ADOLESCENTS AS A UNIQUE CLIENT GROUP

IN THE TREATMENT OF

CHILDHOOD SEXUAL ABUSE

Susan A. Maxwell

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

Master of Social Work

Faculty of Social Work
University of Manitoba
Winnipeg, Manitoba

(c) September, 1993

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

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

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

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

Canada

Name _____

Dissertation Abstracts International is arranged by broad, general subject categories. Please select the one subject which most nearly describes the content of your dissertation. Enter the corresponding four-digit code in the spaces provided.

SOCIAL WORK.

SUBJECT TERM

0 4 5 2 U·M·I

SUBJECT CODE

Subject Categories

THE HUMANITIES AND SOCIAL SCIENCES

COMMUNICATIONS AND THE ARTS
Architecture 0729
Art History 0377
Cinema 0900
Dance 0378
Fine Arts 0357
Information Science 0723
Journalism 0391
Library Science 0399
Mass Communications 0708
Music 0413
Speech Communication 0459
Theater 0465

EDUCATION
General 0515
Administration 0514
Adult and Continuing 0516
Agricultural 0517
Art 0273
Bilingual and Multicultural 0282
Business 0688
Community College 0275
Curriculum and Instruction 0727
Early Childhood 0518
Elementary 0524
Finance 0277
Guidance and Counseling 0519
Health 0680
Higher 0745
History of 0520
Home Economics 0278
Industrial 0521
Language and Literature 0279
Mathematics 0280
Music 0522
Philosophy of 0998
Physical 0523

Psychology 0525
Reading 0535
Religious 0527
Sciences 0714
Secondary 0533
Social Sciences 0534
Sociology of 0340
Special 0529
Teacher Training 0530
Technology 0710
Tests and Measurements 0288
Vocational 0747

LANGUAGE, LITERATURE AND LINGUISTICS
Language
  General 0679
  Ancient 0289
  Linguistics 0290
  Modern 0291
Literature
  General 0401
  Classical 0294
  Comparative 0295
  Medieval 0297
  Modern 0298
  African 0316
  American 0591
  Asian 0305
  Canadian (English) 0352
  Canadian (French) 0355
  English 0593
  Germanic 0311
  Latin American 0312
  Middle Eastern 0315
  Romance 0313
  Slavic and East European 0314

PHILOSOPHY, RELIGION AND THEOLOGY
Philosophy 0422
Religion
  General 0318
  Biblical Studies 0321
  Clergy 0319
  History of 0320
  Philosophy of 0322
Theology 0469

SOCIAL SCIENCES
American Studies 0323
Anthropology
  Archaeology 0324
  Cultural 0326
  Physical 0327
Business Administration
  General 0310
  Accounting 0272
  Banking 0770
  Management 0454
  Marketing 0338
Canadian Studies 0385
Economics
  General 0501
  Agricultural 0503
  Commerce-Business 0505
  Finance 0508
  History 0509
  Labor 0510
  Theory 0511
Folklore 0358
Geography 0366
Gerontology 0351
History
  General 0578

Ancient 0579
Medieval 0581
Modern 0582
Black 0328
African 0331
Asia, Australia and Oceania 0332
Canadian 0334
European 0335
Latin American 0336
Middle Eastern 0333
United States 0337
History of Science 0585
Law 0398
Political Science
  General 0615
  International Law and
    Relations 0616
  Public Administration 0617
Recreation 0814
Social Work 0452
Sociology
  General 0626
  Criminology and Penology ... 0627
  Demography 0938
  Ethnic and Racial Studies 0631
  Individual and Family
    Studies 0628
  Industrial and Labor
    Relations 0629
  Public and Social Welfare 0630
  Social Structure and
    Development 0700
  Theory and Methods 0344
Transportation 0709
Urban and Regional Planning 0999
Women's Studies 0453

THE SCIENCES AND ENGINEERING

BIOLOGICAL SCIENCES
Agriculture
  General 0473
  Agronomy 0285
  Animal Culture and
    Nutrition 0475
  Animal Pathology 0476
  Food Science and
    Technology 0359
  Forestry and Wildlife 0478
  Plant Culture 0479
  Plant Pathology 0480
  Plant Physiology 0817
  Range Management 0777
  Wood Technology 0746
Biology
  General 0306
  Anatomy 0287
  Biostatistics 0308
  Botany 0309
  Cell 0379
  Ecology 0329
  Entomology 0353
  Genetics 0369
  Limnology 0793
  Microbiology 0410
  Molecular 0307
  Neuroscience 0317
  Oceanography 0416
  Physiology 0433
  Radiation 0821
  Veterinary Science 0778
  Zoology 0472
Biophysics
  General 0786
  Medical 0760

EARTH SCIENCES
Biogeochemistry 0425
Geochemistry 0996

Geodesy 0370
Geology 0372
Geophysics 0373
Hydrology 0388
Mineralogy 0411
Paleobotany 0345
Paleoecology 0426
Paleontology 0418
Paleozoology 0985
Palynology 0427
Physical Geography 0368
Physical Oceanography 0415

HEALTH AND ENVIRONMENTAL SCIENCES
Environmental Sciences 0768
Health Sciences
  General 0566
  Audiology 0300
  Chemotherapy 0992
  Dentistry 0567
  Education 0350
  Hospital Management 0769
  Human Development 0758
  Immunology 0982
  Medicine and Surgery 0564
  Mental Health 0347
  Nursing 0569
  Nutrition 0570
  Obstetrics and Gynecology .. 0380
  Occupational Health and
    Therapy 0354
  Ophthalmology 0381
  Pathology 0571
  Pharmacology 0419
  Pharmacy 0572
  Physical Therapy 0382
  Public Health 0573
  Radiology 0574
  Recreation 0575

Speech Pathology 0460
Toxicology 0383
Home Economics 0386

PHYSICAL SCIENCES
Pure Sciences
Chemistry
  General 0485
  Agricultural 0749
  Analytical 0486
  Biochemistry 0487
  Inorganic 0488
  Nuclear 0738
  Organic 0490
  Pharmaceutical 0491
  Physical 0494
  Polymer 0495
  Radiation 0754
Mathematics 0405
Physics
  General 0605
  Acoustics 0986
  Astronomy and
    Astrophysics 0606
  Atmospheric Science 0608
  Atomic 0748
  Electronics and Electricity 0607
  Elementary Particles and
    High Energy 0798
  Fluid and Plasma 0759
  Molecular 0609
  Nuclear 0610
  Optics 0752
  Radiation 0756
  Solid State 0611
Statistics 0463

Applied Sciences
Applied Mechanics 0346
Computer Science 0984

Engineering
  General 0537
  Aerospace 0538
  Agricultural 0539
  Automotive 0540
  Biomedical 0541
  Chemical 0542
  Civil 0543
  Electronics and Electrical 0544
  Heat and Thermodynamics ... 0348
  Hydraulic 0545
  Industrial 0546
  Marine 0547
  Materials Science 0794
  Mechanical 0548
  Metallurgy 0743
  Mining 0551
  Nuclear 0552
  Packaging 0549
  Petroleum 0765
  Sanitary and Municipal 0554
  System Science 0790
Geotechnology 0428
Operations Research 0796
Plastics Technology 0795
Textile Technology 0994

PSYCHOLOGY
General 0621
Behavioral 0384
Clinical 0622
Developmental 0620
Experimental 0623
Industrial 0624
Personality 0625
Physiological 0989
Psychobiology 0349
Psychometrics 0632
Social 0451

ADOLESCENTS AS A UNIQUE CLIENT GROUP

IN THE TREATMENT OF

CHILDHOOD SEXUAL ABUSE

BY

SUSAN A. MAXWELL

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

(c)   1993

ABSTRACT

This practicum focused on individual and group treatment for adolescents who have a history of sexual abuse. Clients were seen at the Community Resource Clinic over a period of seven months. All clients were also involved with the child welfare system. The literature review examines the developmental needs of adolescents. These developmental tasks are then related to the treatment issues relevant to abuse victims. Interventions with practicum clients focused on decreasing the anxiety related to the trauma of their abusive experience. Altering maladaptive beliefs, attitudes, and behaviors that develop as learned responses to abuse (and the aftermath of disclosure) were the other main areas of focus in treatment.

i

ACKNOWLEDGEMENTS

Many people have contributed to the completion of this project and I would like to take this opportunity to acknowledge their input. I am appreciative of the patience, support, and guidance that my faculty advisor, Walter Driedger, has extended to me over this long process. Assistance and encouragement from Dr. Barry Trute and Dr. Laura Mills were also instrumental in the home stretch of preparing this report.

This endeavour has really been an endurance test for me and would not have been possible without the faith and support of family members and friends. Thank you all for letting me struggle with this at my own pace and letting me moan and groan about this work for what must seem like many years. Your appreciation of my breakthroughs and your patience during the dry spells made this apparition come to life in the written form. Special thanks to my mother and father who instilled a love of learning in me. Their support and enthusiasm for their children's projects have always made all things seem possible.

Finally I wish to acknowledge the debt I feel to Elizabeth Hill for her guidance and support. I wish she could be here to share this accomplishment with me as so much of what I know to be true about working with people I have learnt from Elizabeth. This degree is dedicated to her memory and undying spirit.

CONTENTS

SECTION TWO   THE PRACTICUM

INTRODUCTION

The sexual exploitation of children by adults has been increasingly acknowledged as a serious and widespread problem. Courtois (1988) explains that "societal acknowledgement of the prevalence of child sexual abuse has resulted in specialized services directed towards the prevention, detection, and intervention into ongoing abuse" (p.8). Child and Family Services of Central Winnipeg approached the Community Resource Clinic in order to develop therapeutic treatment as part of the specialized services included in intervention. Child and Family Services of Central Winnipeg identified that a large number of adolescent females made up their sexual abuse caseload. The Sexual Abuse Coordinator for the agency expressed concern that these victims were not receiving treatment of any kind. It was agreed that this practicum would focus on psychotherapeutic treatment for adolescent female victims of sexual abuse . The clinical work took place in 1991 between February and October.

This report will first review the sexual abuse literature in general to provide a starting point for readers. The focus will then specifically address adolescents as a unique client population and review treatment issues relative to those who experience sexual abuse in their families. This report will then outline the practicum that developed out of the request for service that was presented by Child and Family Services and the literature review.

SECTION ONE   LITERATURE REVIEW

CHAPTER ONE : Overview of Child Sexual Abuse

DEFINITION AND PREVALENCE OF THE PROBLEM

Incest is a phenomenon that has interested scholars and practitioners in psychology, psychiatry, anthropology, sociology, and biology for decades (Rist, 1979). The prohibition of sex between certain people, incest, is one of the few that appears to be universally cross-cultural. This is probably because the incest taboo has sound sociological, biological , and psychological justification in that "it protects the structure and function of the family system, it promotes the psychosexual development of children, and it safeguards the healthy evolution of the species" (Everstine and Everstine, 1989). For this review several definitions of incest will be discussed. The prevalence of the problem will also be considered in order to try and understand the extent of child sexual abuse in our society.

Sandra Butler (1978) provides a comprehensive definition of child sexual abuse as " any sexual activity or experience imposed on a child which results in emotional, physical, or sexual trauma" (p.12). This definition is a starting point but leaves room for argument whether sexual activity between adults and children would be considered abusive if there is no evidence of trauma in these areas. Finkelhor (1979) suggests that the question of whether a child is capable of giving full and informed consent to sexual activity with an adult will help society understand what is ethically wrong with the behaviors, regardless of whether there is evidence of trauma. Finkelhor argues that children are incapable of consenting to sexual activity because they have inadequate knowledge of the agreement and consequences. Giaretto (1982) also includes the concept of sexual exploitation in his definition of abuse. He concludes that because the partners are mismatched in psychosocial maturity they are "not equally capable of negotiating a mutually beneficial sexual

2

partnership" (Giaretto, 1982, p 22).   Sexual abuse is perpetrated against children that range in age from infants to adolescents and includes a broad spectrum of sexual activity.   Girls are victimized ten times more often than boys (Green,1989). Girls represent 80 - 90 % of victims and males represent an overwhelming majority of sexual offenders (Gelinas, 1983). Boys are also most often victimized by men (Green, 1989). The use of the female pronouns in reference to victims and male pronouns when discussing offenders is supported by these statistics.

The terms, intrafamilial abuse or incest, will be used interchangeably in this report. In the narrowest definition of incest a blood relationship must exist between the child and the offender and intercourse must take place.   Clinicians have moved to a broader definition that recognizes a range of sexual behaviors and an acknowledgement that the presence of a blood relationship is less significant than the psychosocial dynamic of a familial relationship (Sgroi,1982; Russell, 1986; Schaefer and Evans, 1988). What becomes more important than the denotation as a relative is the fact that an emotional bond and trust exist between the victim and offender. The victim's distress is created by the betrayal of this trust regardless of the perpetrator's kinship (Crowder and Myers - Avis, 1990). "It is the relationship, not the biology that is betrayed" (Gelinas, 1983, p.313).   Most child sexual abuse is perpetrated by people whohave ready access to their victims via their family relationships (Sgroi, 1978).   Ward (1984) concurs with this and identifies natural fathers as the largest single group of offenders. Sink (1988) reports fathers, stepfathers, uncles, brothers, and grandfathers among the most frequent perpetrators but singles out abuse by fathers or step fathers as the most enduring and psychologically severe. Courtois and Sprei (1988) cite several studies that conclude sexual contact between fathers and daughters and stepfathers and daughters are the most prevalent forms of abuse. Russell (1988) found 24% of intrafamilial perpetrators were fathers and 26% were uncles. The incest taboo is weakened between step-fathers and daughters (Swan, 1985). This suggests an increased risk for common law partners also but no statistics were found that

3

considered this category separately. This would seem to be an important area that has been overlooked.

With a history of secrecy and misunderstanding of the subject, the magnitude of child sexual abuse as a problem has remained disguised for many years. Recent studies however, have confirmed that sexual abuse is not the uncommon, isolated experience of a few children but rather is a major risk in childhood (Sink, 1988). Figures based on the number of cases that actually come to the attention of child welfare authorities or police can only represent a starting point on which to base estimations regarding the more significant number of cases that remain unreported. Bagley and Thomlinson (1991) suggest that these figures are routinely underestimated . In a national Canadian survey Bagley and Thomlinson (1991) reported that 17.6% of adult females and 8.2% of adult males recalled sexually abusive experiences prior to their 17th birthday. In 1986, Peters, Wyatt, and Finkelhor (1986) set out to review studies of incidence and prevalence of childhood sexual abuse because the information that was available to them at this time was confusing and did not reach any consensus. It is difficult to put forth any figure with conviction when their comprehensive review of prevalence studies in North America reports ranges from 6% to 62% for females and 3% to 31% for males (Peters, Wyatt, & Finkelhor 1986, p.19). "Although even the lowest rates indicate that child sexual abuse is far from an uncommon experience, the higher reported rates would point to a problem of epidemic proportions" (Peters, Wyatt, and Finkelhor ,1986, p.19). Russell's (1988) study found in a random sample of 930 women, the first probability sample ever conducted on this subject, that 16% reported one experience of intrafamilial abuse before the age of 18 years and 12% before the age of 14 years. It is alarming that only 2% of these intrafamilial experiences were reported to authorities (Russell, 1988). Bagley and King (1990) suggest that a reasonable minimal estimate is that 20% of women experience childhood sexual abuse and that 25% of these victims have long-term problems of mental health and severely diminished self-esteem. They further postulate that these figures suggest

4

that 5% of all women in Britain, Canada, and the United States have chronically impaired adjustment because of sexual abuse in childhood.

DYNAMICS OF INCEST

The cornerstone of effective intervention is an understanding of the mechanics and dynamics of intrafamilial child sexual abuse. Sgroi (1982) has identified a predictable pattern of dynamics involved in sexual relationships between adults and children. These dynamics will be examined as they apply to families.

