almost no depression to some mild indicators of depression. This finding is consistent with clinical observations but not of concern as she has appropriately started to grieve the upcoming move of her foster daughter back to her natural parents.

PARENTAL ATTITUDE TOWARDS THE CHILD (IPA)

Refer to Appendix J.

Lori-D and Donna-F showed the greatest increase in scores. This was especially significant because their pre-test scores (with the exception of Laura-d) were already indicative of clinically significant problems, upon the initial intake. However, now their post-test scores indicated a very severe degree of parent-child problems.

Lori-D had missed therapy sessions during the latter phase of treatment, which coincided with her being in crises (e.g., going on an a alcohol binge and her children briefly being apprehended by CFS, and then her striking one of the girls). She was presenting, in the later stage of treatment, as somewhat defeated in attempting to parent her daughters. Her post IPA scores may have been more indicative of her own sense of frustration and defeat, with the job of parenting,

then truly a reflection of her relationship with the girls, although one area no doubt spills over to the next. Lori-D may also have projected her own negative feelings (e.g., of guilt and blame, for the sexual abuse which may have surfaced during treatment), onto the girls, perceiving them as "the problem". Regardless, the treatment team was very encouraged that Lori-D continued to be motivated to change and had sought out more culturally syntonic counselling resources for follow-up treatment.

Donna-F's severe increase in parent-child problems with her daughter was consistent with the clinical team's observations of their relationship. This mother and daughter appeared totally withdrawn and emotional distance from one another, increasingly so as group progressed. The ongoing concerns of the treatment team included the daughter's need to for dyadic therapy with her mother, due to the girl's sense of rejection and her already internalized sense of blame. This situation escalated during the course of treatment, to the point where the daughter had expressed suicidal ideation during one of the latter group sessions. As well mother's inconsistent attendance, which resulted in the daughter's inconsistent attendance as well, probably only served to further magnify their problems. Again, this is a family which the treatment team prioritized for ongoing treatment through the CRC. The questions remains as to whether or not the mother will commit herself to this treatment being offered.

Carol-C, once again, like Helen-B consistently retained the lowest IPA scores with little, to no change, indicating a consistently good parent-child relationship with few problems. Clinical impressions are consistent with these findings. These two mothers, had exemplary attendance which was just one sign of their ongoing support and commitment to their children's healing.

SUMMARY OF FINDINGS

Refer to Appendix J.

Generally, the clinical outcome measures for this group of mothers appeared consistent with the treatment team's clinical observations. There appears to have been a split in the group, with two mothers outcomes indicating a severity of problems while the other two members maintained their strengths with few difficulties. Lori-D and Donna-F indicated a high degree of family dysfunction post treatment and a severe range of parent-child relationship difficulties. While their depression scores also maintained their stability within the mild and moderate ranges respectively.

Whereas the trend for the other two mothers, Carol-C and Helen-B indicated a slight increase in their BF-FAM scores, however, this only brought them up to the low to mean normative range for normal adult, indicating family strength with only minimal family dysfunction. While their IPA score

also corresponded and remained consistently low, indicative of their supportive parent-child relationships.

In examining what accounted for this split in outcome, the following hypotheses exist: In the case of Lori-D and Donna-F, their own extreme emotional neediness was evident from the onset. This emotional neediness remained consistent throughout the group process and probably contributed to their ongoing difficulty be very supportive of their daughters despite their motivation to do so. Although, little is know of Donna-F's history, it is apparent from Lori-D's history, that she was raised in a dysfunctional family and experienced much emotional deprivation which would account for her current clinical presentation. As well, due to the neediness of these two mothers, they were often experiencing their own personal crises making their regular attendance at group difficult. This also limited the extent of their ability to benefit from this short term treatment program. Therefore, as they both greatly warranted ongoing treatment, these two family systems were offered ongoing treatment through the CRC.

Finally, the relationship of the mother to the offender must be considered. The fact that Carol-C and Helen-B had no emotional connection to their child's offender, easied their ability to be supportive of their children whereas, for Lori-D, and especially Donna-F, they had/have an emotional connection with their children's offenders and expressed more ambivalent feelings towards the offenders which may have made

it more difficult for them to clearly support their daughters.

CHAPTER FIVE

FAMILY SYSTEMS INTERVENTIONS

This chapter will include a review of each of the two key systems i.e., System I and System J, for which this author held primary responsibility as case manager.

CASE STUDY FOR FAMILY SYSTEM-I

Primary (Individuals) referenced in the following case study:

Gert-I:	natural/biological mother
Gail-i:	identified patient, group participant, thirteen years old
Georgina-I:	natural sister, eleven years old
Garth-I:	mother's ex-boyfriend and friend, Gail-i's offender
CFS-I:	Child and Family Services social worker

REFERRAL SOURCE AND BACKGROUND INFORMATION

CFS-I contacted the CRC to refer Gail-i and her mother for treatment regarding Gail's history of sexual victimization. CFS-I expressed concern that Gert-I would not

attend group therapy but wondered whether the treatment team would breech their criteria so that Gail-i could still receive group therapy. The mother was motivated to find help for her daughter who was herself motivated to receive therapy. CFS-I hoped that this mother would "change her mind" and enter into therapy as CFS-I believed this family warranted therapy.

During the initial telephone referral CFS-I indicated that Gail-i had first disclosed her sexual abuse by Garth-I to her mother in June of 1991 but the mother had not reported the abuse. Then Gail-i again disclosed to her school counsellor in September of 1991, at which point the school involved CFS-I. CFS-I subsequently apprehended Gail-i for approximately two weeks as they doubted this mother's ability to protect her daughter due to the mother's apparent lack of support regarding the initial disclosure, due to CFS-I's historical concerns with regards to this mother's neglect of her daughters, and due to her suspected abuse of alcohol. Gert-I obtained a lawyer, fought CFS-I and Gail-i was returned home. Since this time the family refused any further voluntary contact with CFS-I.

INITIAL PRESENTING PROBLEMS

Due to difficulty reaching the family on the telephone and then due to an apparent telephone misunderstanding, Gert-I simply arrived at the start of the third adolescent group

session with Gail-i without attending a pre-group interview. Gert-I immediately stressed her dislike and complete distrust of CFS-I. She stressed that her prerequisite to consent to treatment for Gail-i was that CFS not be involved or contacted by the treatment team. The therapist advised the family that she would only contact CFS-I if she believed the children were in need of protection or to report any new disclosures of abuse reported during the course of treatment. Gert-I agreed to this and allowed Gail-i to attend the adolescent group but remained adamant that she would not attend the parallel mothers' group. She did not feel she required any treatment as she had already "put the abuse behind".

CLIENTS' PERCEPTIONS OF THE PRESENTING PROBLEMS

Gert-I said that in addition to the sexual abuse by Garth-I, Gail-i had also just disclosed to her school counsellor that she had been raped by an adolescent at a party in August of 1991. Gert-I wanted Gail-i to get help so that she could "get over this" (the sexual molestations) ..... "so they don't interfere with the rest of her life". Gert-I clearly distinguished that it was Gail-i not she who needed help for the sexual abuse. The family's world view clearly encompassed a distrust of involving outside helpers. Gert-I stressed that she alone deals with the things that happen in her life and she simply " gets on with" the rest of her life

despite such hardships and tragedies. Gail-i, herself expressed wanting help for her sexual victimization by Garth-I. She was protective of her mother saying she had not shared many of her fears and reactions to the abuse with her mother as her mother had enough to deal with working and maintaining the family.