No two families will ever present exactly the same but generalizations can help us be aware of possible family patterns. Sgroi (1982) describes five seperate phases in which the activity usually occurs; the engagement phase, sexual interaction , secrecy, disclosure, and a suppression phase following the disclosure. The engagement phase sets the stage for the possible sexual abuse. An adult within the family or family circle has access to children within that system. The adult then needs the opportunity to be alone with the child. The circumstances may be accidental initially but thereafter an offender can be expected to watch for or orchestrate continued opportunities for private interactions with the child. The adult's position as a favoured adult or simply their implicit power and authority over the child is usually enough to get the child to participate in some form of sexual behavior. Subtle coercion and misrepresentation of moral standards seem to be the norm for engaging children rather than force or threats, although the latter is sometimes present. Those who do not understand why children comply rather than run or scream misperceive the power of adult authority in the eyes of many children, especially when the authority figure is a significant adult in the child's life (Sink,1988). Underlying all these factors is the crucial component that the adult wishes to initiate sex with the child. Finkelhor (1984) considers this motivation to be the first precondition necessary for sexual abuse to occur. He sets three other preconditions that must be met that incorporate sociological and psychological explanations of abuse. The potential offender must overcome internal inhibitions against acting

on the motivation as well as external inhibitors and obstacles. The final factor is overcoming or undermining the child's possible resistance. This may be attributed to the potential abuser or may be caused by other factors related to the vulnerability of the child (i.e., loneliness).

Following engagement the relationship moves into the sexual interaction phase. Sgroi (1982) suggests that this phase is a progression of sexual behaviors. "The progression of exposure to fondling to some form of penetration is very predictable" (Sgroi, 1982, p.15). This progression is typical but of course variations may be encountered. The process may also be prematurely interrupted by discovery or disclosure. Courtois (1988) cautions that a victim's story should not be discounted just because it does not match the escalation Sgroi (1982) suggests. The secrecy phase then follows in order to facilitate repetition of the activity and also to protect the offender from being caught and held responsible for his behavior.

Different explanations have been put forth as to why the child does keep the secret for months, years, or perhaps forever (Courtois and Sprei, 1988; Summit, 1983; Burgess, Holmstrom, and McCausland, 1979). "Very few victims of childhood sexual abuse are known to report the assault to an adult at the time of the incident and even less report the assault to police or child protection authorities" (Bagley and Ramsay, 1986, p.46). The child may be pressured or persuaded to keep quiet because of actual or implied threats. The threat does not necessarily focus only on physical violence. Children are often controlled by threat of separation from their families, of getting into trouble from a third party, or threat of harm to a loved one, or threats to personal belongings. Other children maintain the secrecy because of the pleasure and attention gained through the relationship. The activity may be self-reinforcing on some levels. This is an important dynamic that is sometimes ignored. It must also be considered however, that children may find the sexual stimulation pleasurable and may enjoy the affection and attention bestowed upon them through this relationship. Swan (1985) describes the sexual nature

6

of children and argues that this is natural. "A powerful biological propensity plus the obvious reward and reinforcing nature of sexual experience is enough to explain the extremes to which some children go in pursuing sexual activity" (Swan, 1985, p.64). "The child may cling to the incestuous relationship because of special power derived from being the father's favourite" (Green, 1989,p.1967). These same arguments are sometimes misconstrued to support the notion that children are not necessarily harmed by sexual relations with adults or are willing participants. Giaretto (1982) talks of critics that suggest that trauma is caused to children by the public outcry about sexual abuse and not the abuse itself. There are also a few that "take the extreme view that children might profit from early sexual indoctrination by responsible adults" (Giaretto, 1982, p.2). Of course this point of view does not consider the effects the sexual activity has on the relationship and ignores Finkelhor (1984) and Russell's (1986) arguments about the inability of children to give informed consent. Everstine and Everstine (1989) extend the issue of consent by saying that these children are not freely participating in the incestuous relationship but are bargaining with sexual favours for the affection , attention, and sense of being important, that every child should have as a birthright. "Children have an enormous need for adult closeness and nurturance and too frequently they pay a tragic price for it" (Everstine and Everstine, 1989, p.21).

In order for the abuse to come to the attention of professionals or other family members, something or someone interrupts the secrecy phase, either by accident or design. Accidental disclosure can be brought on by observation by someone else, suspicious physical injury to the child, development of sexually transmitted disease in the child, pregnancy, or concern over the child's age inappropriate knowledge of sex or sexualized behaviors. Purposeful disclosure occurs when a participant, usually the victim, decides to tell a third party about the abuse. The child may have various motives for disclosing and it will be important to explore the reasons for the revelation when it occurs (Sgroi, 1982). For an adolescent the factor that usually triggers the revelation of incest is a

7

power struggle between the victim and the exploitive parent (James and Nasjleti, 1983).

After disclosure attempts to suppress publicity, information, and intervention are typical (Sgroi, 1982). Suppression may be extended to denial of the victim's suffering or denial of the abuse all together. The suppression phase may be marked by verbal pressure that is abusive or threatening and aimed at forcing the child to recant or stop complying with the intervention processes. The perpetrator and other family members, especially the nonoffending parent, may try to undermine the victim's credibility and consequently the allegation of the abuse. Divided loyalties and protection of the family are important factors in all family members reactions to the disclosure and their subsequent supportive or suppressive actions.

These five phases outlined by Sgroi (1982), provide an overview of how abuse typically occurs and allows us some insight into the child's experience. Although this pattern was developed to characterize all types of child sexual abuse, they are usually more pronounced in cases of abuse within a family (Courtois, 1988). Since the family is generally considered to be a place of safety and security that nurtures the growth and development of children, abuse within the family contradicts society's assumptions about families. As it is easier to believe that strangers are the source of danger to our children, the possibility of a trusted relative exploiting a child has been routinely denied because it is so contrary to our view of the sanctity of the family. Sink (1988) points out that the safety of children in their families has been presumed rather than enforced and this continues to put children at risk. Understanding family dynamics within incestuous families will provide a clearer picture of how the protective barrier of the family collapses.

FAMILY DYNAMICS in INCESTUOUS FAMILIES

In the literature the dynamics and characteristics of incestuous families are discussed from many different perspectives. Different philosophical orientations have shaped a multitude of definitions and

8

approaches to the problem of intrafamilial sexual abuse. Humanistic psychology is oriented to the growth and development of the whole person. In describing child sexual abuse this perspective shows a compassionate understanding of both offender and the victim and suggest that they are both responding to forces of socialization and personal crisis (Bagley and King, 1990). Family systems models examine the family as a unit and are concerned with family roles, interactional patterns, and dynamics. This perspective is useful in explaining how the family develops dysfunctional patterns that would place all the members in personal crises either effected by or prone to incest. The feminist perspective incorporates the context of societal norms and sex-role stereotyping into the analysis of family roles and patterns. This perspective can help us to understand how socialization and patriarchal family structures contribute to this problem. This paper will rely on the feminist and family systems perspectives to explain the dynamics of incestuous families, with a humanistic orientation as the foundation.

The feminist perspective sees the abuse of power as a paramount dynamic of abuse (Swink and Leveille, 1986). Feminist theory emphasizes the subjective experience of the abused child, the more powerful role ascribed to males in our society and the less powerful to females, and the sexualization of these power differentials (Courtois, 1988). This model depicts incest as occurring between an active, resistant but powerless victim and a powerful, intrusive, self-serving offender (Brickman, 1984). Brickman describes incest as a direct consequence of the growing independence of women from the protective control of men and the lack of concomitant growth by men. Men who can not deal with equal and independent sex partners look for younger partners or use increasingly coercive techniques or both. Incest then is the end result of this process and can be considered as the extreme or end point on a continuum. Traditional family patterns of authority allow fathers to control what goes on in the family and can render mothers and children incapable of standing up to his authority. "The patriarchal family provides the model for inequality and sex-role conditioning" (Courtois,

9

1988, p.166). Perpetrators sexualize their relationship with a child in order to try and satisfy unmet needs in areas such as affection, dependency, authority, aggression, and sex. Children are seen as the logical choice for their actions because they are so accessible, trusting in nature, vulnerable, and immature. Rencken (1989) calls sexual objectification, the use of those less powerful for sexual gratification, a societal dynamic that is at work in abusive families. This is consistent with the feminist argument that patriarchal society contributes to child sexual abuse by providing the context for which it can occur in the first place (Asher, 1988). Sgroi (1982) agrees that child sexual abuse is a means of acting out non-sexual issues in a sexual way and that inevitably the offender is in a position of power over the child victim.

Conceptualizing the problem of incest from a family systems perspective has contributed to a better understanding and growing acceptance that the problem is at least in part family based (Friedman, 1988). Family systems theory helps understand the precipitants to abuse occurring between parents and children. Systemic thinking allows for consideration of the impact an incestuous relationship has on all family members. Understanding interactions between family members, looking at the rules they have established to govern their interactions, and the structures families create that maintain problematic behavior such as sexual abuse are important issues to family systems theorists (Friedman, 1988). This in no way takes the responsibility for the abusive behavior away from the person that chooses to offend. *"The ultimate decision to act out in a sexual manner with a child is still that of the perpetrator regardless of the preempting variables and factors"* (Friedman, 1988, p.329). This framework identifies incest as a symptom of a dysfunctional family system. Sink (1988) argues that overemphasizing the roles of children and families in incest can only be expected to obscure the perpetrator's responsibility for the abuse. This dilemma can be resolved by using a systemic approach to understand the process of abuse and the aftermath of discovery while causation is examined in relation to the abuser's motives and psychological

functioning (Sink, 1988). Bagley and King (1990) caution that sexual abuse of a daughter by her father can be both a response to family stress and the cause of more stress to all concerned. Several family systems theory models recognize that the child, and usually the mother, are innocent in instigating the abuse but have to share in the pathological misery which the father imposes on his family (Bagley and King,1990). Systemic thinking will be considered useful in assessment as it allows the therapist to comprehend the family's response pattern to the abuse more clearly and to see how the family reorganizes itself after disclosure. The goal of intervention from this perspective is to facilitate change in the patterns of the family's interactions that both contributed to and maintained the problem behavior, while keeping the ultimate responsibility for the incestuous behavior on the adult perpetrator. It may not always be possible to use a systemic intervention with these families but the systemic framework is useful even if the therapist only has access to the child (Rencken, 1989).

Family systems theory provides a context for understanding the meaning and function that the incestuous relationship has for a family . "In any given family, the incestuous relationship may serve an entirely different function and purpose" (Friedman, 1988,p.330). There are many types of family interaction patterns and family relationships can be very complicated so it is impossible to define specific characteristics of these families. Gelinas (1983) emphasizes that incest is relationally-based sexual abuse that occurs because of both individual and family processes. Family systems theorists have attempted to identify what type of relational patterns are typical to incestuous families and have found that boundaries are an area that often appear disturbed in these families. Family systems theorists are interested in boundaries because they influence the structure of incestuous families. The structure of a system is the key determinant of what goes on within the system and what transpires between the system and it's environment. Larson and Maddock (1986) examine boundary disturbances in the following areas; families and their social environments, adult and child generations in

families, interpersonal or role boundaries between family members, and intrapsychic boundaries within family members. They support that looking for difficulties or abnormalities in these boundaries is an important part of understanding family structures that are prone to incest.

There is support for the proposal that incest is a reflection of a family system that is relatively closed, undifferentiated and rigid in both structure and function (Larson and Maddock, 1986; Friedman, 1988). Incestuous families are often described as socially, emotionally, and sometimes even physically isolated. They need to protect themselves from the critical social feedback that the social environment could provide regarding their sexual secret. The incestuous family system creates a rigid psychological boundary between itself and it's external environment (Larson and Maddock, 1986). Friedman (1988) refers to this as psychological insulation against outside input to the system. A scarcity of resources develops as family members are forced to try and meet all their emotional needs within their family system. This closed, highly autonomous unit views outsiders as intruders who are not to be sought out for sharing or intimacy. There is little opportunity for growth and members tend to become overdependent on each other which results in enmeshment. Their boundaries become increasingly rigid to keep the family intact when they come into contact with outside social or legal systems. "The heavy price paid for this isolation is , of course, the family's inability to replenish it's energy through stimulation, support, nurturance and enjoyment derived from contacts with the outside world" (Sgroi ,1982, p.252).

When families are isolated members can become totally dependent on each other. This enmeshment promotes the blurring of boundaries between adult and child generations (Larson and Maddock, 1986). Role confusion is produced when family members are compelled to meet each other's needs regardless of age or developmental stage. This is most clearly evidenced by the child victim's functioning in both a spousal and parental role (Friedman, 1988). Giaretto (1982) found that the severe stress that incestuous relationships put on a family structure cause the

12

family roles to become so blurred that the victim does not know how to relate to her father, mother, or her siblings. These victims often spend their childhood having been a wife and mother to their father, a mother to their mother, and a mother to their siblings (Gelinas, 1983). Gelinas (1983) provides a strong argument that the victim is parentified by both parents through the dysfunctional family interaction patterns but cautions that unless the non-offending partner actively participates or knowingly allows the abuse to continue, she is not responsible for her partner's sexual abuse of their daughter. Role confusion or blurring of roles are considered to be more useful descriptors in these cases (Larson and Maddock, 1986). Role reversal is a loaded term that can sometimes lead to mother blaming if it is understood to indicate that the mother has abdicated her role as a partner and pushed her daughter into her place. James and Nasjleti (1983) provide a a clear example of how a child can act in the parental role without the mother knowing about the abuse. They suggest that if a child does not tell their mother about the abuse it is usually because they do not perceive her as a person that can assume an assertive, protective role. The daughter sacrifices her own emotional and physical well being in order to protect her mother, in essence parenting her (James and Nasjleti, 1983). Feminist theorists agree that mothers need not be automatically held partially responsible for the incest but should be viewed as potential allies for their daughters (Brickman, 1984). Larson and Maddock (1986) describe the role confusion as contrary to the functioning of healthy families as children in incestuous families perform developmental tasks appropriate to adults, and parents resign themselves from certain important responsibilities in order to compete with their children for limited emotional resources. The question of responsibility versus blame remains a common theme in the literature (Bagley and King, 1990). Some explain that "significant blurring of familial role boundaries can only take place when parents permit this to happen and fail to set appropriate expectations and limits for themselves as well as for the children" (Sgroi ,1982, p.244). This explanation must be used with caution so that society does not continue to place unwarranted

responsibility on mothers for crimes of the father.

Families in which incest has occurred can be characterized by boundary diffusion that is witnessed in members lacking autonomy and the power of self-differentiaton (Larson and Maddock, 1986). In a system where there are scarce resources and members are enmeshed, they are forced to yield their autonomy in order to belong. " The family relational imbalances have taught them that they literally have no rights, particularly to needs of their own; nothing is owed to them, inherently or because of their contributions, and they are allowed no claim to needs, reciprocity or even acknowledgement" (Gelinas, 1983, p.319). The structure of the incestuous family is threatened by independent thoughts, feelings, or behaviors of members. Differentness cannot be tolerated as it is seen as distancing and individuation is considered to lead to alienation and disloyalty (Larson and Maddock, 1986). Control becomes a critical factor in family structure in order to discourage autonomous behaviors that will threaten the system. Sometimes the incestuous father sets himself up as the sole communicator with persons outside the family in order to further discourage non-familial alliances (Sgroi, 1982). When this is rigidly enforced it further enhances the parent's powerful position and increases their capacity for abuse of power.

Intrapsychic boundaries become maladaptive in these families as individual personality structures do not fit well with the environment. Family members distort meanings and behaviors in an attempt to minimize the emotional pain and cognitive dissonance that the abuse creates (Larson and Maddock, 1986). Defense mechanisms such as denial are common methods to cope with the pain and trauma while maintaining their emotional dependence and interpersonal enmeshment (Larson and Maddock, 1986). Sgroi (1982) describes that the negative aspects of the internal family functioning must be denied in order to be bearable. Considerable energy must also be spent denying any possible positive or attractive aspects of the outside world in order to maintain the family's isolation. Denial allows the family members to distort thought patterns. Intricate ratonalizations are created to live with symptomatic and

14

problematic behaviors. Denial also helps reduce the fear of exposure of the abuse to the outside world.