Another reason Gail-i may have not been more accessible and self-disclosing with her mother was her expressed concern about the lack of empathy and support she received from her mother. Gail-i expressed concern over the fact that her mother continually distrusted her. Gert-I explained that Gail-i had been acting very out of control (i.e., abusing alcohol, breaking curfew, partying) throughout the past summer. Gert-I said that although Gail's behaviour had greatly improved over the last two or three months she continued to worry and wonder whether she could trust that Gail-i's improved behaviour would continue. Gail-i expressed feeling that her mother viewed her as a criminal ("mom's got spies out on me everywhere"). Mother admitted that she is now hyper-vigilant to Gail-i's whereabouts. As Gail-i's role in the family was historically described as that of a parentified child her mother's current lack of trust in her appeared to be perceived by Gail-i as a further injury to her self-esteem. In discussing the family's safety and legal prosecution of the offenders, both mother and daughter colluded in their refusal to provide police with any statements in an effort to avoid

charges being laid. They adamantly refused to be challenged on their world view that involving the police authority does not protect them but only puts them at greater risk. Gert-I explained that she had grown up "streetwise" and she would continue to use her streetwise skills to keep her daughters safe. Gert-I described how she had already confronted Garth-I who denied the offense and how she had subsequently threatened him, should he not leave her family alone.

FAMILY HISTORY OF SEXUAL ABUSE

MOTHER:

When asked if she had ever been sexually abused, Gert-I said "it was more like a game" and went on to disclose that a family friend (age 17 years at the time) had sexually fondled her when she was seven years old. Gert-I had never perceived this event as sexual abuse. She denied any other sexual abuse experiences.

DAUGHTERS:

Gert-I disclosed that two years ago she had been alerted by the school principal that an eighteen year old male neighbour in their housing development had involved a number of children, including her daughters Gail-i and Georgina-I, in sexual games. These games engaged the children in various sexual acts (e.g., disrobing, kissing). Gert-I said this

offender was subsequently charged. Gail-i declared that her involvement in the games had been minimal and overall minimized the sexual nature of the games. Gert-I also appeared in deny the seriousness of the situation and declared that she remained unsure as to what had actually happened. Georgina-I who had originally given a statement to police saying that she had been forced to perform fellatio on the offender later withdrew her statement, claiming she had lied. Given the family's distrust of involving any outside authority (such as the police) it is not surprising Georgina-I withdrew her allegations.

More recently Gail-i disclosed that Garth-I who had also acted as a substitute caregiver for years while Gert-I worked, had sexually and physically abused her from ages eight to eleven. The abuse finally ended when Gert-I, still unaware of the sexual abuse, discontinued Garth-I's role as caregiver due to his ongoing, intense conflict between he and the girls, most particularly with Gail-i. Gail-i was asked by the therapist to write (as she felt unable to verbalize) a history of her sexual abuse experience. Gert-I was, for the first time, made <u>aware</u> of the extent and the nature of Garth-I's offenses. Over the course of four years, Garth-I had terrorized Gail-i forcing her to engage in increasingly advanced sexual acts moving from fondling to cunnilingus and fellatio, then progressing to simulating intercourse, and finally attempting anal and vaginal penetration. Gail-i also

described how physically abusive Garth-I had been to her (e.g., he attempted to choke her on several occasions and had bruised her body). It appeared that Garth-I had abused Gail-i in a fashion similar to that of an abused wife, indicative of some perception of role reversal on his part. Gail-i's diary revealed the isolation she had felt and her feelings of shame, guilt and worthlessness. Unfortunately, Gail-i was again revictimized this past summer, when she became intoxicated at a party and was later raped by an adolescent in attendance at the party.

FAMILY OF ORIGIN

Gert-I was born the middle child of a poor farm family of seven children. She was born to a mother of Native ancestry and a father of German ancestry. She remained quite vague when she described her parents and her siblings. She described her father as having been" hard on her" mother and queried whether her mother had also suffered an emotional break down at some point. She described that her mother, in return for the maltreatment by her father, had been harsh on her children. Gert-I felt she had a special status in her family as she was spared much of her mother's wrath in comparison to her siblings. Gert-I described that she was presently in a parentified or caretaking role (e.g., needing to help them find work) with regards to her siblings. She

described her parents as being of little support to her and only felt burdened by her contacts with them. She described that she continued to be emotionally close and acting as a caretaker for her mother, while she was more distant with her father. She denied any abuse by either parent.

Gert-I's mother suffered a major debilitating stroke in her mid-thirties and was subsequently placed in institutional care. Twelve year old Gert-I and her two sisters were placed with their grandmother. A year later the children were placed in foster care as grandmother could no longer manage. Gert-I continually ran from her foster homes and eventually ended up in a detention home. It appeared that in an effort to emancipate from her child welfare placements, Gert-I, at the age of sixteen, became involved with an alcoholic common-law partner, many years her senior, who repeatedly physically abused her. Soon after she was pregnant with their first baby, Gail-i, whom her alcoholic partner also physically abused. Three children later, and after five years of living in this abusive environment, Gert-I finally escaped with her daughters.

Soon after this Gert-I began a relationship with Garth-I who showed a tremendous interest, not only in her, but in her children. This had impressed her. A destructive repetitive pattern for Gert-I appeared to have developed, that is: her quick attachment and subsequent dependence on controlling, abusive male partners. After a few years of dating Garth-I

(she denied he lived with the family) Gert-I ended the relationship as he was far too controlling and "strange" (e.g., he equated himself to God). Yet she continued to rely heavily on him as a substitute caregiver for her girls. She explained this was because she desperately needed to work evenings and had difficulty securing anyone else as a babysitter. Gert-I is presently in another relationship with a man whom she defined as "decent" and "nothing like the others". To date, Gail-i has also attested to this description and has consistently denied any abuse by mother's present boyfriend.

INTERGENERATIONAL THEMES

In contrast to her own childhood experience, Gert-I felt her own children "have nothing to complain about" as they have far more physical and material comforts than she ever had as a child. She recognized the importance of satisfying the physical needs of her children but neglected to recognize the importance of satisfying emotional needs (i.e., for nurturance,safety and security). This is perhaps as she herself apparently never had these needs satisfied by her own parents. This behaviour was never modelled for her in her own family of origin.

It is significant that Gail-i is now the age Gert-I was when she was removed from her family, apprehended by CFS, and

placed in foster care where she began to act "bad". Gail-i has shared her mother's experience as she was also apprehended by CFS for a brief period. This perhaps helps to understand Gert-I's present hyper-vigilance towards Gail-i and her complete distrust and apprehension of CFS. Gert-I appeared to have projected and relived her own fears of abandonment which she experienced in her on family of origin through her recent experiences with Gail-i's apprehension. Gert-I is compelled to duck the CFS authority. In her view, they are responsible for stealing children from their parents, hence depriving both the child and the family. This has been her experience as a child, and now as a parent. She believes that in such situations, both parents and children are innocent victims of the system.

The parentification of children who are left to care for themselves; coupled with an extreme protectiveness of ones parents, especially of ones mother; appear to be intergenerational trademarks or themes within this family. Another theme is the inability of parental figures in this family to be empathic, nurturing, and emotionally connected with their children.