Larson and Maddock's (1986) conceptualizaton of boundary disturbances in intrapsychic, interpersonal, intergenerational, and societal interaction patterns is useful in explaining a range of behaviors that frequently occur in abusive families. The social isolation caused by rigid societal boundaries can lead to many problems. Social isolation may lead to membership in subcultures of society. Isolation increases suspiciousness of all outsiders and supports family cohesiveness. Overly rigid societal boundaries inhibit appropriate informational exchange between the family and their environment regarding sex-related beliefs, attitudes, and values. The confused boundaries between generations in the family allows for erotic contact between the parent and child subsystems and also contributes to children believing that it is their role to meet their parents needs (James and Nasjleti, 1983). Interpersonal boundary disturbances contribute to the belief that one member's survival depends on the survival of the other and that any change in the family system threatens that survival. Individuals perform self sacrificing behaviors for the good of the family. Confused interpersonal boundaries lead to chaotic family patterns where there is no sense of emotional or physical privacy. Accumulatively, these boundary disturbances create a structure that permits or may even encourage child sexual abuse within a family. Before the effects of this abuse can be considered the meaning of the abuse to the family will be discussed.

MEANING TO THE FAMILY

Interfamilial child sexual abuse does not serve the same function in each family in which it is found. If we look at the meaning that the family attributes to the abuse we will gain some insight into purpose and motivation for the behavior. Like all human behavior, incest is meaningful within the context in which it occurs (Larson and Maddock, 1986). The function that the incest serves in a particular family comes from the

15

network of meanings which tie together family members and influences their patterns of interactions. Larson and Maddock (1986) identify four basic functions that the sexual involvement with children can serve in interpersonal exchange processes. They outline that it is important to consider whether the incestuous behavior is an "affection-exchange process", an "erotic exchange-process", an "aggression-exchange process", or a "rage-exchange process". This will assist in determining the meaning of sexual abuse to each family and in effectively planning intervention.

A significant amount of incestuous behavior functions as an "affection-exchange process" between two ore more family members of different generations (Larson and Maddock, 1986). Offenders may appear to be involved in some form of courtship of their victims, that is usually carried out in a clandestine manner. The sexual behavior is seen as a misguided attempt to show affection or feel emotionally close. The lack of healthier, more acceptable forms of physical nurturance and affection within the family contribute to the development of this interactional pattern (Larson and Maddock, 1986). It also increases the likelihood that the child will not resist the sexual contact as it meets their natural needs for physical closeness and affection. The victim may also be reluctant to give up this position of special attention and privilege. "She may develop a hostile, competitive relationship with her mother and other siblings and aligns with her father in intrafamilial conflicts" (Larson and Maddock, 1986, p.33). Developmental factors may eventually undermine the relationship by creating conflict between the participants. The offender turning to a younger sibling or the victim entering adolescence may lead to disclosure. Family members may show anxiety, depression, and exaggerated dependency needs when assessed but display relatively effective functioning in their social environment (Larson and Maddock, 1986). Victims might eventually display stress related symptoms or problematic behaviors based on their isolation in the community and in their own home.

The "erotic-exchange process" is evident in families that sexualize

all interactions. Eroticism is projected into language, physical appearance, clothes, recreation, and humour (Larson and Maddock, 1986). Family members are socialized into this atmosphere and may feel little anxiety about their atypical behavior. If they do try to exercise control over their bodies or seek out privacy they may be shamed or made to feel guilty by other family members. Although violence is infrequently used to encourage participation, power and control are seen as strong but subtle influences that ensure compliance. It is not unusual for this type of family structure to include one or more members who are symptomatic and this may eventually lead to the discovery of the family secret. Inappropriate sexual behavior by younger family members at home or in the community, extra-familial sexual abuse by a family member, or the tracing of neighbourhood rumours about the family may lead to suspicions of an incestuous system (Larson and Maddock, 1986).

In the "aggression-exchange process" offenders "use sexualized anger to deal with their frustration and disappointment over various aspects of their lives" (Larson and Maddock, 1986, p.36). The intent appears to be to hurt someone in the family through anger and even violence in his sexually abusive acts. The perpetrator chooses to hurt a more vulnerable and powerless member of the family rather than the actual source of his hostility. The diffuse interpersonal boundaries that are part of these systems allow the perpetrator to believe that his abusive behavior will actually effect the person to whom the hostility is directed. Typical distortions are seen in this family structure but individual psychopathology is also a factor. The offenders behavior in these cases are driven by feelings of low self-esteem and shame that may be associated with their own childhood history of sexual abuse (Crowder & Myers - Avis, 1990).

The "rage - expression process" is the final functional type of incestuous behavior that Larson and Maddock (1986) identify. This is considered to be one of the most pathological of family systems. The offender acts out his unfocused, primitive anger or rage on a family member who is less threatening. Usually the anger will be focused on a

child. This process may contribute to development of individual psychopathologies in other, or all family members. Coping strategies developed within this system are often very maladaptive when applied outside the family.

These exchange processes are characterized by pervasive and enduring interaction patterns that, once identified through assessment, can be examined in treatment (Larson and Maddock, 1986). Crowder and Myers - Avis (1990) criticize this conceptualization because it does not address the dynamics of power and control within the family system. "Since power and control are always present in sexual abuse, it is thus limited in it's usefulness" (Crowder and Myers - Avis, 1990, p. 23). They make use of Larson and Maddock's concepts however as a description of individual and interpersonal behavior in the process of intrafamilial abuse. It is included here for the same reason as well as my belief that it provides an understanding of the possible meanings the abuse has to the family that is involved. Power and control are considered to be more important in the dynamics of interfamilial abuse rather than in the meanings families develop for the abuse. Understanding the dynamics of incestuous families, the meanings that sexual abuse has been given in a family, and knowing the range of effects that may be presented can prepare helpers to more effectively meet the family where they are and plan appropriate interventions.

EFFECTS

Evidence continues to accumulate that clearly suggests that child sexual abuse is a serious mental health problem that is consistently associated with disturbing aftereffects in a significant portion of it's victims. Browne and Finkelhor (1988, 1986) provide two comprehensive reviews of both the clinical and empirical literature for initial and long term effects of child sexual abuse. They have set an arbitrary cut off point at two years following the termination of the abuse to delineate initial from long term effects. "The empirical literature does suggest the presence - in some portion of the victim population - of many of the initial effects reported in

the clinical literature, especially reactions of fear, anxiety, depression, anger and hostility, and inappropriate sexual behavior" (Browne and Finkelhor, 1986, p.152).   They caution however that because many of the studies were technically weak the results should be considered promising but not conclusive. Their review also found that many of the long term effects suggested in the clinical literature have been empirically confirmed.

"Adult women victimized as children are more likely to manifest depression, self - destructive behavior, anxiety, feelings of isolation and stigma, poor self-esteem, a tendency toward revictimization, and substance abuse. Difficulty in trusting others and sexual maladjustment, such as sexual dysphoria, sexual dysfunction, impaired sexual self- esteem, and avoidance or abstention from sexual activity has also been reported by empirical researchers, although agreement among studies is less consistent for the variables on sexual functioning"

(Browne and Finkelhor, 1986. p.162).

Haugaard and Repucci (1988) have also reviewed the empirical and clinical literature and divide their findings into emotional, behavioral, and sexual consequences. Emotional consequences include feelings of guilt, anger, depression, and helplessness. These emotional effects play a major role in the development of many adverse behaviors. Some victims internalize their distress, resulting in somatic complaints, sleep pattern disturbances, nightmares and self-destructive behavior. Others externalize their distress, which leads to aggressive behaviors, acting out, and sexual activity with both younger and older individuals (Haugaard and Repucci, 1988).   Finkelhor and Browne (1985, 1988) have developed a clear model to organize the wide range of effects documented in sexual abuse literature. Their conceptual framework separates the effects into four areas that could each be considered

traumagenic. The conjunction of these four areas "in one set of circumstances makes the experience of child sexual abuse somewhat unique" (Finkelhor and Browne, 1988, p.62). Traumatic sexualization, stigmatization, betrayal, and powerlessness are conceptualized as the central trauma causing factors of child sexual abuse. Each factor has it's own resulting psychological consequences and behavioral manifestations (Finkelhor and Browne,1988). This framework gives form to the wealth of problems associated with child sexual abuse. Finkelhor and Browne (1988) suggest that the operation of each of these dynamics alters a child's emotional and cognitive orientation to the world. Trauma is created through the distortion of the child's worldview, their self-concept, and their affective capacities.

Finkelhor and Browne (1984) define traumatic sexualization as "a process in which a child's sexuality (feelings and attitudes) is shaped in a developmentally inappropriate and interpersonally dysfunctional fashion as a result of sexual abuse"(p.181). This can happen in a variety of ways such as a child being rewarded for sexual behavior inappropriate for the developmental level or the child learning to acquire affection and attention through sexual behavior. Offenders transmit confusing messages to children about acceptable sexual behaviors and morals and focus attention on sexual parts of the body. For some children sexual experiences become associated with frightening memories and this connection persists. "Children who have been traumatically sexualized emerge from their experience with inappropriate repertoires of sexual behavior, with confusions and misconceptions about their sexual self-concepts, and with unusual emotional associations to sexual activities"(Finkelhor and Browne, 1988, p. 63). Different sexual abuse experiences produce a dramatic range in type and extent of traumatic sexualization. Experiences in which a child is a more active participant, and activities in which a child is enticed rather than forced will produce a more sexualized victim. A younger child who has little or no understanding of the sexual nature of the activity will probably be less sexualized than a child who is old enough to realize the sexual

implications.

Betrayal is the second category of traumagenic dynamics and refers to the process "by which children discover that someone on whom they were vitally dependent has caused them harm" (Finkelhor and Browne,1984, p.182). Child victims feel betrayed by both the offender and other family members. At some point the child may realize that the offender has misrepresented or lied about moral standards and manipulated their behavior. Family members who were not protective or fail to believe and support the child can increase the child's sense of betrayal. "Inability to trust is directly linked to the victim's low self-esteem and past experiences of betrayal" (Sgroi, 1982,p.122) Of course there is an increased sense of betrayal in intrafamilial offences (Brickman, 1984) but the degree of betrayal may also be effected by how the child feels about the offender. If the child was suspicious of the offender's behavior from the outset it will be less of a betrayal than if the child saw the activity as positive initially and then realizes they were mislead (Finkelhor and Browne, 1988).

"Powerlessness refers to the process in which the child's will, desires, and sense of efficacy are continually contravened" (Finkelhor and Browne,1988, p.64). They theorize that the repeated invasion of the child's territory and body space creates a basic sense of powerlessness that can be exacerbated by the degree of coercion and manipulation involved. Other aspects of the abuse that also contribute to this dynamic are the child's inability to stop the abuse, lack of response when a child tries to get help, or a child's realization that they are trapped in the situation by their own dependency. Brickman (1984) documents that all the incest survivors she has worked with discuss the many strategies they tried in order to avoid the incest. Powerlessness is more than just a psychological experience as the victim simply does not have the power to change the offender's behavior. When a child is able to bring the abuse to an end or at least exert some control over its occurrence they may feel more empowered (Browne and Finkelhor, 1986).

The final dynamic Finkelhor and Browne (1984) develop,

21

stigmatization, "refers to the negative connotations -- for example, badness, shame, and guilt -- that are communicated to the child about the experiences and that then become incorporated into the child's self-image" (p.184). The negative messages can be sent through direct or subtle behaviors and communication with the offender. Negative or judgmental responses from family members or the general community can also have lasting effects on a child's developing self-image.

After outlining these four seperate themes that are possible sources of trauma in child sexual abuse victims Finkelhor and Browne (1984,1988) propose that the framework be incorporated into assessment. Clinicians would attempt to determine what degree of trauma a client has experienced and which of the four themes are relevant. The traumagenic model was developed further by taking the effects cited in the literature and categorizing them under the applicable traumatic dynamic. They hypothesize that traumatic sexualization is particularly associated with impacts on sexual behavior and confusion about sexual norms and standards. These effects would include sexual dysfunctions, promiscuity, sexual anxiety, and low sexual self-esteem found by many researchers (Shapiro and Dominiak, 1990; Jehu, Gazan and Klassen, 1985). Stigmatization would be most clearly related to long-term cognitive effects such as guilt, poor self-esteem, a sense of differentness, and isolation. This is associated with secondary problems such as drug and alcohol abuse, criminal involvement, suicidal ideation, suicide attempts and other self-destructive behaviors. Betrayal would seem most plausibly associated with effects such as depression, dependency in extreme forms, impaired ability to trust and to judge the trustworthiness of others, and anger. Some of the behavioral manifestations Finkelhor and Browne (1988) associate with this are vulnerability to subsequent abuse and exploitation, discomfort in intimate relationships, and marital problems. The anger stemming from betrayal is part of what may lie behind the aggressive and hostile posture of some sexual abuse victims, particularly adolescents (Browne and Finkelhor, 1986). Antisocial behavior and delinquency sometimes associated with

a history of victimization are also an expression of this anger, and may represent a desire for retaliation. Finally, powerlessness is likely to be associated with fear and anxiety, a lowered sense of self-efficacy, perception of the self as a victim, and sometimes an identification with the aggressor as an attempt to regain some sense of power. "Manifestations here might include nightmares, somatic complaints, depression, running away, school problems, employment problems, vulnerability to subsequent victimization, aggressive behavior, delinquency, and/or becoming an abuser" (Finkelhor & Browne, 1988, p.67). Responses in this category are both signs of being resigned to a victims position and desperate attempts to demonstrate that they can regain the power that was taken away from them.

The traumagenic dynamics can be useful to clinicians in several different ways. Firstly the conceptualization provides many new hypotheses to test that will yield more specific information regarding what is damaging about child sexual abuse. It can also be used as a starting point for developing assessment instruments that are more specific to child sexual abuse. Finkelhor and Browne (1988) propose that their traumagenic framework can already be used as an aid in assessing impact of abuse as it prompts clinicians to check for problems in all areas and can be used to guide effective intervention planning.

The effects of an incestuous relationship may also be presented in treatment in a disguised version if the problem has not been previously disclosed. Gelinas (1983) discusses how the untreated negative effects can repeatedly create symptoms and problems that will make therapy unsuccessful. The usual disguised effects seen in a victim that has not yet disclosed are depression, and problems with impulse control and dissociation. "Clinicians facing sexually abused patients who present without sexual abuse as their chief complaint are first met with what appears to be a fortress of defensive structures. Most commonly seen are denial, projection, acting out, splitting, displacement, distortion, and acute regressive states" (Shapiro and Dominiak, 1990, p.69). Schaefer and Evans (1988) describe typical patterns of self-abusive behavior found in

23

people where incest is eventually uncovered. They hypothesize that self-mutilating behaviors such as cutting or carving skin, pulling out hair, or burning and a variety of eating disorders are methods that victims use to act out their pain without acknowledging the source. Many of the effects described in the literature will be present both before and after disclosure in differing degrees. Of course the evidence of symptomatic behavior in the victim is often the first clue that leads to detection of incestuous families. Disclosure does not magically make these problematic behaviors disappear as they have usually become well entrenched methods of coping.

Gelinas (1983) made some of the first connections between incest victims responses and other survivors of trauma. Incest victims are observed to sometimes alternate between numbing or denial and repetitive intrusions of vivid recollections and exaggerated affective states. Some would argue that the aftermath of childhood sexual abuse represents what is commonly referred to in the field of mental health as post - traumatic stress disorder (Briere and Runtz, 1988). The long term trauma of incest leads to delayed responses that are characteristic ways of reacting to immense stress, consistent with victims of war, terrorism, or rape. Many suggest that intrafamilial child sexual abuse may produce either delayed or chronic post - traumatic stress disorder (Briere,1989; Gelinas, 1983). Briere and Runtz (1988) feel that the label of post traumatic stress disorder is not broad enough to encompass the wide range of symptoms that are reported with great frequency in sexual abuse survivors. In order to avoid the stigma of multiple psychiatric labels that could be attached to the "specific constellation of psychological disturbance arising from severe childhood sexual victimization" a more useful term was created (Briere and Runtz, 1988, p.92). "Post sexual abuse trauma" is considered a specific form of post - traumatic stress disorder (Briere, 1989). This term represents a more global description of the long term effects seen in incest survivors. Many of the symptoms of post-abuse trauma are then explained as either logical, adaptive responses of victimization that become inappropriate in the postabuse

environment or as conditioned reactions to abuse-related stimuli that persist into later life (Briere, 1989). Post sexual abuse trauma is a more appropriate categorization of the long-term effects as it recognizes their developmental and adaptive aspects. This distinguishes post sexual abuse trauma from the more static aspects of delayed post traumatic stress disorder (Briere and Runtz, 1988).

MEDIATORS OF LEVEL OF EFFECT

Research has rarely found sexual abuse to be without damaging consequences for the victim (Briere, 1989). It is clear, however, that all children do not react to the experience of being sexually abused in the same way. It has not been clearly established which factors account for the range of response. Long term victimization, involving violence or coercion, that is perpetrated by highly valued and trusted family members is likely to contribute to the most damaging consequences (Dolan, 1991; Bagley and King, 1990). Factors believed to mediate the degree of damage are wide ranging. Experiences that are of short duration and where the victim is given strong support upon disclosure seem to cause a lesser degree of traumatization (Dolan, 1991). It is less traumatic for victims when responsibility is placed clearly on the perpetrator. This responsibility may be placed on the perpetrator through legal means or social repercussions if the offender does not accept the blame of their own volition (Dolan, 1991). Degree of intrusiveness of the activity and the age at the time of victimization may be relevant mediators of the level of effect. Results in these and other hypothesized relevant areas remain contradictory or negative. At this point there is no specific contributing factor that has been consistently associated with a worse prognosis (Wachtel and Scott ,1990).

There is some evidence that gender is a strong mediating factor in victim responses to childhood sexual assault. Different patterns of response are seen in male and female victims. McGregor and Dutton (1990) cite a 1984 study by Carmen, Rieker, and Mills that concluded that male victims display symptomatic behavior in aggressive ways while

females acted out in self-destructive ways. The same study also found that females tend to internalize their anger and pain as depression and low self esteem which increases their risk for revictimization. Males externalize the same affect and seem more likely to inflict their anger on others rather than themselves.

In intrafamilial cases the support of the non-offending parent and siblings has been proven to be an important factor in reducing the impact of the abuse (Conte and Berliner, 1988; Everson et al., 1989). Everson et al. (1989) found that less than 50 % of mothers in their study of 100 cases could be classified as consistently supportive of their children, with 25 % of them siding completely with the perpetrator. They also found a strong relationship between the mother's current relationship with the offender in that it was easier for those who were divorced or separated to support the victim. Mothers who fail to support their children may be struggling with their own personal problems and are incapable of responding to the distress and emotional needs of their children (Everson et al., 1989). "Immediate intervention aimed at supporting mothers and helping them to believe, empathize with, and offer consistent emotional support and protection of their children may be the most effective way of reducing the child's emotional stress and disruption following disclosure of incest" (Everson et al., 1989, p.206).

Developmental processes can be considered an important mediator as many theorists propose that effects change as the child matures and that new developmental tasks such as adolescence, adulthood or parenthood can cause certain effects to appear or reappear (Wachtel and Scott, 1990). It has not been determined whether responses to sexual abuse follow a similar pattern across preschool, school-age, and adolescent age groups (Friedrich, 1990). There is evidence that the effects of childhood sexual abuse are the most serious during adolescence (Rist, 1979). This supports Finkelhor and Browne's (1986) hypothesis that since no relationship could be found between the age of onset of abuse and the degree of behavioral disturbance that the most important variable may be the stages of development through which

26

the abuse persists rather than the age of onset. Incest victims have their development affected and modified by their experience. This will be further explored in a seperate section pertaining to the developmental issues that adolescents face and how this relates to the effects of incest. A brief review of the literature pertaining to treatment for victims will precede the focus on developmental issues.

CHAPTER TWO : Treatment

INTRODUCTION

One of the difficulties in reviewing the literature on treatment for adolescent victims is that most information focuses on child or adult populations and it is difficult to know what is and is not relevant to an adolescent. An adolescent may be closer to an adult in chronological age but may have regressed considerably in dealing with the aftermath of the abuse disclosure. Conversely, a young adolescent may be so parentified that they are used to being treated like an adult and may relate to the therapist in a more adult manner. Some argue that developmental distortion is an effect of abuse that is unique to each victim (Watchel and Scott, 1991). Intervention should be developmentally appropriate rather than focusing on the variable of age. An adolescent sexual abuse victim seeking treatment can present in many forms. An adolescent who is being treated during the initial crisis after the disclosure may have different treatment issues than an adolescent who was abused as a child but entering treatment for the first time. Abuse that happened in the past, historical abuse, may be being acknowledged for the first time. It also will be different if the client disclosed the abuse as a child but has never had the opportunity to make sense of the experience. In these cases it is no secret that the abuse took place but for any number of reasons treatment was never made available or deemed necessary. If the abuse is historical, literature discussing work with adult survivors may be the most relevant to these adolescents. If the abuse was ongoing perhaps the literature relating to children's responses and treatment needs is the most applicable as it is more likely to include managing the immediate crisis. Adolescents may also fall into the category of those who enter into treatment because acting out behavior has lead to therapeutic intervention without any acknowledgement of a history of sexual victimization.

TREATMENT GOALS

Bagley and King (1990) provide a very general starting point stating that healing is a process of learning to enjoy living with oneself in the world. In their work they see the goals of therapy as "helping survivors to express acceptance of a full range of emotional responses, put the abusive experience into a historical and emotional perspective, and empowering the former victims to rebuild their own self-esteem and confidence" (Bagley and King, 1990, p.154). Russell (1986) adds that treatment goals must include coming to terms with a world in which bad experiences happen to oneself and also restoring a damaged self-image. Everstine and Everstine (1989) set a goal of working towards the child being able to externalize the sexual abuse as an event rather than having it remain part of her self-concept. They see this as imperative to the development of a healthy self-concept and a sense of self-worth. Courtois and Sprei (1988) recognize that goals will vary according to the needs of each client. In treatment's least intense form, short term counselling that provides reassurance, information, and support may be sufficient (Courtois and Sprei,1988). Women suffering the most serious effects may require long-term reconstructive treatment that involves breaking the secret, catharsis, and a reevaluation of the incest (i.e. it's circumstances and its effects). A comprehensive discussion of long term therapy goals is provided by Courtois and Sprei (1988). The goals for which they elaborate for adult victims, are the establishment of a therapeutic alliance; acknowledgement and acceptance of the occurrence of the abuse; exploration of issues of responsibility and complicity; breakdown of feelings of isolation; recognition, labelling and expression of feelings; catharsis and grieving; cognitive restructuring of faulty beliefs; insight and behavioral change; education and information giving; separation and individuation. For children, therapy should provide a time to "begin to express their feelings about the sexual abuse, their families, and about the events which have occurred since disclosure. Individual therapy allows victims a safe time and place to "put the pieces together" and to begin rebuilding their self-esteem" (Porter, Blick, and Sgroi, 1982, p.142).

Rencken (1990) discusses different goals to consider depending on whether the intervention is immediate or delayed (over a year since the last abusive episode). In immediate interventions therapeutic goals involve a process of empowering the child by reinforcing the reporting of the incest, rebonding with the nonabusing parent, assertiveness and self-protection, redefining their relationship with the offender, resumption of age-appropriate roles whenever possible, and positive control and attitudes regarding sexuality. In delayed interventions it can be expected that the victim will have built up defenses to cope with the abuse. "Although these defenses may have initially have been functional, they will probably present significant obstacles to both identification and treatment of affective, relationship, and sexual issues" (Rencken, 1990, p.86). A major treatment issue and goal is the expression of the repressed emotions.

THERAPY OVERVIEWS AND PHILOSOPHY OF TREATMENT

From a feminist perspective a victim's pain and it's consequences are the central feature of incest (Brickman, 1984) and will be the focus of treatment. Trauma and suffering in the victim are assumed to be present and treatment emphasizes believing in and supporting the survivor and her experience. In Brickman's (1984) opinion these are long range goals rarely accomplished in anything less than two or three years. Courtois and Sprei (1988) consider the symptoms that a client exhibits as the symbolic way that she communicates about her experience while defenses are viewed as skills devised to survive the trauma. All the symptoms and defenses that victims present must be understood in context and not pathologized (Courtois and Sprei, 1988). Dismantling the defenses is essential to beginning work on the underlying material and will in turn lead to symptom remission over the course of therapy. A feminist perspective is consistent with a survivor - oriented perspective and recognizes that childhood sexual abuse may be relevant to a variety of adolescent and adult mental health problems and that therapeutic attention to these historical events may have a significant impact on

current psychological functioning (Briere, 1989). This does not ignore the possibility that other aspects of the clients childhood have also been destructive but assumes that the most distressing problems presented will be related to the experience of intrafamilial sexual abuse. Family therapy is seen as a final step in a sequence of interventions with the first priority being to provide the child with a safe and nurturing environment.

Briere (1989) also incorporates a phenomenologic perspective into his work that emphasizes the notions of reaction and accommodation in the development of later abuse-related problems. It views many of the symptoms of post-abuse trauma as either logical, adaptive responses to victimization that become inappropriate in the postabuse environment or as conditioned reactions to abuse-related stimuli that persist into later life. As well as helping the therapist to understand the child's experience of abuse, a phenomenological analysis points to the need to "stay with the clients experience in adulthood". This applies to the content of therapy as well as the process of treatment. The process must fit the clients current psychological and emotional state so that it remains congruent with the clients ability to process new information or feelings and her immediate experience. The clients internal state must also be constantly monitored as there is a tendency to move faster than the survivor can tolerate (Briere, 1989). This philosophy of treatment is essentially a growth model that sees that survivors have made appropriate accommodations to a toxic environment. These accommodations were useful at one time but these survival behaviors and perceptions need some updating as they tend to become problematic later in life. This is vastly different from a clinical or medical model that might consider the same symptoms as pathological and focuses on curing weaknesses.

A family systems perspective can be successfully incorporated in work that comes from a feminist perspective and is survivor oriented (Courtois and Sprei, 1988; Hogan, 1990). From a family systems perspective (that is consistent with a feminist model) it is not wise to foster contact between offender and victim until the perpetrator accepts full responsibility for the abuse Systemic work can be done using individual

and then dyadic work as a medium until it is realistic to consider working with the entire family. Individuals can develop in isolation as parts of a healthy system and have the safety to work on individual issues. Family reconstitution will be considered a goal of treatment but not at the expense of the adolescent's sense of security. Henry Giaretto (1982) developed a well known and often copied model of treatment for the entire family. The Giaretto model prescribes individual counselling for all family members plus concomitant group work with relevant peers, i.e., victims group, offenders group, etcetera. The treatment procedure then involves mother-daughter counselling, marital counselling, father-daughter counselling, and finally family counselling. Bagley and King (1990) describe a similar model where they clarify that success is not necessarily the total reconstruction of the family but more importantly establishing healthy functioning in whatever portion of the family chooses to remain together.

Intrafamilial sexual abuse is usually traumatic. Therefore it is important to develop an understanding of how trauma and the associated anxiety will be addressed in treatment. Many of the symptoms related to sexual abuse can be explained as attempts to master or cope with the anxiety produced by traumatic stress, either through approach strategies or through avoidance and denial (Roth and Cohen, 1986). Stress produces physiological arousal as well as cognitive and behavioral responses. When these responses are "elicited by situations or stimuli that pose no external danger or threat of harm and interfere with adaptive behavior they are likely to be labelled as anxious" (Wheeler and Berliner, 1988, p.229). Anxiety is an unpleasant state that people are generally highly motivated to reduce or eliminate. Behavioral coping responses may involve avoiding situations related to feelings of anxiety. For abuse victims this may initially entail avoiding their offender. This same response can become overgeneralized and problematic to the point of producing it's own anxiety.

"As the processes of generalizing and / or higher-order
conditioning proceed, the child might experience anxiety in

the presence of persons or situations far removed from the initial abusive experiences. While the anxiety might have been adaptive initially, in the sense that it alerted the child to the dangers posed by her father or even of the potential dangers of, for instance, being alone with men, in the long run as the process of generalization and higher-order conditioning evolve and the child's developmental level and needs change, the anxiety could become maladaptive and even debilitating" (Wheeler and Berliner, 1988, p.230).

Avoidant behaviors and thoughts minimize the discomfort of anxiety and their successful avoidance reinforces it's continuation. Repression is explained as a learned process of avoiding thoughts or events associated with anxiety (Wheeler and Berliner, 1988). Repression is a damaging coping mechanism because the sufferer is never able to examine whether their fear or anxiety remains necessary. Repression also interferes with the acquisition of more appropriate coping strategies and skills. Repression "interferes with higher cognitive processes ... [and] inhibits the use of language to help to understand, distinguish, and sort out the stimuli that are producing or maintaining anxiety" (Wheeler and Berliner, 1988,p. 231). Approaching the source of the anxiety allows for the observance of changes and developments that might make the situation more tolerable (Roth and Cohen, 1986). Approach strategies can suggest appropriate action and encourage ventilation of affect. Approach and avoidance strategies both have their place in managing the anxiety that sexual abuse creates. Avoidant strategies may be therapeutic if they allow for a gradual recognition of threat and prevent the individual from being overwhelmed (Wheeler and Berliner,1988). Wheeler and Berliner (1988) suggest interventions "directed toward active but gradual "mastering" of anxiety through strategies that gradually foster engagement and coping with the anxiety and fears and minimize counterproductive denial and avoidance" (p.231).

The other theory base that is useful in understanding children's responses to sexual abuse is a social learning perspective. A "major

pathway to postabuse maladjustment is through the maladaptive social behaviors, beliefs, and attitudes that children learn from sexual abuse and the adaptive ones that they fail to learn" (Wheeler and Berliner, 1988, p.232). Social learning terms can be linked to the effects that Finkelhor and Browne (1985, 1988) have described in the traumagenic framework so that work is based on a "substantial body of psychological theory" (Wheeler and Berliner, 1988,p.232). Social learning processes help explain a clearer causal relationship between the abuse and the documented effects. Berliner and Wheeler (1988) develop "a formulation that is based on assumptions about hypothesized causal processes" (p.228). The offender models, instructs, reinforces, and punishes certain sexualized behaviors in their victims. The child does not have the cognitive, social, or emotional capacities to regulate the sexualized behaviors they acquire (Wheeler and Berliner, 1988). Victims learn that sexual behaviors can be used to avoid punishment or to earn reinforcers. Social learning theory predicts that the physical arousal the abuse may create can lead to disinhibited sexual expression in the child in other situations (Wheeler and Berliner, 1988). This leads to the stigmatization and traumatic sexualization effects that have been discussed elsewhere. Victimization can alter certain beliefs about the world that non-victimized people assume to be true. Assumptions about personal invulnerability, a perception of the world as meaningful and predictable, and a positive self-concept are assumptions that can be shattered by victimization (Janoff-Bulman & Frieze, 1983). "While children may not have such well-formed assumptions about the world, sexual abuse affects their ideas about themselves, about others, and about relationships that mediate their behavior and future development" (Wheeler and Berliner, 1988, p.233). For a victim of sexual abuse the lack of control over something as fundamental as their own body teaches them about powerlessness. The child comes to expect that they can only produce undesirable outcomes and their sense of self-efficacy is diminished (Wheeler and Berliner, 1988).

TREATMENT MODES

Overwhelmingly the literature supports combinations of group, individual, and family treatment for intrafamilial sexual abuse cases. Sgroi (1982) is one of the few that addresses that family treatment is often not possible because families are unable to appropriately confront the problem within their family. James and Nasjleti (1983) suggest that only 1 in 10 cases are amenable to and appropriate for family treatment. This sounds rather pessimistic and may be a reflection of only the initial position families take at the point of disclosure. During the crisis period, following disclosure of abuse in a family, individual treatment for non-offending parents and offenders can attempt to move both parties towards appropriate readiness for family treatment. It is most important to work towards dyadic sessions with victims and mothers as this support is crucial to the victim's recovery (Everson et al., 1989). Family treatment (that includes the offender) is not possible however as long as the offender does not accept responsibility for his abusive behavior. Other family members will not be considered amenable to family sessions while they continue to react to the disclosure with denial and hostility. In cases where the child is the only family member available for treatment clinicians can still be effective in individual and /or group treatment although it is not the optimal approach (Sgroi, 1982). Individual treatment with victims can be seen as both a stepping stone in preparation for eventual family work and a valuable experience in it's own right. Only in situations where there is appropriate acceptance of responsibility by the perpetrator and support for the victim from the non-offending parent can individual therapy be seen as a short term proposition in preparation for dyadic and family work.