SUMMARY OF CONTACTS

Regular dyadic sessions were maintained with twelve contacts attempted but only six contacts completed. Contacts

focused primarily on the mother-daughter dyad but because the mother failed to attend, two individual meeting were held with the daughter. These individual sessions focused primarily on strategies to reengage the mother, and on helping prepare the daughter to talk with her mother. In the mother-daughter sessions both parties presented as very defended, guarded and colluded to protect each other. This kept the therapist, the "outsider" out thereby maintaining their closed family system. Neither mother nor daughter presented with much motivation to improve their dyadic relationship. However, with regards to group treatment, Gail-i seemed comfortable with the group context and content. She was very much a group leader and exemplified good social skills. Nevertheless, she consistently maintained limited self-disclosure in group, with regards to her family. Perhaps in this way she maintained loyalty to her family.

SUMMARY OF TREATMENT THEMES AND INTERVENTIONS

It is important to note that it was the therapist's agenda to engage this mother and daughter in dyadic work, especially as this case did not meet the team's screening criteria in that the mother refused to attend the parallel caregivers group. It had never been the mother's desire nor intention to engage herself in any part of the treatment contract except to provide transportation for her daughter.

She remained adamant that she did not require any help but clearly wanted to secure help for her daughter. The treatment team was equally firm in their view that the daughter should not participate in group without her mother's participation in some form of treatment.

As Gert-I remained adamant she would not attend mother's group the therapist's alternative, which she passively accepted, was dyadic counselling with her daughter. Her passivity and reluctance was exemplified by the fact that she attended only half of the scheduled dyadic meetings encouraged by the therapist. Clearly family therapy had never been this mother's priority but instead that of the therapist. Hence, from the onset the dynamic which ensued was the family's passive resistance to meeting the treatment contract which had been created from the therapist's agenda versus that of the clients. Engaging and joining with this mother-daughter dyad therefore proved very difficult, as both were very well defended. This mother withdrew from attending particularly after a session in which the therapist had challenged her parenting skills.

The challenge in working with this system was not to repeat and mimic an authoritative role similar to that of CFS. That is, to pressure this mother into becoming a better parent. This proved to be a difficult and tempting challenge as it was evident from the onset that she continued to be vulnerable to inadequately protecting her children. The

challenge for this therapist was instead to support the mother while also supporting the daughter and to gradually help the mother herself come to her own insights about her parental responsibility with respect to her children's safety and protection (rather then the therapist becoming yet another outside authority criticizing her parenting skills. This anticipated criticism only reinforced her view of the need for the family system to remain closed.

Gert-I was credited for her ongoing support of Gail-i's participation in the early adolescent group as evidenced by her transporting her to and from group and by purchasing a large cake for her to share with her fellow group members during their final group celebration.

Significant issues for this mother appeared to be: her constant need to distance from any emotional or affective discussion with her daughter, her reluctance to support and validate her daughter, her longstanding and continued parentification and role reversal with Gail-i, and her overwhelming resistance to review the sexual abuse experience in order to acknowledge what needed to change (seemingly for fear that this would expose her own feelings of guilt and blame which she consistently denied and guarded against). As she denied any responsibility for the sexual abuse or what needed to change as a result of the abuse in order to better protect her daughters, a safety plan and safe guards regarding current caregivers and mother's boyfriend was only briefly

reviewed.

Gert-I's only goal for therapy was to receive reassurances (i.e., a guarantee from her daughter that she would no longer exhibit dangerous "acting out" behaviour). However, Gert-I was reluctant to accept Gail-i's reassurances nor were her actions congruent with these reassurances. That is, if Gert-I trusted Gail-i, she would need to validate her daughter.

Significant issues for Gail-i were: her aggression towards her sisters, her growing internalized frustration with her mother's parentification of her, her frustration with her mother's ongoing inability to trust or validate her, her difficulty talking with her mother about any of her frustrations and some "post-traumatic" like symptoms (e.g., fears and nightmares involving her offender) which were triggered by a phone call from her offender.

Gail-i displayed more insight then did her mother into her own individual treatment issues, but shared her mother's difficulty raising and addressing their relationship. She appeared to fear risking even further rejection by her mother. Gail-i invested more energy and worked harder within the group context on her individual issues of victimization then she did on the relationship with her mother within the dyadic sessions.

SUMMARY OF CHANGE WITHIN THE FAMILY SYSTEM

It proved difficult within this brief an intervention to initiate much substantial change within this mother-daughter dyad. As this family was very apprehensive and distrustful of helpers, any intervention needed to proceed very slowly in order to prove successful and this was difficult to accomplish within a brief model of therapy. The gains made within four sessions were limited. This mother was made aware of the extent and nature of her daughter's sexual abuse. She clarified to her daughter her absolute belief in the authenticity of the sexual disclosures and clarified that complete responsibility was totally with the offender alone. The mother and daughter also received some education with respect to the dynamics of sexual abuse in general, thereby contributing in some way to deter further revictimization. Furthermore, the mother explored the safety of her present babysitting arrangements for her daughters. The mother was assisted to begin to empathize more with her daughter (e.g., she better understood why her daughter may have kept the abuse a secret or had attempted to show signs indirectly and mother therefore felt less angry and less betrayed). She also understood some of the effects on her daughter's behaviour as reactions resulting from her sexual victimization (e.g., her testing of the safety with her mother's current boyfriend). The parentification of Gail-i (another

intergenerational theme) was identified and the need to decrease this was stressed. The mother initiated only limited change in this area, perhaps in part due to her own limited social support network. Gail-i may have also been unconsciously reluctant to abandon this position due to the elevated hierarchical status it provided her within the family. Gail-i may have been able to abandon her parental role only if it had been substituted with more validation from her mother for her other talents and strengths.

EVALUATION OF THE FAMILY SYSTEM

	Gert-I		Gail-I	
	BF-FAM	BDI	BF-FAM	IES
Pre score	31	0	20	44
Post score	NOT COMPLETED (NC)		16	NC

Gert-I 's pre BDI score of zero indicated she was not experiencing any depressive symptoms. Because of her general level of apprehension and distrust, this score of zero indicating no symptoms of depression was thought to be how she felt she should respond, versus a true response. This zero score is also consistent with the therapists observations of her denial and repression of any negative feelings (e.g., guilt or blame) related to the sexual abuse experience. She

refused to complete the IES as claimed it was "irrelevant" for her therefore Gail-i alone completed this measure. Gert-I's pre brief FAM III score of 31 was consistent with the mean range score for clinical families. Specific items of concern for Gert-I within the family revolved around "role assignment" and "communication" which proved somewhat consistent with therapist's observations. That is, it was not clear who should do what functions in the family and that direct verbal communication was problematic.

Due to the family's irregular attendance, the final dyadic session was used to complete termination of therapy with the family and no time remained to complete the post measures (as mother allowed only a limited amount of time). Hence, the post measures were sent home to be completed and returned but they were never returned. No other measures were completed by Gert-I.

Gail-i's pre IES score of 43 indicated a score higher than the comparison mean score (Horowitz, et al., 1979). This indicated a high subjective stress reaction in response to the crisis of the sexual abuse for Gail-i. This is consistent with Gail-i's reports of post-traumatic symptoms and her personal distress resulting from the sexual abuse. This is also consistent with the family's denial of the meaning and consequences of the sexual abuse experiences. It is interesting to note that Gail-i's avoidance subscore which identifies unconscious aspects of denial was also higher than

the clinical mean. This again confirmed her tendency to deny and repress the impact and consequences of her sexual abuse. Her pre FAM III score was 20, which is well above the mean score for adolescent's in the clinical population which again (as was with Gert-I's BDI score) raised the suspicion of the influence of a high social desirability effect which was consistent with this girl's distrust and denial. Her post FAM III score was reported to have decreased down to 16. This indicated that family functioning had slightly improved in her view. However, this score may also have been indicative of the ongoing denial of family problems or problems in family functioning.