Treatment approaches with incestuous families described in the literature tend to be highly eclectic and pragmatic in that they respond to each clients unique needs (Friedrich, 1991; Courtois and Sprei, 1988; James and Nasjleti, 1983).

INDIVIDUAL TREATMENT

Little information is available that addresses specific treatment methods for child and adolescent victims (Bagley and King, 1990). Wheeler and Berliner (1988) provide one of the few "attempts to develop, refine, and empirically evaluate systematic interventions" (p.227) Wheeler and Berliner (1988) divide their intervention strategies into those designed to reduce anxiety and those aimed at treating socially learned responses. They appreciate that the complex presentation of abuse effects and their volume suggest multiple interventions will be necessary with this population. Wheeler and Berliner (1988) offer interventions based in theory "in an effort to pull together the diverse strands of an emerging field" (p.245).

"Treatment of fear and anxiety involves reducing the arousal to fear-producing cues and teaching management strategies for neutralizing the subjective feelings of anxiousness" (Wheeler and Berliner, 1988, p.236). The very process of therapy lends itself to anxiety reduction as the client will be encouraged to gradually expose themselves to the subject of their anxiety, the sexual abuse, allowing them to master their fears and apprehensions. Ventilation of affect is also a large part of anxiety reduction as "appropriate expression of affect may, over time, reduce the power of abuse cues to elicit arousal and discomfort" (Wheeler and Berliner, 1988, p.236). Anger and grief will be important focuses of treatment. These emotions need to be expressed in a safe environment where clients can learn constructive strategies for managing them. The therapist can assist in resolving grief by helping the client move through the stages of mourning. Rituals and positive reminiscing can be part of this work (Wheeler and Berliner,1988). An adolescent may need support to understand that "sad feelings are acceptable and do not reduce the seriousness or wrongfulness of the abuse" (Wheeler and Berliner, 1988, p.237). Angry feelings also need to be expressed through whatever means the adolescent may be comfortable with including discussion, reenactments, drawing, and writing. Having clients identify and describe their emotions helps to develop relevant and age-appropriate

management strategies. Specific anxiety-reduction strategies can also be developed for a client's unique concerns such as nightmares or anxiety about their ongoing safety. This may involve relaxation training and acquiring problem-solving skills for older children that will assist them in coping with anxiety and fears (Wheeler and Berliner, 1988).

Wheeler and Berliner (1988) provide specific strategies for treating socially learned responses to sexual abuse. Areas that they address include ; altering attributions of responsibility, explaining the offender's behavior, restoring expectations of self - efficacy, traumatic sexualization, and sexual behavior problems (Wheeler and Berliner, 1988). The most obvious way to work towards altering attributions of responsibility is by providing the young person with a "straightforward explanation of what has happened and assurances that they are not culpable for their abuse" (Wheeler and Berliner, 1988, p.239). This can be complicated by the struggle to construct explanations that are developmentally appropriate and incorporate current beliefs in the study of sexual abuse. Children need to be provided with explanations about why adults are assumed to be more responsible and educated regarding the issue of consent (Wheeler and Berliner, 1988). It is imperative to elicit information and beliefs regarding the child's perceived participation in the abuse or their accommodation of it's continuation. For example a child who has initiated sexual activity or taken favours for their compliance will need to be helped to understand the choices that they made (Wheeler and Berliner, 1988). There may be some guilt that is appropriate for a child to feel regarding their own behavior and it is not therapeutic to absolve such feelings without examination (Porter, Blick, and Sgroi, 1982).

Explanations of the offender's behavior also need to be developmentally appropriate and knowledge based. It is recommended to avoid "sickness" as a reasonable explanation as it is associated with not being in control of one's behavior and confuses responsibility issues (Wheeler and Berliner, 1988). Distorted beliefs must also be examined in relation to this issue.

Victims can be taught more effective coping skills that help restore

their expectations of self-efficacy (Wheeler and Berliner, 1988). This may include reenacting scenes where the client avoids or conquers the offender, imagining helping a friend with a similar problem, or planning how they will be different as a parent (Wheeler and Berliner, 1988). Children and adolescents can learn to identify "preabuse warning signs" so that they will feel less vulnerable to revictimization (Wheeler and Berliner,1988, p.242). The therapeutic relationship counters the negative model of the abusive relationship and assists children in improving relationships with other concerned adults in their network (Wheeler and Berliner, 1988). Children's feelings of powerlessness and isolation can be reduced by the acquisition of problem solving, social, and communication skills (Wheeler and Berliner, 1988).

"Although not all children have sexual behavior problems following sexual assault it should be assumed that the abuse will have a potentially damaging effect on their ideas about sexuality or will facilitate engaging in sexual behavior that is potentially harmful" (Wheeler and Berliner, 1988, p. 243). Intervention needs to focus on providing age appropriate sexual information, values clarification, and development of a personal set of beliefs regarding sexuality (Wheeler and Berliner, 1988). Even though sexual education may seem premature for some young victims it is always important to provide victims with accurate information to challenge the misinformation that the abusive experience creates. Individual treatment can also address personal boundary disturbances that abuse can distort. The therapeutic relationship can model appropriate physical boundaries between people and also in relation to personal belongings. Children need to be confronted and instructed regarding intrusiveness and appropriate alternatives provided (Wheeler and Berliner, 1988). Other interventions in this area are behavior management strategies for sexually inappropriate behavior and developing family rules around privacy and acceptable sexuality (Wheeler and Berliner, 1988).

"What children believe about the sexual abuse and their role in it's occurrence, their attitudes about themselves, and their expectations of others are significant foci of treatment" (Wheeler and Berliner,1988,

p.235). It is important to determine what the child's beliefs are in order to examine their appropriateness and utility. "Distorted beliefs may contribute to many emotional and behavioral problems. It follows that the correction of distorted beliefs is likely to be accompanied by the alleviation of such problems" (Jehu, Klassen, and Gazan, 1986, p.50). Interventions in this area are all "based on the premise that beliefs have a significant influence on feelings and actions" (Jehu, Klassen, and Gazan, 1986,p.49).   Cognitive restructuring interventions attempt to change distorted beliefs and lessen or extinguish the accompanying mood states (Jehu, Klassen, and Gazan, 1986). As sexual abuse has such a profound influence on children's developing belief systems it seems promising that cognitive restructuring can uncover and change many distortions for victims seeking treatment.   To correct distorted beliefs the client first has to become aware of their beliefs, then examine the distortions they contain, and finally adopt more accurate beliefs (Jehu, Klassen, and Gazan, 1986). "Relevant beliefs are often revealed to the client and the therapist during their discussion of the client's problem and history" or may be gathered through questionnaires and exercises (Jehu, Klassen, and Gazan, 1986,p.50). A thorough discussion of the range of common distortions is provided by Jehu, Klassen, and Gazan (1986), with many excellent examples. They suggest that the client and therapist become familiar with the possible distortions. Beliefs are then examined looking for evidence of the distortions. The therapist and the client explore more accurate and realistic beliefs that can be substituted for the distorted beliefs. Provision of information, logical analysis, decatastrophizing, distancing, and reattribution are all useful procedures in exploring more accurate beliefs (Jehu, Klassen, and Gazan, 1986). Information can be provided through questioning or more direct provision. Factual data may be needed to refute distorted beliefs. This can be provided verbally or in prescribed reading or video materials. Logical analysis entails reviewing whether the conclusions that the client has arrived at are supported by facts. Consideration is given to alternative conclusions that are based on appropriate   information   (Jehu,   Klassen,   and   Gazan,   1986).

Decatastrophizing allows for the consideration of many possibilities rather than the tendency to settle on the worst possible scenario (Jehu, Klassen, and Gazan, 1986). The client's perspective must be widened to take all relevant information into account. More realistic considerations can be made this way. "Distancing refers to the process of a client shifting from a subjective to an objective perception of her own beliefs, so that they are no longer regarded as self-evident truths but rather as hypotheses that may or may not be valid" (Jehu, Klassen, and Gazan, 1986, p. 61).

Briere (1989) concludes that the most important aspects of therapy with abuse survivors are the generic principles of psychotherapy. A therapist who is caring, non-exploitive, and reliable coupled with a therapeutic environment that fosters self-awareness, self-acceptance, and independence has the most to offer abuse survivors regardless of the methods or techniques that therapists choose to use as vehicles. Sexually abused children often take longer to form a trusting relationship with the therapist that is secure enough to allow them to begin to explore the actual abuse (Einbender, 1991). This requires great patience from the therapist, who may feel pressure from other parties (e.g., caseworkers, parents) to make the child deal with the sexual abuse before the child is ready to do so.

GROUP TREATMENT

Group therapy with adolescents usually occurs in conjunction with some combination of individual, dyadic, and family treatment. At a minimum it is advisable to have each group member working with an individual therapist (Crowder and Myers - Avis, 1990). The commitment of a natural support in the client's network is an alternative resource to explore if the client cannot access individual therapy. Accepting a client into a group that invites her to expose her pain without first establishing that she has sufficient resources to support her as she heals, is clearly doing her a disservice. A psychotherapeutic group can be traumatic for some clients and will not be appropriate until individual counselling can build up their ego strength and reduce their anxiety (Bagley and King,

1990). This kind of group experience cuts through the clients' natural defense structures and their awareness of significant issues is increased as they see other members work in the group context. Recovering lost feelings of anger or grief can be overwhelming and some adolescents will not be prepared to be this vulnerable or will not have supports available to them to make this a safe option. The advantage of working in a group mode is the unmatched opportunity it presents to "break through the isolation, the feeling that no one else can possibly understand, the feeling of being a freak, the ideas that all incest victims are crazy, or nymphomaniacs, or ugly, or poor, or bad" (Swink and Leveille, 1986, p.130).

Social support groups or psychoeducational groups are other options to psychotherapeutic groups. Adolescent survivors often have poor social skills, limited age appropriate socialization, and distorted or inadequate knowledge of human sexuality. Psychoeducational or social support groups can address these deficits without encountering the same risks that are part of the healing process in a psychotherapeutic group. It is imperative to clearly identify what type of group is being offered when recruiting clients so that their expectations are realistic. It is best to plan for the appropriate group by taking into account resources available and the client population that needs service. Running a smoothly functioning psychoeducational group will be a more rewarding and growthful experience for both clients and therapists than having these same people take part in an under resourced psychotherapeutic group (Crowder and Myers Avis, 1990).

Goals of group treatment have both process and content components.

> " Process goals include (1) making the group into a safe
> place for its members to discuss their experiences of sexual
> abuse, (2) creating clear boundaries for the members,
> leaders, and the group as a whole, and (3) structuring the
> group to enhance positive interpersonal interactions.
> Content goals refer to the type of issues that are addressed

in the group, such as assisting group members to understand some of the interpersonal and power dynamics that preceded and permitted their victimization". (Crowder and Myers - Avis, 1990, p. 39)

Process tends to dictate the type of content that will arise. A group structure that feels safe and predictable to the group members will encourage the members to make the most of their experience. This type of group environment promotes more personal risk taking and gives adolescents the chance to share their experience and expand their self-awareness (Crowder and Myers - Avis, 1990).

Group experience is especially relevant for adolescents as they are developmentally becoming far more involved with peer relationships. The betrayal of trust that the abuse experience has caused will exacerbate their normal tendency to distance from adults (Crowder and Myers - Avis, 1990). It provides the opportunity to break down the isolation created by the abuse experience in a way that individual therapy cannot (Knight, 1990). Being with other adolescents that have been through similar experiences is seen as a crucial factor in healing (Knittle and Tuana, 1980). The group experience provides a safe milieu for adolescents to speak because the focus is not always on the individual and each member can participate at their own comfort level. Adolescents also seem to see the group experience as a social one and may be less resistant to treatment in this format. Group members act as mirrors for each other which is sometimes an easier way to address issues. It is sometimes easier for victims to understand that offenders are to be held responsible for abuse when they are supporting another victim's disclosure. Recognizing that another group member was not to blame for the abuse that member has experienced allows listeners to contemplate that this also holds true in their own abusive experiences. The group also provides the opportunity to develop new interactive skills in a low risk setting and to develop a social support network that can exist outside the group. The cost and time effectiveness factor that group therapy offers are advantages for the therapists are often cited in the literature (Kitchur and

Bell, 1989;Crowder and Myers Avis, 1990). There is general consensus that working with a co-facilitator is advantageous as mutual support and a variety of skills make working with this intense and volatile population less stressful. Opinions differ regarding the use of male therapists.

In setting up a group treatment program careful attention must be given to the numerous pragmatic decisions that will affect the group format. For psychotherapeutic groups, where the focus is on process issues and intensive expression of feelings, the format often recommended is that of short term arrangements (10-16 weeks) where the adolescent has the option of recontracting for subsequent sessions (Crowder and Myers - Avis, 1990). In this client-centred framework, adolescents can leave the group when they feel ready to do so. Crowder and Myers - Avis (1990) found this to be on average between one and two years. There appear to be many advantages in this style of group that will end up being a mixture of some returning members and the new members that start each cycle. Old members model new behaviors and skills through their increased comfort with self disclosure. Group cohesion is strong as returning members have established loyalty to the group and and have developed trust in the group leaders. Taking breaks at the completion of the each group cycle (10-16 weeks) creates clear beginning and ending points for members. This will help create natural opportunities for people to leave or join the group.

Other models of group structure include 10-12 week sessions without the opportunity to re-attend. The criticism of short-term arrangements like this is that it will be increasingly difficult to establish trust and this can hinder work by keeping interactions on a superficial level. The Giaretto (1982) model proposes three stages of group treatment in the "Daughters and Sons United" treatment program. The first group experience is a 16 week open group that is offered during the crisis phase following disclosure. The adolescent then moves into the second group that focuses for 16 weeks on the personal impact of the abuse and dysfunctional family dynamics. The third phase is a psychoeducational group that focuses on human sexuality. There is no

43

empirical data that supports an optimum length although some authors felt that any group treatment over six months overemphasizes the abuse experience (Kitchur and Bell, 1989). Berliner and MacQuivey (1982) describe an adolescent group that is ongoing rather than time limited that would also have the advantage of mixing seasoned members with newcomers. They admit new members only on the first meeting of every month for organizational purposes and find that the clients participate on average for six months to a year.

Kitchur and Bell's (1989) review of the literature found that authors vary a great deal on the questions of age of members and group size. While some recommend no more than a two or three year age span others have included nine to seventeen year olds in the same group without significant difficulty. Sugar (1986) supports that three year gaps in age would be the maximum acceptable range, particularly in early adolescents (12-14 year olds). With large age ranges it is feared that all members will not be able to function effectively in the group because their developmental tasks are too disparate to allow them to really understand one another and work effectively. Hazzard, King, and Webb (1986) solve this argument by proposing that level of maturity is more relevant than chronological age as a criteria on which to judge potential group members suitability. They fail however, to suggest how a client's level of maturity could accurately be assessed. For group size optimal numbers range from minimums of three to four and maximums of six to seven, although some included as many as ten to twelve without difficulty (Kitchur and Bell, 1989). Most models see the need for a pre-screening interview of potential members to assess the girl's interest in and appropriateness for the group being offered, as group treatment is not a panacea for all sexually abused adolescents. The pre-screening meeting is especially important for adolescents as it allows a joining process to begin that will help reduce their anxiety in entering the group (Crowder and Myers - Avis, 1990). Many clinicians discuss the structuring of snacks into the group format as a symbolic way to nurture the group members (Hazzard, King and Webb, 1986; Porter, Blick and Sgroi, 1982).

Snack time also provides a natural opportunity for building social skills and fosters group cohesiveness.

THERAPEUTIC PROCESS

Incest therapy may take many different formats. The task of treatment may be " broad or limited, long term or short term" (Sgroi, 1982, p.107). Most of the literature supports that the recovery process when addressing incest related issues will require long-term treatment of one to several years duration (Courtois and Sprei, 1988). It is also noted however that some survivors may be overwhelmed by a time-unlimited arrangement without a specific focus and may require the security of time limits and specific goals. "Adolescent victims are generally more assertive about the types of therapeutic endeavours they will engage in and the length of their participation" (Wheeler and Berliner, 1988, p.235). Adolescents can be expected to discuss and negotiate what type of treatment they will accept.

Courtois and Sprei (1988) describe a therapeutic process that involves the survivor addressing the past with a supportive ally in order to find meaning in the abusive experiences, rework the tasks of maturation that were either missed or experienced prematurely, and grieve the losses of childhood. Bagley and King (1990) review several complimentary models of treatment that emphasize understanding the abusive experience by putting the abuse in perspective. Releasing pent-up emotional energy and restoring and rebuilding a sense of self worth were also seen as important parts of the recovery process (Bagley and King,1990). Finding meaning in the abuse experience may necessitate uncovering the meaning that the victim attributed to it at an earlier developmental stage as this ancient definition often fuels continued guilt and inwardly directed anger (Briere, 1989). When a child realizes that they are being hurt, their knowledge of the world and their limited cognitive abilities make sense of the experience in very simplistic ways. Children are taught that adults are always right and only hurt children when it is deserved by the child (Briere, 1989). Children cannot tolerate

45

the idea that their parents, upon whom they are dependent, are bad. This leads a child to conclude that they (the child) are bad. "The dichotomy that "either I am bad or they are", especially given the added proviso that "it isn't them", may continue into adulthood in an unconscious, relatively unchanged form" (Briere, 1989, p.88). Believing that they themselves are bad is a more tolerable way for children to make sense of what is happening. "Although such black and white thinking may be appropriate for the age group of the average child victim, it can be quite problematic later in life" (Briere, 1989, p.88).

Most of the literature on the treatment of post traumatic stress emphasizes the need for adequate emotional discharge whatever the trauma may be (Briere, 1989). Release of emotion is seen as necessary to accomplish full recovery although trauma often motivates people to avoid any feeling or events that might remind them of the experience. Wheeler and Berliner (1988) recommend emotional catharsis as an integral part of treatment in children. Briere (1989) points out several reasons why emotional release may get increasingly difficult as victims gets older. Over time victims learn to suppress the experience of painful emotion because to recognize it would distract them from their daily task of avoiding trauma and maintaining sanity. They develop various coping strategies to keep feelings at bay, creating a short-term solution to the post-abuse trauma. The defenses are seen in full strength in psychotherapy where clients understand that expression of affect is otherwise quite likely. Emotional release comes to be seen as dangerous with common fears that they will be overwhelmed by intense affect or that they will lose control of themselves (Briere, 1989). The clinician must obviously approach the necessary task of feelings with care and be prepared to accept all emotions.

CHAPTER THREE : Adolescents as a Unique Client Population

INTRODUCTION AND DEFINITIONS

Most of what is known about psychotherapy is based on work done with adult populations. There is less detailed literature regarding children as clients and even less that focuses on adolescents and their mental health issues. There are many developmental characteristics of adolescents that must be taken into account when planning and implementing therapeutic services (Tramontana and Sherretts, 1984). This review will establish a definition of adolescence and consider their developmental needs before moving into the subject of treatment for this age group. Consideration will be given as to how these developmental tasks might interact with the effects of intrafamilial sexual abuse before proceeding with a discussion of how treatment is best offered to this population.

There is a popular understanding that all adolescents will experience deep emotional difficulty. This life stage is seen as being characterized by instability, psychic storm and stress regardless of any extraneous factors (Fishman, 1988). From this perspective adolescence is characterized by frequent mood swings, an increased propensity for acting out, a tendency to use distortions, delusions, and fantasy, a preoccupation with self, sexuality, and hedonism, and a high intensity of feelings (Tramontana and Sherretts, 1984). If all of this was accurate it would make even "normal" adolescents appear to be quite disturbed at times. Those adolescents who are also experiencing the aftereffects of childhood sexual abuse on top of this expected turmoil may really be at odds with their environments. In the last twenty years there has been some effort made to test the notion of emotional turbulence in teenagers. Evidence is accumulating that supports the opposing position that much of adolescence is characterized by a more continuous process of intellectual, social, and biological development that is relatively emotionally uneventful (Fishman, 1988; Healy and Stewart, 1984; Offer,

Ostrov, and Howard, 1981). A review of longitudinal studies (Tramontana and Sherretts, 1984) concluded that the amount of conflict and turmoil associated with adolescence is limited and that in reality this population's sense of competence and self-esteem is high. Healy and Stewart (1984) present a definition that they feel represents some middle ground in this discussion. Adolescence is seen as a general course of gradual biological, intellectual, and social development interrupted by periods of psychological upheaval and change (Healy and Stewart, 1984). They argue that most often the psychological upheaval and emotional turmoil are the consequents of psychological transitions that are part of adolescent development. Any major change in the life of the adolescent that involves an increase in novel stimuli and motivates efforts at mastery, constitutes a significant psychological transition for the adolescent. The adolescent's experience of the transition will determine the emotional significance and impact of the change (Healy and Stewart, 1984). Psychological transitions can be related to the developmental tasks experienced in adolescence that are explored in the next section of this discussion.

Without a firm understanding of what "normal" adolescence does or does not look like, mental health professionals will continue to confuse acting out based on internal psychological conflicts and rebellion for a "just" cause. Offer, Ostrov and Howard (1981) use the example that a young delinquent may actually be telling us more about problems they are having in their family than with their own sexuality or aggression. Adolescents with severe identity problems or emotional turmoil are not just experiencing a part of normal growing up. It is not helpful to ignore symptomatic behavior by reassuring young people and their parents that the problems will disappear in time. A history of childhood disturbance and a gradual rather than sudden onset of symptoms is a poor prognostic sign in acting out teenagers. In these cases the symptoms appear to signify larger, underlying difficulties that have been developing for some time (Tramontana and Sherretts, 1984). "The clinician needs to be able to diagnose what is presented to him, yet he can do this only when he has

a broader perspective on the varieties of adolescent behavior that includes a realistic view of normal adolescents" (Offer, Ostrov, and Howard, 1981,p.128).

DEVELOPMENTAL TASKS

Most observers regard adolescence as one of the most critical stages of human development particularly as it prepares one for psychosocial functioning as an adult (Feldman and Stiffman, 1986; Crowder and Myers Avis, 1990). Frequently cited tasks of this development stage or transition period include separating and individuating from parents; developing satisfying peer attachments, with the ability to love and appreciate the worth of others as well as themselves; developing a sense of identity in familial, social, sexual, and work areas; and developing a flexible set of life goals for the future (Knittle and Tuana, 1980; Offer, Ostrov & Howard, 1981; Allen - Meares and Shore, 1986). Offer, Ostrov, Howard, and Atkinson (1988) generalise that as "socializers", adolescents are most concerned with social relationships, particularly in establishing friendships and developing a capacity for empathy with others. As "cognizers", they struggle to understand the world in a rational, coherent way. Issues of separation and individuation which are first encountered by the young child are reexperienced in adolescence at a new level of awareness (Crowder and Myers - Avis, 1990). This leads to reexamining and redefining the adolescent's concept of her limits, personal boundaries, and life tasks.

This life stage is sometimes separated into early, middle and late adolescence (Mishne, 1986). It is felt that each stage represents different developmental issues and essential psychic transformations. In early adolescence, from 12-14 years old, there are numerous role changes that effect the individual (Mishne, 1986). The entrance into junior high school identifies the departure from childhood and necessitates the adoption of a new set of reference persons, values, and behaviors. The early adolescent often feels compelled to exaggerate their independence which results in rebellious attitudes towards adults and parents in

49

particular. In education circles junior high school (12-14 year olds) is thought to be the most challenging group with which to work as this period of life is characterized by the highest degree of turbulence, unruliness, belligerence, and defiance (Mishne, 1986). This age group is also facing the struggle of coming to terms with their changing bodies which seems to spark a variety of reactions. Tramontana and Sherretts (1984) describe this age group as more impulsive, more action-oriented, less thoughtful, less purposeful, and much more likely to act out. Middle adolescence, 14 - 17 years old, is characterized by a more intense emotional life and a turning toward heterosexual love concurrent with increased withdrawal of cathexis from the parents (Mishne, 1986). It is reported that cognition has become more realistic, objective, and analytical in this age group. Interests, skills and talents have emerged and self-esteem is more stable. Late adolescence, 17 - 18 years old, is seen as a stage of consolidation and stabilization where more predictability, constancy of emotions, and mature functioning can be expected. "There is an increased capacity for abstract thought and organized application of intelligence" (Mishne, 1986, p.21). Piaget's theory of cognitive development in adolescence is quoted in the work of Allen - Meares and Shore (1986). Formal operational thought is believed to begin in adolescence and should be mastered by late adolescence. "The adolescent can think abstractly and can consider the range of possibilities when presented with a particular situation, formulate hypotheses, and utilize cause and effect reasoning" (Allen - Meares and Shore,1986, p.72). Of course cognitive development in adolescents will proceed at different rates and with varying degrees of success. Some adolescents will continue to think in more concrete states and will never master the ability for abstract thought (Allen - Meares and Shore,1986). Healy and Stewart (1984) see the adolescent age span embodying a gradual shift from relatively strong dependence on the family unit to relative autonomy and a sense of personal responsibility, but recognize that some dependence on the family will serve as an anchoring point in the lives of adolescents. Whatever definition is accepted, adolescence is

a developmental period characterized by rapid physical change, striving for independence, exploration and implementation of new behaviors, strengthening peer relationship, sexual awakening and experimentation, and seeking clarity relating to self and one's place in the larger society (Rencken, 1990).

Attempts have been made to determine what makes the difference between those who move through these developmental tasks unscathed and those that struggle. Research indicates that a complex array of social and psychological factors influence one's transition through this period (Feldman and Stiffman, 1986; Rencken, 1990). Both the choices an individual makes in their attempt to meet the challenges as well as the circumstances that surround them (over which they have little control) contribute to symptomatic behavior in adolescents and the risk of being labelled problematic. Rencken (1990) takes a very strong position, arguing that the effects of sexual abuse have been proven to be so broad based, that until it is definitely ruled out, it's presence should be assumed in the majority of adolescent problems. The effects of sexual abuse present special considerations for this life stage whether the abuse is historical or current. When working with an adolescent population, the psychological and emotional difficulties experienced by sexual abuse victims must be recognised in light of the developmental tasks that they are facing (Knittle and Tuana, 1980).

DEVELOPMENTAL TASKS IN RELATION TO EFFECTS OF SEXUAL ABUSE

James and Nasjleti (1983) outline, that in general, sexual abuse is harmful to a child's development for many reasons including: the loss of childhood innocence; alienation from peers; pressure on the child because they are singled out from siblings; burden of keeping the relationship a secret; the experience of emotions too powerful to be worked through with a child's mental mechanisms; overloading stimulation and insufficient tension relief; and forming an alliance with one parent against another. Specific developmental problems related to

51

adolescents have also been raised in the literature as they face new developmental tasks carrying this disruptive baggage with them. Clearly the experience of sexual abuse during or prior to the onset of adolescence has a major negative impact on the successful accomplishment of the necessary developmental tasks. Sexual abuse violates familial roles and social taboos, thus burdening the victim's passage through adolescence with a mantle of shame and confusion (Crowder and Myers - Avis, 1990). The adolescents need for peer relationships, a sexual identity, and separation from parents exacerbate the problems in sexually abusive families. The adolescent is often caught in the double bind of becoming increasingly angry towards the perpetrator while still feeling the need to protect the family. Self-blame and shame increase if the adolescent has been taking rewards or extorting favors (James and Nasjleti, 1983). Adolescents are narcissistic and egocentric by nature and tend to view causality in terms of themselves which makes them especially vulnerable to self-blame (Everstine and Everstine, 1989). Coping with an incestuous environment tends to consume so much of a child or adolescent's emotional energy that it interferes with their social development (Everstine and Everstine, 1989). This can be especially detrimental for adolescents as they are expected to be socially maturing but may have serious deficits. Sexual abuse interferes with the child's movement through the normal sequence of developmental stages (Crowder and Myers - Avis, 1990). Developmental tasks that are not achieved at the appropriate age are carried into later functioning. This can then disrupt normal emotional, cognitive, and behavioral functioning unless and until they are addressed and healed. Sexually abused adolescents are often encountering the challenges of adolescence at the same time as negotiating earlier developmental tasks that have not yet been successfully completed (Crowder and Myers - Avis, 1990).

The dramatic cognitive growth that takes place in adolescence can cause any unresolved or unrevealed sexual trauma to surface as concepts that did not make sense before now become clearer. An adolescent struggles with the problem in new ways as they are more

aware of their exploitation (James and Nasjleti, 1983). This is relevant whether the abuse is current, recent or historical. A child of 6 years old does not understand the full sexual or social meaning of being assaulted but a 14 year old does. Adolescents will have a renewed need to process the experience in a way that answers the questions that the new developmental stage has raised (Everstine and Everstine, 1989). Increasing cognitive skills allow the first opportunity for reflective analysis of emotional experience (Taylor and Pritchard, 1980). Adams - Tucker (1984) points out that although the adolescents increased cognitive development and sociodevelopmental status might be expected to increase their verbal skills and ability to communicate, in reality this is not the case. The regression, fear, or shame that may accompany the disclosure of abuse make adolescents more hesitant to acknowledge the problem in an interview than younger victims.

The development of a new conception of one's sexual self and the establishment of interactive sexual relationships are normal developmental tasks of adolescence (Crowder and Myers - Avis, 1990). Abused adolescents come face to face with the "abnormality" of their early sexual experiences as they witness their peers' excitement and anticipation regarding their developing sexuality. Peers plan and review together their experimentations with sexual activity. Adolescent victims often adopt one of two extreme positions about sexuality. Some seem to withdraw from sexuality all together. Others overemphasize their sexuality through seductiveness or promiscuity that attempts to prove to themselves and the world that they are not afraid of sexuality. Promiscuity is seen frequently and is explained as an adolescent recreating components of their abusive experience as a reaction formation or attempting to deny the anxiety aroused by the trauma (Shapiro and Dominiak, 1990). Gomes-Schwartz et al. (1990) describe that some adolescent victims act out conflicts through sexuality. It can be difficult to distinguish sexual acting out from revictimization at times as the abused adolescent may feel that they are involved in a consensual relationship or experience that others would clearly define as abusive. Adolescents

53

victimized as children are at a higher risk of being revictimized (Everstine and Everstine, 1989). These adolescents often put themselves in very dangerous situations. Offenders often seem to be able to sense their increased vulnerability and manipulate opportunities to revictimize these young women.

Wachtel and Scott (1991) integrate Finkelhor and Browne's (1985) "traumagenic framework" with related developmental tasks.
Traumatic sexualization would directly relate to sexuality, stigmatization is linked to self concept, powerlessness to efficacy, and betrayal relates to the ability to form trust relationships. These developmental tasks all have increased significance in the adolescent life stage. Abuse effects are believed to manifest over time and will interact with new stressors over the course of time. One important class of stressors are developmental tasks because everyone is effected by them (Watchel and Scott, 1991). "Current reviews of the literature seem to recognize these developmental triggers but fail to give adequate attention to them" (Watchel and Scott, 1991, p.108). The developmental tasks of adolescence can be expected to produce "developmentally specific effects" that were not present in childhood and may not persist into adulthood (Browne and Finkelhor, 1986b, p.177). Conversely, certain effects may be persistent but will be experienced in different forms as a victim matures.

Therapists providing treatment to adolescent incest victims have consistently noted several issues which need to be addressed in therapy. Hazzard, King, and Webb (1986) see emotional reaction of others, court testimony, and personal emotional reactions as short-term issues for adolescents. Long-term issues are family relationships, interpersonal relationships, sexuality, self-esteem, and self-assertion. Knittle and Tuana (1980) identify common therapeutic issues seen in this population as isolation and alienation from peers, distrust of adults and authority figures, guilt and shame, fear of intimacy with the therapist and other adults, anger turned inward in the forms of depression, suicide, and self-mutilation, unmet dependency needs , helpless victim mentality, and development of social skills.