CASE STUDY FOR FAMILY SYSTEM-J

Primary (Individuals) referenced in the following case study:

Pauline-J:	maternal grandmother, caregiver for Pam-j
Pat-J:	natural /biological mother
Pam-j:	identified patient, twelve years old, adolescent group member
Penny-J:	natural sister, fifteen years old, under the care of C.F.S.
Phil-J:	Pam-j and Penny-J's offender
Penner-J:	Peter-J's biological father and Penny-J's offender
CFS-J:	Child and Family Services social worker

REFERRAL SOURCE AND BACKGROUND INFORMATION

CFS-J referred Pam-j and her mother to the CRC for sexual abuse treatment. Pam-j recently disclosed to her sister Penny-J, who resides in a group home under apprehension of CFS that, like her sister, she to had been sexually abused by Phil-J. Phil-J had been a border with their grandmother who at the time of the abuse had been Pam-j's primary caregiver. Penny-J promptly reported this disclosure to her group home worker who then involved CFS-J.

CFS-J originally became involved with this family two years ago in response to Pat-J's inability to control Penny-J which had resulted in some physical abuse by the mother. Penny-J was consequently placed in the care of CFS. Pat-J, a single parent mother, has had a long history of difficulty parenting. As a result of this, Pam-j was raised by Pauline-J from the age of five up until recently (four months prior to the referral to the CRC) but was recently returned to her mother (at the mother's request) due to Pam-j's behaviour (e.g., she had been involved in setting a fire). CFS-J was also seeking support for Pat-J with regards to parenting Pam-j who was quickly proving to be "too much" for Pat-J to handle. CFS-J anticipated that, like her sister, Pam-j might soon end up in foster or residential care. CFS-J also expressed concern for the intergenerational, multi-problem nature of this family.

CLIENTS' PERCEPTIONS OF INITIAL PRESENTING PROBLEMS

Pat-J and Pam-j attended a pre-group interview which was very brief at Pat-J's insistence. This mother and daughter presented as anxious and apprehensive both with the process and with each other. Pat-J was guarded, defensive and impatient while Pam-j appeared frightened and remained fairly quiet throughout most of the meeting. However, when asked, Pam-j explained that Phil-J had abused her when she was six years old. Pat-J interjected that this disclosure had only come to light 2 to 3 weeks ago and that she did not know whether she yet believed Pam-j. Pat-J queried whether Pam-j was simply using these allegations for attention.

It was obvious from the point of intake that this mother was having difficulty supporting her daughter and that their was much tension and conflict between them. Yet despite their apprehension, both mother and daughter agreed to attend the parallel sexual abuse groups offered. Pat-J specifically wanted help for Pam-j as she feared that Pam-j was at great risk to run away and become involved in prostitution.

Within the first week of mothers' group Pat-J presented in crisis with regards to managing Pam-j's behaviour. She was concerned that too much attention and importance was being placed on Pam-j's sexual victimization versus her "bad behaviour". She declared that her concern was Pam-j's present destructive behaviours (e.g., beating up her brother, fighting

at school, leaving her dirty underpants in her drawers, not listening and getting into trouble) which were proving to be too great a parenting challenge for her. Pat-J adamantly refused to consider that the two (i.e., the sexual victimization and some of these obnoxious behaviours) might be connected and she continued to reiterate that Pam-j was using the disclosure as an excuse for her present "acting out" behaviour.

FAMILY HISTORY AND INTERGENERATIONAL THEMES

Within this family there exists an intergenerational history of sexual abuse, spousal abuse, family violence, alcoholism and teen pregnancies dating back at least three generations. The family present with a limited social network and present as a very enmeshed, closed system with a high degree of triangulation amongst the three generations, with members vacillating between the role of victim and aggressor.

To begin, grandmother, Pauline-J was sexually abused as a child by her own mother's boyfriend. Then later she was pregnant at fourteen and was subsequently twice married to violent, alcoholic men. Her latter husband sexually abused her eldest daughter (Pat-J's sister), his step-daughter. There is also great suspicion that Pat-J was also sexually abused. Although she has not yet formally disclosed, she has questioned her own sexual abuse as her memory of childhood is

for the most part totally repressed. The few memories that she recollects are violent and painful. Pat-J also has a psychiatric treatment history of depression, suicidal attempts and hospitalization.

Pat-J, like her mother, was a teenage parent at seventeen with Penny-J and lived with her mother. Pat-J has had a long history of dependence on her mother, especially with regards to her mother raising her children for extended periods of time. As well, Pat-J has a long history of physically abusive, destructive common-law relationships. Each of Pat-J's children have separate biological fathers. Pam-j's father is described as having been alcoholic and physically abusive. Pam-j has minimal contact with her father.

Already both of Pat-J's daughters have been sexually abused. Penny-J was sexually victimized by her step-father (her brother's natural father) when she was approximately seven/eight years old. At this same time, Penny-J (was revictimized) as she and Pam-J (then approximately 5 or 6 years old) were both sexually abused by Phil-J.

SUMMARY OF CONTACTS

Pat-J attended three of the five parallel mothers group sessions. This mothers' group began with small numbers and then dissolved due to "drop-outs". Pat-J was one such "drop out". She left prior to the close of group.

As Pat-J had initially presented in crisis over her inability to manage Pam-j the treatment team made efforts to pursue her and as such offered a home visit to meet with her individually at her earliest convenience. She cancelled this meeting and subsequently withdrew from any further treatment.

Pam-j was subsequently placed with Pauline-J following a physical assault by Pat-J and due to Pat-J's withdrawal from any form of therapy. The therapist attempted to offer service to Pauline-J as she was once again the primary caregiver to Pam-j, and attempted to reengage Pat-J in therapy through joining with Pauline-J and asking her assistance. One home visit (a case planning session) transpired with Pauline-J, CFS-J and the therapist (Pat-J refused to be involved). There was also telephone contact with both Pat-J and Pauline-J who expressed ongoing concerns for Pam-j and questioned whether the adolescent group was helpful for her. Throughout this period Pam-j continued to attend the adolescent group, only missing two out of the fifteen sessions. While the therapist encouraged Pam-j to also engage in individual sessions the result was only one session at which point Pam-j confirmed her unyielding desire to enter into "care". By way of follow-up for Pam-J, upon completion of the adolescent group, the therapist recommended individual therapy once a stable placement was found and a support worker secured (which had been a recommendation from the onset by the therapist).

SUMMARY OF TREATMENT THEMES AND INTERVENTIONS

Initially, the priority in working with this family system was to join with Pat-J in an effort to provide crisis intervention (to include a safety plan) with regards to her parenting of Pam-j. Further to this, to begin to encourage Pat-J to move to empathize more with and support Pam-j around her sexual abuse and then to facilitate this process if possible. As well, to offer appropriate individual support and therapy for the mother due to her "neediness". As the mother-daughter conflict quickly intensifying and as Pat-J simultaneously hesitated, in committing herself to begin any family intervention, within weeks a crisis resulted (i.e., Pat-J physically assaulted Pam-j, leaving her with a black eye and a bruised and swollen nose).

CFS, aware of the assault, assessed the need to temporarily place Pam-j with her grandmother to ensure her safety but had intended to return her immediately to Pat-J, believing Pat-J was committed to and actively engaged in therapy through CRC. The therapist advised CFS that clearly Pat-J had not yet committed herself to the therapeutic process in that, to date she had only sporadically attended the mothers' group and had postponed the start of any family intervention. As a result of this informational exchange, CFS deemed that Pam-J should continue to reside with Pauline-J pending her mother's ability to take responsibility for the

assault and commit herself to individual and family therapy as a means for ensuring a plan of safety. As Pat-J perceived this stance by CFS to be a personal defeat (as her other daughter was also in care against her wishes) she retreated "into hiding" and withdrew from any further contact with CFS or CRC. She displaced her anger and blamed Pam-j for the incident and subsequently punished Pam-j by avoiding and withdrawing completely from her and from any form of therapy.

The significant challenge in intervening with this system was to assure Pam-j's safety while maintaining neutrality with regards to CFS. That is, to provide CFS with necessary treatment information (which resulted in the apprehension), but also to distinguish with the family that the decision to place Pam-j was that of CFS (whose mandate is to protect children) not that of the therapist. Also, it was important to emphasize the therapist's desire to ally <u>with, not against</u> the family in an effort to keep CFS from being on "their back" and have Pam-j returned to Pat-J. The therapist offered to assist the family in devising a plan to propose to CFS, in the effort to secure Pam-j's return home. Overall, the therapist was unsuccessful as Pat-J perceived the apprehension as a sign of the therapist's alliance with CFS against her. Therefore, the therapist had little hope of joining with this parent to provide treatment. Despite the therapist's efforts to reengage with Pat-J, the damage done proved irreparable.

Subsequently, efforts were made to engage Pauline-J and

Pam-j in dyadic therapy in an effort to sustain this placement within the family but this also proved impossible as neither were motivated. Therefore, near the end of the group therapy Pam-j was eventually placed in a series of foster homes. This inability for the family to stay united may have resulted from the intense triangulation in the family (i.e., Pauline-J and Pat-J against Pam-j; Pam-j and Penny-J; against Pat-J; and so forth). Pauline-J expressed a feeling of divided loyalties i.e., being torn between her loyalty to her own daughter,Pat-J and her granddaughter, Pam-j. As well, Pam-j herself had no desire to continue to reside with either her grandmother or her mother. This was partly a result of her romanticized misconception of foster or residential care (fuelled by her sister's current experience positive experience in a residential treatment facility). Pam-j and her mother therefore choose to repeat the dysfunctional family pattern. Pam-j reenacted her older sister's script which resulted in her being taken into care by CFS-J.

SUMMARY OF CHANGE WITHIN THE FAMILY SYSTEM

Pam-j repeated her sister's behavioral pattern. That is, she was removed from her family and placed into the care of CFS whom the family considered to be the enemy. Family members were free to unit to fight against the enemy (now outside the family). Pat-J was again unable to utilize the

support offered her so as to break this self-defeating pattern (i.e., parental victim in relation to CFS). In this way, neither the daughters nor the mother or grandmother appear to have changed their pattern of family functioning (i.e., their unique means of regulating emotional distance and closeness within the family. Consequently, Pam-j is now safe from the physical assaults of her mother and Pat-J no longer needs to battle to control Pam-j's behaviour. Pat-J is now free to blame CFS for any future acting out behaviour on the part of Pam-j which may in turn enable her to become more supportive and empathic towards Pam-j. Again this seems indicative of the family's pattern of triangulation alternating between victim and persecutor roles.

Significant issues for Pam-j herself were: her emotional "neediness"; depressions resulting from her mother's rejection and abandonment; intense sibling rivalry; jealousy and violence; and healing from her sexual abuse experience. In group, Pam-j's sense of isolation was reduced as she received much support for her familial problems and her current crisis from both her peers and the group therapists. She was able to discuss her abuse experiences (both physical and sexual) and learned more about related behavioral dynamics and effects. As well, the group educated Pam-j with regards to improving her problem solving and coping skills as well as improving her self-esteem and body image. Despite these gains, Pam-j's behaviour did regress the last few weeks of group as she moved

from one foster home to another. She began acting in a manner which would soon lead her into a restrictive residential environment or closed treatment facility which she believed would provide her with a more enjoyable lifestyle.

EVALUATION OF THE FAMILY SYSTEM

	PAT-J				PAM-j		
	BF-FAM	BDI	IES	IPA	BF-FAM	BDI	SES
PRE	36	15	49	41	38	9	28
POST	NOT COMPLETED				39	17	27

Pat-j's BF-FAM score of 36 represented a high score for a clinical family which was consistent with the high and longstanding degree of family dysfunction she experienced. Pam-j, like her mother, verified this high degree of family dysfunction by also scoring high (above the comparison mean) for an adolescent within a clinical family. The pre BF-FAM scores proved consistent with the therapist assessment regarding the highly dysfunctional nature of family functioning.

With regards to depression, Pat-J scored 15 which indicated she suffered from moderate, bordering on severe, symptoms of depression. This again was consistent with her presentation of self in therapy and with her past history of depression. Pam-j, like her mother, scored as moderately

depressed and this proved consistent as her reaction(s) to her current situational crisis within the family. Given both the high degree of depression in mother and daughter from the onset, therapeutic intervention was clearly warranted.

As for the IES, only Pat-J completed this as a pre-measure and indicated a high score (49) of subjective distress, ten points above the comparison mean score of 39.5. This was consistent with her presentation of being in subjective distress and crisis. It appeared that Pat-J's avoidance subscale was high and this would be consistent with her need to deny the impact of the sexual abuse.

Pat-J scored 41 on her IPA which reflected a very significant problem in this parent-child relationship. This was clinically obvious from the onset (pre-group meeting).

No other measures (i.e., post measures) were completed by Pat-J as she "dropped out" of treatment. A further evaluation of Pam-j's pre and post group therapy scores are included in the evaluation section following the description of the early adolescent group.

CHAPTER SIX

LEARNING AND PRACTICES THEMES

INTAKE AND PRE-GROUP PROCEDURES

It was somewhat surprising that the team had difficulty securing a sufficient number of appropriate referrals, particularly from inner-city CFS agencies given the constant cry for more treatment resources. This may in part have been due to the pervasive overworking of CFS line workers who perhaps have little time left to follow through with any referrals outside their own agency. CFS workers may also have felt have felt "burned" by past experiences of attempting to get clients mental health services but then having them rejected, as their clients do not meet the program's, sometimes numerous, screening criteria. This latter factor may have been operating within our program as the team had screened out a two or three potential referrals from various agencies. Moreover, the low number of referrals probably had to do with the fact that the treatment time had sought referrals through communication with the CFS managers versus their line staff directly. Direct contact with line staff probably would have sped up the referrals and increased the numbers of referrals.

The literature indicates the need to screen group members

for some degree of homogeneity and particularly with children, the need to limit the age span of members by only two or three years (Berliner, 1982). The need for this was validated and reinforced. In the adolescent group, for example all members shared some degree of Native Canadian heritage and all had some experience with foster care, directly or indirectly (through siblings being in care), these two commonalities proved to further promote a solid group identity. As well in completing any group exercises and in facilitating group process it was beneficial to have members within the same developmental and life stages (e.g., the eldest member, the only grandmother, in the caregivers' group had some difficulty "fitting in"). These factors may have been better screened for through more extensive use of pre-group sessions.