54

"This is a time when young people are most interested in their sexuality; there are secondary sex characteristics appearing, growth spurts, and important metabolic changes. There is an excitement and a fear about the changes that are occurring. There is a push to move away from the family and a pull to return to safety. Many sexually abused adolescents are pushed out of the home before they are ready, and regressing emotionally does not bring them to a safe place, but rather a place of fear and confusion. Friendships are most important during this transitional identity time of adolescence, but most sexually abused teenagers do not have friends nor do they know how to make friends." (Knittle & Tuana, 1980, p.241).

Adolescents living outside of their home environments present additional concerns that are rarely discussed in the literature. One study concluded that children who had experienced disruptions in their family environment showed more psychopathology 18 months after disclosure (Gomes-Schwartz et al.,1990). Children living away from both parents had the highest levels of emotional disturbance (Gomes-Schwartz et al., 1990). It is impossible to determine if this represents children that were seriously emotionally damaged before the abuse was disclosed or if separation from the family is the ingredient responsible for the distress. Relatively few studies have "attempted systematically to relate maternal support to child outcomes following disclosure" (Everson, 1989, p.198). Lack of maternal support is a key factor in setting a negative chain of events in motion. This chain begins when a child must be removed from their home and family (Everson et al., 1989).

The nature and meaning of each abuse situation has to be seen in relation to the developmental status of the victim. It must also be expected that certain effects will appear or reappear as issues in relation to the new developmental tasks that adolescence and other lifestages present. The corrective experiences provided through individual and group therapy can support and assist these young women in coping with their maturational conflicts.

TREATMENT PROBLEMS AND RECOMMENDATIONS

One of the most obvious problems that the review of the literature regarding working specifically with adolescent sexual abuse victims uncovered is the limited number of clinicians and researchers that separate this population out from children or adults (Wachtel and Scott, 1991). The wealth of information that addresses treatment issues with adult survivors can still be relevant but it needs to be kept in mind that adolescents present unique treatment needs. Sturkie (1983) feels that any thematic content that is suggested for adult survivors can be modified to fit the developmental tasks with which a different client group may be struggling. For example, adolescent victims may have started dating and the themes of powerlessness and sexuality are most relevant when specifically addressed within this context. Feldman and Stiffman (1986) contend however, that symptomatolagies that appear in adolescence may be quite different from those which occur in adulthood for mental health problems in general. This would suggest that adolescents need to be approached as a separate and unique entity and simply modifying adult issues or treatment methods is not the best way to serve this population.

Family sabotage is a perennial problem in child psychotherapy but especially with sexual abuse victims. Hazzard, King, and Webb (1986) caution that as an adolescent becomes appropriately upset about family events, becomes more assertive, or becomes emotionally close with her therapist, family members are likely to feel threatened or upset. Parents may sabotage therapy at this point by terminating prematurely. There may also be resistance in more indirect ways such as being unable to

organize transportation. With or without parental sabotage, transportation and inconsistent attendance are frequently mentioned as problems in providing therapy to children and adolescents (Kitchur and Bell, 1989).

In working with an adolescent population some practical suggestions have been made about how to be most effective. It is very important to have considerable flexibility in therapeutic approach. Adolescents tend to drop in and out of therapy. They can fluctuate between feelings of helplessness and independence. They may become panicked and frightened by either of these positions and attempt to distance themselves emotionally during these times. They also have the capacity to be uncooperative when they judge that things are going well then become demanding and want immediate response when they are in crisis (Tramontana and Sherretts, 1984). Everstine and Everstine (1989) suggest that communicating with a traumatized adolescent requires a delicate balance of reaching out to the hurt and frightened child inside without offending the client's appropriate striving for independence. "Both aspects of the adolescent psyche must be worked with in order to conduct successful treatment and such a feat is not easily accomplished" (Everstine and Everstine, 1989, p.68). Zayas & Katch (1989) point out that at times the adolescent client will present in extreme states of anxiety, panic, or depression and allow the therapist to focus quickly on the problem. At other times, however, the same adolescent will need room to approach the problem at a pace that is non-threatening. The greatest obstacle to engaging adolescents in treatment may be establishing trust with them. Developmentally related fears of exposure, dependency, and loss of autonomy further compound difficulties in establishing trust with this age group (Zayas and Katch, 1989). Tramontana and Sherretts (1984) offer the following comprehensive list of practical guidelines for working effectively with adolescents.

1. Be cautious about sensitive areas in adolescent life such as appearance and privacy.
2. Do not prevent the adolescent's desire to feel

unique and seperate, i.e. it may not be reassuring
for the client to hear that many others feel or
behave the same way and it may cause them to
generate stranger symptoms.
3.   Be firm but compassionate, sensitive but
strong.
4.   Avoid manipulation and autonomy struggles in
which adolescent may try to engage therapist
because they will lose respect for you if they can
manipulate you.
5.   Avoid arguments about differences in
perceptions and deal primarily with behaviors.
6.   Provide structure without being authoritarian
by making expectations, structures, and
limitations clear.
7.   Be cautious during periods of silence or in
use of premature insight as the adolescent will
feel vulnerable if therapist seems to be able to
magically read their true feelings.
8.   Do not emulate the language, conduct or dress
of the client. It may serve to put them more at
ease but it does not make the therapist any more
therapeutic.
9.   Remain flexible in approach and avoid
countertransference due to occasional lack of
participation and co-operation.
10.   Avoid   the use of cliches, preaching,
futurizing or lectures as the adolescent is often
tied to the here and now.
11.   Schedule in order to avoid outside activities
that are important to the adolescent.
12.   Attend primarily to the adolescents deeds and
not their words.
13.   Be sincere and genuine as adolescents will
look for opportunities to confirm their reasons
for mistrust of adults.
14. Be consistent as true change may be delayed or

prevented without a consistent and persistent approach. (p.299)

RESEARCH ON OUTCOME OF PSYCHOTHERAPY WITH ADOLESCENTS.

It is a complex task to measure the success or failure of psychotherapy with adolescents. There are a number of potentially confounding factors that can obscure and complicate the appraisal of therapeutic change in adolescents. The natural course of maturation and development may cause changes in personality and symptom manifestation that are difficult to assess. In long term treatment this is especially relevant as maturation brings about profound changes in the ability and behavior of adolescents that confound the effects of therapy. The adolescent is often experiencing profound influences from their family, peers, and other environmental factors. There may be simultaneous interventions undertaken by parents, schools, or other agents. All of this makes isolating the effects of psychotherapy problematic.

Tramontana and Sherretts (1984) discuss a review they undertook in 1980 of outcome research that focused on adolescent clients. They looked for common themes in the research regarding qualities that adolescents valued in a therapist. The adolescents valued someone that could engage with them as a real person. The adolescents gave high ratings to a relaxed, caring person who would reveal appropriate feelings with spontaneity but who would still remain objective and insightful in dealing with their problem.

Bagley and Thomlinson (1990) reviewed outcome research and found that although a wide variety of approaches are documented there is very little research regarding their outcomes and few appropriate instruments to measure child sexual abuse treatment programs. They conclude that a major challenge lies ahead in this area and that at present program evaluation of adolescent treatment programs is in it's infancy.

SECTION TWO - THE PRACTICUM

CHAPTER FOUR : The Practicum : Participants and Procedures

STRUCTURE

Individual clients were seen at the Community Resource Clinic (CRC). Treatment was provided once a week. Duration of service varied from three to seven months depending on referral date and completion of an intake session. Prior to the intake session, pertinent information was gathered and discussed with the adolescent's Child and Family Service (CFS) worker. The CFS worker attended the intake session with the client and was contacted only as necessary after that. Each client also had a variety of environmental supports that included group home staff, foster parents, natural parents, step-parents,and grandparents. These people were valuable sources of information and support at times. On several occasions it became necessary to directly involve other members of the adolescents social network in the treatment process. This took a variety of formats including an individual meeting with a client's father (offender), meetings with a client and group home staff, a planning meeting with a family and their CFS worker, numerous phone contacts with a foster parent and two sessions with a client, her stepmother, and the stepmother's therapist. Two of the mothers were involved in their own individual treatment at this time, one through the CRC and one through her own arrangements with a psychiatrist. It should be mentioned here that the names of all clients and their family members have been changed in this report to protect their privacy.

Group treatment was also offered to practicum clients but participation was voluntary. Two of my clients started their individual sessions after the group had already commenced so it was not possible to give them this option. The group ran for ten weeks and had a psychoeducational orientation. The group started with six members and was closed for membership after the first two sessions. Two members

attended only once and twice respectively, so the actual membership turned out to be four. The group was co-facilitated by Luvia Treftlin, another MSW student completing her practicum at the CRC.

Clients were seen at the CRC for the most part although there were some interesting exceptions. Debbie lived close to the downtown clinic so a ritual developed of walking her home at the end of the session. Carmen at times also required assistance to get home and would get a ride with me. Over the summer holidays it became difficult for Anna to be transported to the clinic by group home staff so we met at her home several times and went for drives, walks, and on one occasion a bike ride. There were also a few occasions where Anna would get restless in sessions at the clinic and we would spend part of the session walking in the community. Bonnie always made her own way to the clinic. Our final meeting took place at her apartment. The purpose of this meeting was to get her measures completed and to meet her newborn daughter.

Sessions generally went for sixty minutes and were held weekly. Anna and Debbie required a lot of flexibility in scheduling over the summer as they both had many outside activities to accommodate.

SUPERVISION

Walter Driedger provided supervision for my individual cases on a weekly or biweekly basis. Walter Driedger was the Director of the Community Resource Clinic at the time of this practicum and a member of the Faculty of Social Work. Supervision included some review of taped sessions (video and audio) as well as ongoing consultation and case planning. Dr. Laura Mills supervised the group treatment on a bi-weekly basis. Dr. Mills is a clinical psychologist and is the Clinical Supervisor of group therapy at the Manitoba Adolescent Treatment Centre. Supervision included sharing of resource materials and bi-weekly consultation. Discussion in consultations focused on planning, reviewing members reaction to material in session, and group dynamics.

Walter Driedger, Laura Mills and Dr. Barry Trute of the Faculty of Social Work made up my practicum committee.

REFERRAL PROCESS

At the time of this practicum Child and Family Service agencies were set up for seven different regions of Winnipeg. Referrals were to come from Central Winnipeg as that was the agency that specifically made the request for services. In January 1991 the agency referred 4 girls that seemed appropriate for this practicum and the abuse coordinator for Central CFS was to continue canvassing workers for more referrals. By March only three more adolescent females had been referred from Central region. Of these seven in total only two eventually agreed to or were appropriate for this practicum. Reasons that the referrals did not work out included the adolescent moving out of the area, entering a placement that provided treatment, and workers suggesting client's who were not prepared to be in counselling. In April in an attempt to increase referrals, Northwest CFS and Ma Mawi Wi Chi Itata Centre were contacted. Two referrals came through Ma Mawi Wi Chi Itata but one was much too young and the other chose not to be involved. Northwest's Abuse Coordinator let workers in the agency know about my project but only three referrals were made. Of these three, two were not interested once the service was made available and the other one attended for 4 sessions before she moved out of the city. These sessions were held outside of the clinic as this girl had no way to get downtown. Sessions would be held in locations closer to her home, parks and restaurants, as I had to go pick her up and I was not prepared to spend too much time in transit. By June referrals from Central had totalled nine. Of these nine, three were engaged in ongoing treatment, two attended intake sessions and rescheduled but never returned, and four declined or became inappropriate. At the end of June four other clients from Central were picked up from a departing student's caseload. Of these four one remained engaged in treatment for nine sessions, one for three sessions, one for two sessions, and the fourth client had not really engaged with the original therapist and chose to not continue with me. Of these 18 referrals only two were engaged in therapy with me at the start of the group. One dropped out after the first session and chose not to

participate in the group and the other took part in the group when she was not absent from her placement. Three other participants in the group became my individual clients after the group ended and are included in the description of the cases that were picked up from the departing student. The table below summarizes the eventual disposition of all referrals fielded. This time period was a very frustrating part of the clinical work as so many of the referrals eventually fell through.

	NUMBER OF SESSIONS				
	0	1	2-4	5-10	OVER 10
NUMBER OF REFERRALS					
CENTRAL	4	3	2	2	2
NORTH WEST	2	0	1	0	0
Ma Mawi WI	2	0	0	0	0
TOTAL (18)	8	3	3	2	2

TABLE 1: SUMMARY OF REFERRALS AND OUTCOMES

INTERVENTION

Interventions in this practicum are based on the model of treatment developed by Wheeler and Berliner (1988). The therapeutic interventions that they propose are based on their conceptualization of the abuse experience as traumatic to the child victim. The child's victimization and experience are the immediate focus of therapy and individual or group therapy are the primary modalities recommended.

Specific interventions are described in Chapter Two of the literature review under the heading individual therapy. All interventions attempted

63

to continually gather information that clarifies the victims beliefs and attitudes about their experience of sexual abuse. Distorted beliefs were corrected through interventions based on a model Jehu, Klassen, and Gazan (1986) provide for cognitive restructuring.

Before attempting to undertake therapy that focuses on the child's victimization I realized that it was necessary to establish a safe therapeutic environment for the child and build a therapeutic alliance. Wright, Everett, and Roisman (1986) see establishment of intimacy as the first stage in the evolution of psychotherapy with children. "This is the foundation for change, and little can be expected to occur in the therapeutic relationship without it " (Wright, Everett and Roisman, 1986, p.29). "The initial focus of the therapist must be directed toward establishing an intimate relationship with the child, since intimacy is the medium in which therapeutic growth occurs" (Wright, Everett, and Roisman, 1986, p.31). In my work it was imperative to acknowledge with the child that we worked together because of their sexual abuse experience but also inform them that we would only approach the subject at the pace that they were able to tolerate as safety and trust developed in our relationship. Briere (1989) suggests that the survivor's internal state must always be monitored with regard to pace of therapy as a common danger is to move faster than the client can tolerate.

ASSESSMENT AND EVALUATION

Assessment and evaluation involved both informal and standardized measures. There are no psychological measures that specifically assess the impact of child sexual abuse (Wheeler and Berliner, 1988) so a combination of measures was considered to assess self-esteem, experience of trauma, and beliefs about sexual abuse. Pre and post tests were completed for the Rosenberg Self Esteem Questionnaire, the Impact of Events Scale, and a psychoeducational scale.

The Rosenberg Self - esteem scale (Robinson and Shaver, 1973) was developed as a self-report measure of the self-acceptance aspect of

self-esteem. There are 10 items on the scale, one half of which indicate high self esteem and the other half indicating low self-esteem. The respondent answers using a four point scale that ranges from strongly disagree to strongly agree. Traditionally the items are scored only as agreement or disagreement regardless of whether it is a strong or moderate response, receiving either a 0 or a 1. Moran and Eckenrode (1992) describe an alternative method of scoring that they duplicated from a 1986 study they cite by Schilling and Savin-Williams . Moran and Eckenrode (1992) made use of the system that Schilling and Savin-Williams developed and evaluated, where each answer is scored 0,1,2, or 3. This four step method demonstrated significantly greater person - separation reliability than the two step method (Moran and Eckenrode, 1992). A score of 0 then is given when the answer is "strongly agree" to a statement indicating low self-esteem or "strongly disagree" to a statement indicating high self-esteem, a 1 given when the answer is "agree" to a statement indicating low self-esteem or "disagree" to a statement indicating low self-esteem, and so on. This produces a range of scores from 0 - 30. This practicum made use of the latter scoring method as it was seen as producing more meaningful results.

The Impact of Events scale was devised to measure the stress associated with traumatic events (Horowitz, Wilner, and Alvarez , 1979). It is easily used to repetitively track the response to a specific traumatic event over a period of time. The measure provides two subscores for intrusive and avoidance experiences. This scale has been proven to be reliable and a sensitive indicator of change. It has been used with people of various educational, economic, and cultural backgrounds, and all seem able to understand it and seem comfortable with it .