The pre-group meetings proved most beneficial in assisting therapists in selecting a workable group composition. It also proved critical to abide by the selection criteria during pre-group meetings although this was difficult as helpers at times had to say "no" and screened some candidates out. This is where the power of the entire team and the peer support was useful, in convincing members how certain family systems where not yet suitable for this type of intervention. As well pre-group meetings laid the foundation for an initial assessment which was critical given the longstanding dysfunctional nature of many of these families.

It proved advantageous when the potential case manager for a system was available to facilitate the pre-group meetings. As well it was helpful for clients to meet with their group facilitators prior to the start of group in order to decrease initial group anxiety. The whole issue of continuity of therapists seemed critical from the onset of the joining process as many of these family systems had very chaotic, unpredictable family histories. As well, given that most families were very distrustful of outside help and had never engaged formally with any mental health services, therapists needed to be most attentive to facilitate good joining and engagement. Hence, clients were often accommodated to and some meetings occurred in the clients home.

INTERVENTIONS

THE GROUPS IN GENERAL

In general the benefits of running these groups with a co-therapists was obvious. Again, given the importance of assuring continuity in the treatment process for these families, it seemed essential to work with a co-therapist. As well, given the frequent crises occurring in these family systems, it was also sometimes essential to have the flexibility for one therapist to be available to leave the

group session to tend to a crisis.

Given the emotional neediness and the extent of deprivation experienced by these family systems the provision of snack was crucial. It served to nurture the clients while also promoting socialization. However, with the children, it was also important to set some limits on the amount of snack per child, as excessive overindulgence was common.

As well, with regards to transportation it was essential from the onset to contract (with CFS) around the provision of adequate i.e., a safe means of transportation, to and from group, especially for the children. Transportation problems subsequently contributed to attendance problems which became problematic to the group process especially given the small group numbers. These transportation arrangements were tedious to pursue but proved essential in facilitating more regular attendance. As cited in the literature (Corman, 1989), regular attendance appeared to be a factor in distinguishing, to some extent, high versus low group achievers.

With regards to duration or length of group, overall it was observed that at minimum fourteen weeks were required for group. However given the short treatment duration versus the family's longstanding history of problems it was not surprising that most members desired that group sessions be extended. It was apparent that towards the closure of the groups (more so in the caregivers' group) the members ventured

into a more intimate level of disclosure (e.g., natural mothers revealing their distrust and fears regarding CFS). It would appear that, if the groups continued members may have risked more particularly with regards to exploring their own family of origin work.

LATENCY NON-OFFENDING CAREGIVERS' GROUP

Two central learning themes surfaced in working with this group. Due to the longstanding (intergenerational), multi-problem nature of these families; their subsequent neediness and emotional deprivation; their frequent crises (some of which were protection issues), there was an overwhelming need for some individual therapy to occur before their start in group therapy, as cited in the literature by Sturkie (1983). As this had not occurred in within the treatment program and group process was negatively affected and interfered with.

With regards to mixing natural mothers and foster mothers into one caregivers' group the impressions are mixed. The mothers themselves were just slightly mixed with respect to this, although most appeared to appreciate the mixture. It was evident that foster parents can benefit by developing more empathy for the families of their foster children. As well natural mothers, who are less defensive, can benefit from some good parental role modelling. However the tensions inherent in this mix surfaced within group and needed to be monitored

and mediated by therapists particularly at the onset of group. Overall this mixture proved beneficial within this particular caregivers' group.

EARLY ADOLESCENT VICTIMS' GROUP

The learning which surfaced for the therapists in this group verified the literature i.e., the need to operate a structured group for victims this age (Berliner, 1982; Kitchur & Bell, 1989). When therapists attempted to relax the group structure members responded by making it known that they thrived on the group's stability and predictability and wanted it to return (e.g., regular use of the journals). Another major theme that was reinforced in the group, which is highlighted in the literature (Kitchur & Bell, 1989; Knittle & Tuana, 1981) was the need to process the girls' past sexual abuse, as well as the need to support them in dealing with their current life crises.

As well, therapists discovered the need to deal with the issue of personal safety and protection (e.g., safety plan) with members from the onset of group sessions, due to the highly chaotic and volatile nature of these multi-problem families. The need for this was highlighted when one group member was physically assaulted by her mother within the first weeks of group.

It proved difficult to judge the merits of operating such a group (adolescent victims) with both a male and female therapist. The mix appeared beneficial in raising and challenging issues of sex role stereotypes. Including a male therapist did not appear to impede the group's process and development in anyway. Instead it seemed to provide the girls with the opportunity to witness a positive role modelling of healthy male-female relationships. According to the group evaluation forms completed by members, all but one member found it equally as easy to talk to the male therapist. As indicated in the literature (Kitchur & Bell, 1989) no definitive answers exist with regards to the influence of the gender of therapists.

FAMILY SYSTEMS THERAPY

In retrospect, case managers (who were involved in providing family intervention to each system), should have been assigned from the onset to coincide with the start of group. The highly dysfunctional nature of these family system together with the short treatment duration of this program both deem the need to initiate group and dyadic work with mothers and victims simultaneously, from the onset of treatment.

The most significant learning that occurred was that the

therapists strict need to vigilantly maintain the distinction (both through words and actions) as a mental health worker, engaged solely in treatment, while leaving any protection and safety issues in the hands of the CFS workers. This proved difficult in the family systems work for this therapist as both her cases were managed by a relatively inexperienced CFS worker who had difficulty enforcing the CFS mandate. Given the distrustful, closed nature of these family systems this distinction is absolutely critical both from the onset (i.e., intake) and throughout the treatment process.

A TEAM APPROACH

As previously noted, given the dysfunctional, multi-problem nature of these families, coupled with their isolation and distrust of helping systems, it proved almost essential to operate within a team approach, in order to prove successful. There were benefits for both the client system and the helping system. For the client system, the team approach allowed for a more comprehensive treatment package then is generally available to clients. As well, the quality of the clinical work offered to these families was enhanced by the regular supervision and consultation provided to the four core therapists. The four therapists also regularly met and "debriefed" in an effort to deliver both a comprehensive and well coordinated treatment package (i.e., good coordination

between the parallel groups therapist, and between the group and family therapists). Although this meetings proved very time consuming, their benefits outweighed their costs to the therapists' time, and problems were noted when this was not adhered to. As well, peer support was available on a regular basis and was often required particularly due to the emotionally depleting nature of this work which also involved tending to many crises. This team approach appeared to serve both clients and therapists alike in providing a comprehensive parallel treatment program. The benefits of coordinated service through the use of therapy or treatment teams as cited in the literature by Trepper & Barrett (1986) are obvious, and are demonstrated by this treatment program.

CHAPTER SEVEN

CONCLUSIONS

The general conclusions based on this practicum are that adolescent group therapy for female child sexual abuse victims and a parallel group model for the non-offending caregivers of latency aged female victims, combined simultaneously with family systems interventions, are effective components of an overall systemic treatment approach to intrafamilial child sexual abuse. Based on clinical observations, client feedback and clinical outcome measures, all the client systems (i.e., children, adolescents and their parents) appear to have achieved apparent gains from this systemic parallel treatment program, despite the multi-problem realities and crises in their lives. Overall the program met its treatment goals i.e., it was successful in educating the families regarding sexual abuse dynamics, issues, and safety and prevention planning, decreasing stigmatization, increasing social support, developing social skills and coping skills, releasing feelings, increasing communication and strengthening the mother-daughter relationship.

However, both groups could have benefitted from additional time to cover, perhaps from the onset of group, work on improving personal safety and coping skills and identifying ways to expand their limited social networks given

the chaotic and isolated nature of these families. As well additional time could have been utilized to more adequately reinforce the concepts of coping and mastery i.e., developing a sense of being a survivor versus a victim, as cognitive perceptions consistent with the role of a victim seemed well entrenched in both the adolescents and the natural mothers. In this way, more could have been done to build the sense of self-worth and self-esteem in all family members. Given that in the adolescent group the girls personal disclosures of abuse did not occur until the latter phase of group, members did not have adequate time for resolution and were not prepared for termination. As members level of trust grew more towards the close of both groups, with more time permitted, members may also have ventured into more crucial family of origin work.

It is also important to comment on the contrasts between the two groups i.e., the adolescents victims group and the latency non-offending caregivers' group. As there appeared to be more commonality amongst the adolescents from the onset they appeared more consistently supportive of one another then was the caregivers' group with its mix of natural and foster parents. As well the adolescents seemed to have assumed more ownership for their group then did the caregivers who consistently resisted assuming ownership and remained dependent on the facilitators. Above all the adolescent group appeared to have been more psychotherapeutic in nature with

members acquiring more insights into their behaviours and that of fellow members while the focus of the caregivers' group remained primarily educational and supportive. This was further reflected by the titles used for the clinicians operating the groups, that being the term therapist for the adolescent group while using the term facilitator for the caregivers' group. The significant similarity in both groups was that members continually presented with various crises which were dealt with in the group context, often providing therapists with a natural opportunity to lead into a discussion on relevant themes e.g., coping, safety.

Given the dysfunctional, closed nature of these family systems, and their traditional distrust of helpers the gains made in this treatment program are significant "in circumventing the cyclical nature of child sexual abuse and in reducing the likelihood of further abuse within these families" (Hildebrand & Forbes, p. 285). However given the short term nature of this treatment program, all of the adolescent family systems were referred for further additional individual and or family therapy. Four of the five adolescent family systems were committed to return to the CRC for additional service. As well, the adolescent group, as a result of the petition put forth by its members, was scheduled to continue in the form of a guided self help group, operated through the CRC. In dyadic therapy, the goals of improving the communication (especially regarding the sexual abuse) and

improving the relationship between the adolescent and the caregiver were only minimally achieved in system (I) and not at all achieved in system (J), primarily due to the lack of motivation on the part of the family. These two family systems i.e., I and J highlight the importance of the initial intake and screening process and the need to better assess a family's motivation and readiness for family intervention from the onset of treatment.

It would have been most beneficial to engage the natural mothers in individual therapy from the onset of treatment as all of them provided to be exceptionally needy (i.e., emotionally needy) themselves and desperately in need of nurturance themselves. This neediness limited the caregivers group's ability to meet their weekly intended agendas and limited group process, to almost resembling individual therapy at times. The adolescents may also have benefitted from individual therapy in order to assist them in preparing for dyadic sessions with their mothers. Also family systems interventions (i.e, mother-daughter dyadic sessions) should have began from the onset of group therapy and perhaps would also have benefitted from additional time. Overall families appeared to need more time to integrate group learning into their family systems.

PERSONAL REFLECTIONS

I was able to accomplish my learning goals in this practicum. In terms of my own clinical practice some of the most significant learning themes included: recognizing the importance of nurturing and supporting these caregivers in order to enhance their own ability to parent more effectively, the importance of structure, continuity and limit setting in the therapeutic setting for these families, the importance of distinguishing and maintaining clear roles and boundaries with other social services i.e., Child and Family Services, so as to maintain a clear distinction between treatment versus protection services (which is essential for these families), and the utility of clincal outcome measures in clinical practice. As well working as part of a clinical team I further acquired skills with regards to constructive team work which only further reinforced for me the importance of seeking ongoing consultation and supervision in my clinical practice. I have also achieved further confidence in my group therapy skills however as I had only limited opportunity in this practicum to further develop my family therapy skills this will continue to be a goal of mine.

Moreover, with respect to my use of "self" I have developed further awareness into the extent of my ability to be empathic and nurturing. However, throughout this practicum I have also been challenged to become and to model more

assertiveness and clearer personal boundaries. In this way, I was able to accomplish a long awaited personal goal. That is, the experience of being a woman working with non-offending mothers and their daughter who had experienced intrafamilial child sexual abuse, forced me to look more closely at the issue of power and control in all aspects of my life. I have realized that, an essential therapeutic responsibility has been providing these girls and their mothers with knowledge and also empowering them while modelling this in the course of my therapeutic interactions with them. The challenge has been for me to respectfully empower these women and build their sense of self-esteem by recognizing the use of my own personal power in relationship to them and as a role model in all my interactions. I have recognized, in large part the need for me to better use my own personal power (i.e., be more assertive) while also remaining conscious of the effects of power and control in my interactions with others (i.e., not to be critical and authoritarian), in order to most effectively facilitate mastery over the sexual victimization for these mothers and their daughters.

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Appendices

Appendix A

Latency Group(s) Intake Information

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

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

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

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

Appendix B

Early Adolescent Group(s) Intake Information

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

* Jointly prepared by Kathy Anderson and Barb Gajdek

INTAKE INFORMATION FOR EARLY ADOLESCENTS AND CAREGIVERS														
	Child's Age	Number of Offenders	Relationship of Offender to the Victim	Age(s) When Offended	Most Recent Disclosure to Whom	Reported and Investigated	Police Disposition	Duration of Sexual Abuse	Nature/ Type of Abuse	Adolescent has History of Physical Abuse/ Neglect	Adolescent in Care of .... at Time of Group	Mother/ Caregiver has History of Sexual Abuse	Caregiver's Marital Status
Pat J.												✓	single parent
Pam j.	13	1	boarder living in the home	6	older sister who reported to CFS	✓	no charges laid	?	penetration	✓	biological mother, then to grandmother, then into foster care		

* Jointly prepared by Kathy Anderson and Barb Gajdek

Appendix C

Group Evaluation Forms

ADOLESCENT GROUP - EVALUATION FORM

1. In what ways was the group helpful to you?

____

____

____

2. Were there things about the group that made it harder for you to participate?

____

____

____

3. What was the most important thing you LEARNED in group?

____

____

____

4. Which ACTIVITY helped you the most with your sexual abuse?

____

____

____

5. When it came to talking about my feelings in group, most of the time I felt:

   Safe Unsafe

6. When it comes to protecting myself from abuse, the group has helped me to protect myself:

   Much better Better No difference

7. How easy was it to talk with the group leader, Barb?

   Somewhat easy Easy Hard

8. How easy was it to talk with the group leader, Ron?

   Somewhat easy Easy Hard

9. The number of sessions should have been:

   More Same Less

10. Write any other comments you have about the group:

____

____

____

LATENCY AGE MOTHER'S GROUP - EVALUATION FORM

1. Was group helpful to you?

   Very helpful | Somewhat helpful | Not helpful

2. What was the most helpful?

3. What was the least helpful?

4. The number of sessions should have been:

   Fewer | Same | More

5. How easy was it to talk with the group facilitators?

   Somewhat easy | Easy | Hard

6. Did you feel that you knew what your child was learning or doing each week in the children's group?

   Always | Sometimes | Never

7. Are you more able to talk with your child now?

   Yes | Somewhat | No

8. Ny understanding of sexual abuse and its effects now is:

   Greater | Same | More confused

9. My ability to protect my child from further abuse now is:

   Greater | Same | Less

10. How did you feel about mixing foster mothers and natural mothers?

* Jointly prepared by Kathy Anderson and Barb Gajdek

Appendix D

Adolescent Sentence Completion Form: My Story of Sexual Abuse

MY STORY OF SEXUAL ABUSE

My offender's name(s) is ______________________________.

He was my (what relationship to you) ______________________.

I would describe him as being ____________________________.

He first started to abuse me when I was __________ (years old).

The things my offender did that hurt me were _______________

____

____

____

These things happened at (the place) ______________________.

At the time the sexual abuse made me feel _________________

____.

I did not know what to do about it because ________________

____

This went on for ____________________ until (what happened that stopped the abuse) ___________________________________

____

I did not share the abuse with my mother because (only if this applies to you) ______________________________________.

Today I feel ________________________________towards the offender.

______________________ is responisble for the sexual abuse.

Today I feel ______________________________ about myself.

The hardest thing for me still is _______________________

____.

Appendix E

Adolescent Group(s) - Clinical Outcome Measures

Preadolescent Age - Measures

	FAM	IPA	BDI	IES	Self-Esteem
Rose-G					
Pretest	40	Rh-32,Ru-37	21	56	
Posttest	30	Rh-21,Ru-22	3	55	
Rhonda-g					
Pretest	22				25
Posttest	23		0		29
Ruth-g					
Pretest	32				
Posttest	37		12		31
Alice-H					
Pretest	28	15	5		
Posttest					
Ann-h					
Pretest	35*		22		23.5
Posttest	21**		3		30
Pat-J					
Pretest	36	41	15	49	
Posttest					
Pam-j					
Pretest	38		9		28
Posttest	39		17		27
Gert-I					
Pretest	31		0		
Posttest					
Gail-I					
Pretest	20		10	46	33
Posttest	16		6		34

* Re: Alice-H
** Re: New foster mother

Note: Jointly prepared by Kathy Anderson and Barb Gajdek

Appendix F

Adolescent Girls - Completed Group Evaluation / Feedback

EARLY ADOLESCENT GROUP - FEEDBACK FORM										
	In What Ways Was Group Helpful to You	**Were There Things About Group that Made it Harder for you to Partic-ipate**	**What was the Most Important Thing You Learned**	**What Activity Helped You Most with Your Sexual Abuse**	**When it Came to Talk About my Feelings in Group, Most of the Time I Felt**	**When it Comes to Protecting Myself From Abuse, the Group has Helped me Protect Myself**	**How Easy was it to Talk with Group Leader Barb**	**How Easy was it to Talk With Group Leader Ron**	**The Number of Group Sessions Should Have Been**	**Write any Comments You Have About the Group**
Ruth g.	every way, I liked it	no, it was good	to talk about my problems	all of them	safe	much better	easy	easy	more	I want it (group) to go on for a long time
Rhonda g.	that I can talk about my problems	no, not really	that no one can touch you, only if you say they can	when someone was reading my paper/ (disclosure)	safe	much better	easy	easy	same	I like the group, I hope we can still have (continue) the group
Ann h.	helped me express myself, get what I was feeling about my abuser	no	that it's not my fault, it's my abuser's fault	when we read other person's story (disclosure)	safe	much better	very easy	not that easy	lots more	I think that Ron and Barb did a great job with us; I think they should do more groups
Gail i.	built up my self-esteem and confidence, helped me with the pain of my sexual abuse	no	it wasn't my fault, it was my offender's	everything	safe	much better	somewh at easy to talk to	somewha t easy to talk to	more	Good Work!
Pam j.	to talk about problems	no	how to solve problems	the story Ron read (about a woman's sexual abuse in childhood)	safe	better	somewh at easy	somewha t easy	more	none

Appendix G

Caregivers' Sentence Completion Form:
A Letter To My Daughter

DEAR

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

NOW, I WISH I HAD

FROM NOW ON I WILL

I WANT YOU TO KNOW THAT I FEEL

TOWARD FOR HAVING SEXUALLY ABUSED YOU.

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

SOME OTHER THINGS I WANT TO TELL YOU ARE

* Jointly prepared by Kathy Anderson and Barb Gajdek

Appendix H

Support Networks Exercise
(Completed by the Latency Caregivers' Group)

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

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

* Jointly prepared by Kathy Anderson and Barb Gajdek

Appendix I

Latency Caregivers - Completed Group Evaluation/ Feedback

Latency Age Mother's Group Evaluation *

Helpful?
Lori-D - Very Helpful
Donna-F -Very Helpful
Helen-B - Very Helpful
Carol- C - Very Helpful
Most Helpful?
Lori-D - Talking about problems
Donna-F - Feel less alone - Getting this off my mind
Helen-B - Discussing Heidi-b's problems and problems of other children
Carol-C - Listening to others and knowing its not just you
Least Helpful?
Lori-D - nothing
Donna-F - nothing
Helen-B - Weekly check-in
Carol-C - nothing
Number of sessions?
Lori-D - Same
Donna-F - More
Helen-B - More
Carol-C - Same
Talk with group facilitators?
Lori-D - Easy
Donna-F - Somewhat easy
Helen-B - Easy
Carol-C - Easy
Knew what children were doing?
Lori-D - Always
Donna-F - Always
Helen-B - Always
Carol-C - Always
More able to talk with child now?
Lori-D - Yes
Donna-F - Yes
Helen-B - Yes
Carol-C - Yes
Understanding of sexual abuse?
Lori-D - Greater
Donna-F - Greater
Helen-B - Greater
Carol-C - Greater
Ability to protect?
Lori-D- Greater
Donna-F - Greater
Helen-B - Greater
Carol-C - Greater
Mixing foster mothers and natural mothers?
Lori-D - Good for foster moms - need to learn to cope
Donna-F - Fine for my first experience with mixing
Helen-B - Mutually beneficial
Carol-C - Interesting - good ideas

* Jointly prepared by Kathy Anderson and Barb Gajdek

Appendix J

Latency Group(s) - Clinical Outcome Measures

LATENCY AGE - MEASURES

	FAM	BDI	IES	IPA	CAM	CDI
Lori-D						
Pretest	32	6	35	Lu-27,La-14		
Posttest	35	5		Lu-52,La-40		
Lucy-d						
Pretest					35	25
Posttest					43	17
Laura-d						
Pretest					24	9
Posttest					31	3
Carol-C						
Pretest	19*	13	43	11		
Posttest	25	1		10		
Cindy-c						
Pretest					24	4
Posttest					6	9
Helen-B						
Pretest	21	4		19		
Posttest	24	8		21		
Heidi-b						
Pretest					28	7
Posttest					15	15
Donna-F						
Pretest	17	14	49	30		
Posttest	30	10		43		
Dee-f						
Pretest					44	12
Posttest					7	15
Erica-E						
Pretest	29	4		27		
Posttest						
Ellen-e						
Pretest					**11	3
Posttest					***23	3
Fran-A						
Pretest	31			19		
Posttest						
Fiona-a						
Pretest					16	0
Posttest					32	3

* Three items not marked
** Re: Erica-E
*** Re: New foster mother

Note: Jointly prepared by Kathy Anderson, Barb Gajdek and Karen Garney