The educational scale entitled "Things To Think About and Things To Learn" was adapted from a psychoeducational questionnaire developed by Melanie Grace and Dr. Kathryn Saulnier for a practicum done in 1984 (Grace, 1984). They developed their 12 item survey with true or false responses based on common misunderstandings about sexual abuse in the general population. My version used 8 of their items,

changed three to either simplify the language and take the focus off of a parent responding, and discarded one item. To this 9 other items were added. The Grace/Saulnier (1984) scale was developed for use with parents that were being assisted in the crisis stage, following the disclosure of sexual abuse in their families, to measure their knowledge of sexual abuse. They felt it would indicate areas that needed to be included in the educational component of their intervention. As victims of child sexual abuse are often trying to make sense of their experience it seems important to assess the level of information they are working from and take the opportunity to correct some of the misconceptions they may have developed. Morison and Greene (1992) developed a 40 item child sexual abuse questionnaire based on areas where there appears to be a general consensus in the literature. They employed a 6-point Likert scale that gave respondents the chance to indicate the extent to which they agree/disagreed with a statement, with 1 indicating strong agreement and 6 indicating strong disagreement. This measure would have been very useful as it is very thorough and stays away from subjective questions about feelings/responses. In hindsight it was obvious that the wording of some of my questions implied that certain responses are typical and that the girl may have responded negatively if she herself had not experienced that reaction or be at a different point in the processing of the event. The two questions that raise this concern are #15 ("A lot of children who have been sexually abused feel very angry") and #16 ("Children who have been sexually abused sometimes think that they are ugly or look different than other children"). The other 18 questions could probably stand up to the same standard that Morison and Greene (1992) used where the correct responses are linked to specific references in the literature. See Appendix 1.

The formal measures were not used in any way during the treatment sessions. For the few clients where they were given the option of discussing the results there was no interest shown in looking at the measures once they were completed. As a clinician unfamiliar with the use of standardized measures I gave the scores little attention until it was

time to write up my practicum experience. It seems worth mentioning that it was a pleasant surprise to see evidence of change in positive directions on the majority of the scales.

Informal assessment will use Finkelhor and Browne's (1984, 1988) conceptualization of traumagenic dynamics as a guide to organize and categorize my understanding of each client's unique experience of sexual abuse.

The model of traumagenic dynamics will be considered useful in providing information about the possible effects of abuse that may be relevant for each case. It fits well with Wheeler and Berliner's (1988) work in that it assesses the potential for trauma and allows clinicians to anticipate effects that might be expected. "Once an assessment was made about the experience according to the four traumagenic dynamics, a clinician should be able to draw inferences about what some of the predominant concerns of the victim would be, and also some of the subsequent difficulties that might be expected" (Finkelhor and Browne, 1985, p.195).

"Consideration of the level of support and of the family environment of the victim should also be part of any clinical assessment conducted with these cases" (Conte and Berliner, 1988, p.90). No formal measure was used for this but it was considered at intake and termination.

SIMILARITIES AND DIFFERENCES AMONG CLIENTS

Of the four cases that will be profiled there are surprising similarities as well as an interesting range of differences. The two 13 year olds, Anna and Debbie, would be classified as young adolescents. Carmen was mid-adolescent (15 years of age) and Bonnie was in late adolescence (17 years of age). The young adolescents were the most involved in acting out behaviors and presented difficulties in getting along with peers. The mid-adolescent was the most involved in self-introspection and presented no behavior problems. The late adolescent was in the process of launching into an independent living situation and was several months pregnant when we met. Before learning of her

pregnancy, Bonnie had ongoing struggles with alcohol and truancy. Anna, Bonnie, and Debbie were all living in placements outside their families and had been for several years. Their abuse had occurred between 2- 6 years ago. Carmen was different in that her abuse had just been recently disclosed and was still occurring at the time of disclosure. This family was still in immediate crisis. It is interesting that Carmen eventually did go into foster care but this occurred after our work together had terminated. Anna and Carmen were both supported by their mother and step-mother when the abuse was discovered. They were appropriately protected and the women moved away from the offenders. They both came into care later because of other issues in the family. Bonnie and Debbie were not supported by their mothers and came directly into foster placements for this reason. Three of these girls were abused by at least two different offenders. Offenders included biological fathers, mother's partners, and brothers. Two of the girls talked about incidents of physical abuse as well. All of them witnessed physical violence between their parents. One girl was Metis, one was a South American immigrant, and the other two were Caucasian. All except Carmen had grown up in the city of Winnipeg.

Anna and Bonnie were the most unpredictable attenders. Bonnie was hit and miss in attending throughout the 6 months I knew her but was usually consistent in taking the time to cancel appointments. Bonnie took two months to agree to attend an intake appointment after her initial referral and was clearly the most ambivalent of these four clients about engaging in treatment. Anna's attendance was similarly hit and miss from one week to the next but only because of transportation problems and frequent unauthorized absences from her placement. Anna did not seem to have much choice about her attendance if she was at the group home, as the staff would drive her down. In this sense she could be considered the least voluntary of my four clients. There were two time periods where she missed for 2-3 sessions in a row because of extended absences from her placement. Carmen and Debbie were very steady attenders.

At my point of termination two of the girls, Carmen and Debbie, indicated a strong desire to continue therapy with another student. Bonnie was clearly not interested in further work and Anna remained somewhat ambivalent. Anna later did continue in therapy at the CRC but there was a lapse of several months.

GROUP SUMMARY

This section will discuss the composition, timeframe, agenda and topics used in the group that was facilitated as an adjunct to this practicum. As the group experience was not the main focus of the practicum and was only participated in by two of the four clients summarized in this report a discussion of group process will not be put forth. The clients individual participation in the group and evaluation is included in their respective summaries.

The group started out with 7 members and a spot was being kept open for another girl who intended to come but could not make the first meeting. Only 2 of the girls were from my individual caseload while the other 6 made up Luvia's caseload. One client from my contingent dropped out after the first session and never did attend an individual session besides intake. A client of Luvia's also stopped attending at this point . The client that did not make the first session later decided she was not interested in attending. After the 3rd session another of Luvia's clients decided the group was not appropriate for her and stopped attending. At that point we reached a core of 4 regular attenders. This core was made up 3 children that were in foster care and one who lived with her mother. The age range was 11 - 14. Two of the girls that dropped out were older than this age range by a few years. For all of the regular attenders this was their first group treatment experience.

The group was scheduled to run for 10 weeks but turned out to be 8 because of a statutory holiday and the school year ending sooner than was realized. Any make up sessions proved impossible to coordinate between 6 people's schedules. There had also been some hold up in beginning the group to accommodate the school Spring break. The group ran every Monday from late April to mid June. Sessions were held from 4:15 - 6:00 p.m. The clinic was not open to other clients on this evening. We started out meeting in large

interview rooms thinking that the intimacy would provide more safety for the participants. In actuality it felt contrived to be crowded into a small space and produced a level of intimacy the participants could not seem to tolerate. After the 2nd week we began to hold the session in the central meeting space of the clinic. This space proved to be ideal. There was a central table area that was a gathering place for snack and group discussion. There was plenty of room to accommodate people working on individual assignments with privacy but in the same room which made supervision easier. The large space also allowed for group activity that could get active and boisterous.   There was also a couch area that was an alternative gathering place for discussions that seemed to feel more intimate. The walls of this room were textured glass and provided worry free opportunity to tack up whatever visual aids we needed.

After the first week a pattern was established as to how we would approach each session. Depending on how the group was responding to topics/activities the agenda would be adjusted. This sometimes took the form of staying longer on a topic than anticipated or moving quickly through things but for the most part the pattern remained intact. Snack time was provided at the beginning of each session as it provided a natural way to bring people together and accommodated people joining in as they arrived. Late in the snack time we would go through a check in activity that involved everyone sharing one good thing and one bad thing that happened to them in the last week. We would then proceed into an icebreaker or group building exercise that took many different forms. After this any points of business within the group were discussed. This would lead into introducing the specific topic of the week on which information would provide the focus for and activity and discussion. This was really the meat of the session and would be expected to take up the most time, 20 - 30 minutes. To wind down a relaxation and or self nurturing activity would be introduced. The group always ended with each girl spending some time journalling which also provided an opportunity to correspond with the facilitators. The girls left their journals at the clinic and were aware that during the week Luvia and I would spend time reading and responding to what they had written.

The topics we attempted to cover in the group were gathered from other

models of psychoeducational groups. They included 3 session geared to covering information specific to sexual abuse and the feelings associated with this experience. Other topics covered included offenders, non-offending parents, assertiveness skills, relationships with males, personal safety, values clarification, and sex education. The group section started with an introductory session where goals and group rules were established and ended with a party to celebrate their participation.

CHAPTER FIVE : CASE STUDY 1 - BONNIE

PRESENT SITUATION

Bonnie was a 16 year old girl who was referred to the Community Resource Clinic in February. She did not agree to come into an intake appointment until the 6th of May and was ambivalent about agreeing to therapy at all. Bonnie lived in a foster home in the inner city. The foster parent's name was Lynne. Bonnie had been dating her 22 year old boyfriend Jack for 1.5 years. Bonnie's mother, Sara, lived in Winnipeg. Bonnie and Sara visited when Bonnie initiated the contact but this had been infrequently. Bonnie had three older brothers that do not live with Sara. She saw her brothers more frequently than she saw Sara.

Bonnie found out she was pregnant in March and was due in October. She was scheduled to have an abortion but changed her mind at the last minute. At the point of intake she was planning to raise the child herself but was aware that the CFS worker had serious concerns about her ability to do this. Bonnie saw engaging in therapy as one of the ways she could prove to her worker that she was preparing to be a parent. Bonnie had recently switched to a special school program for pregnant students.

ABUSE HISTORY

Bonnie first came into the care of Child and Family Services when she was 11 years old because of physical abuse by her mother. At that time she was refusing to go home and live with Sara . She later disclosed to her worker that her mother's common law husband, Lee, had raped her when she was 5 years old. He continued to sexually abuse her until she was 11 years old. When Sara was informed of this she accused Bonnie of coming onto Lee and called Bonnie a bitch. After being in care for awhile Bonnie returned home for a short period of time. Lee was out of the picture and Sara had a new common law, Frank. Frank attempted to rape Bonnie. Bonnie again disclosed the abuse to her CFS worker. Sara did not support that Bonnie was telling the truth at that time. Bonnie became a permanent ward of CFS and has remained in foster care.

FAMILY HISTORY

Bonnie's father died when she was 9 months old but she maintained a relationship with her paternal grandparents. She had also maintained visiting relationships with numerous maternal aunts and uncles. Bonnie was Metis but it is unclear if this was the race of one or both both parents. Bonnie had difficulty accepting this information as she had strong negative feelings about Native people.   Sara has had a problem with alcohol for a long period of time. Sara had also chosen to stay with two different offenders when her daughter disclosed sexual abuse. Sara had been very non-supportive to Bonnie and seemed unable to respond to the needs of her children in general.

When Bonnie first came into care she was at Jessie group home. She remained there for three years. The placement eventually broke down because Bonnie frequently ran away and went drinking. At that point she returned to Sara's home for a short period.   She came back into care again in the Spring of 1989, after the attempted assault by Frank. Bonnie stayed in a receiving home for awhile before being placed with an adult cousin. This placement proved to be inappropriate and did not last long. The cousin was in her early twenties and not mature enough to be a stable role model for Bonnie or provide a consistent environment. Bonnie returned to the receiving home until the Spring of 1990 when she moved into her present foster placement with Lynne.

Bonnie described that she had no real relationship with her mother because they are unable to communicate with each other.   Bonnie felt that she did not trust anyone in her family because " they all have big mouths" and told each other everyone else's business. Bonnie could think of several examples when information she had trusted with one family member was spread throughout the family. Bonnie felt the only relationships that she trusted were with Jack and Lynne. It was also reported that Bonnie and her CFS worker, Kate, had developed a close and meaningful relationship. They had worked together for over four years. At the time of intake however, their relationship was quite strained because of decision making around Bonnie's baby and a cancelled lunch appointment. Bonnie did not appear to have any other strong supports in her life.

PRESENTING CONCERNS

In the year that Bonnie had been with Lynne she had developed quite a predictable pattern of taking off with an older male cousin every 3rd weekend to go drinking. The CFS worker was concerned that Bonnie may be involved in a sexual relationship with this cousin and that she may be an alcoholic. Before the pregnancy Kate was very concerned that Bonnie was spinning her wheels for the last few months and was becoming increasingly stuck in a negative pattern. Bonnie seemed to have found new motivation to get herself organized since becoming pregnant. She had been falling behind in school before the pregnancy but seemed quite committed to her new program. The worker remained concerned about Bonnie's ability to parent because of her lack of supports, her drinking problem, and her unresolved issues around her sexual abuse.

Bonnie's concerns centred around doing whatever she could to prove to Kate that she was prepared to be a parent. Bonnie acknowledged that although she was happy about the pregnancy she was nervous about it and would like to talk about this in our time together. Bonnie was clear from the beginning that she was not very interested in talking about her family. Bonnie did not feel that her drinking was problematic and did not want to engage on this topic either. Bonnie had shared with Kate that she was not comfortable talking about her sexual abuse. Bonnie felt focusing on abuse related material would be difficult because she was shy and did not want other people to know about the abuse. Bonnie remained apprehensive about engaging in treatment. At first she agreed only that she would come the next week and see how she felt after that. Bonnie was very determined that she would remain in control of our work together. It seemed to intrigue her that this control would be given to her without any haggling. Bonnie seemed to appreciate that I was a neutral party and not connected to the same agency that employed Kate. As she was presently mad at Kate this worked strongly in my favour to get at least the initial commitment for attendance from Bonnie.

Developmentally Bonnie was preparing for independence and parenthood at the same time. She presented as very mature in her thinking and actions and seemed older than her 16 years at times. This fluctuated with a less

74

mature, impulsive presentation where she became a young woman looking for direction.

PROCESS

Bonnie's pattern of attendance seemed to reflect her ambivalence about attending therapy. She attended 7 sessions including the intake session to which Kate brought her.   There was also one home visit to facilitate termination and completing scales after her baby was born. In total we met 8 times in 6 months. Bonnie attended 4 sessions in a row in May.   At this point she seemed most motivated to prove to Kate that she was capable of keeping this commitment and doing her part in preparing to parent. Bonnie called to cancel her first two appointments in June, attended 1 in mid June, then became inaccessible until July 24. She called to make appointments for the 24th and 31st of July but missed both of them.   She kept appointments on August 6 and September 23 but cancelled three others in this time period.

On most occasions Bonnie called to cancel and reschedule ahead of time. When she was challenged as to whether she would prefer a different scheduling pattern she insisted that she preferred to make weekly appointments. On one occasion after she had cancelled for several weeks in a row she became agitated when I could not fit her in when she desired. She wanted an appointment made for the following day and insisted that she was only available at one certain time. She was mad that I could not rework my schedule around her request but I felt I needed to be firm that she was being unreasonable.   Bonnie was always offered alternative appointments when possible .   There was one 5 week period in June and July when there was no communication between us. I gave her two weeks before I actively tried to contact her.   After several weeks of not reaching her at her home I was informed by the worker that she was staying with an aunt while her foster parent was away. By the time Bonnie contacted me 5 weeks had passed and another 2 weeks went by before she actually came in for an appointment. Bonnie said this lapse was not because she did not want to come to therapy but because of logistics.   Her aunt lived too far away to get back and forth from the Clinic.

In spite of this scheduling nightmare, Bonnie always came in prepared to

75

work. She let herself engage more and more with me and gained some degree of comfort in the therapeutic relationship. In her last session in September she spoke very clearly about her relationship with her mother and opened up on an emotional level without getting sarcastic or superficial . Bonnie resisted any attempt to discuss the possibility of continuing work with another student after I left. She was clearly of the opinion that she had done her time in treatment.

ISSUES and THEMES

Bonnie's pregnancy demanded that she work through many decisions. In the month prior to her intake she had planned to have an abortion but changed her mind at the last minute. Jack had been encouraging her to go through with this plan. Bonnie then talked about raising the baby herself but was not real clear how this could be accomplished . Two months into our work together she informed me that she then planned to give the baby up for adoption. Bonnie had not discussed this decision with her CFS worker yet. She talked about this change of heart with little affect except that Jack was pleased with the decision. Bonnie became very unavailable after this session. By the time of our next meeting, 7 weeks later, Bonnie was again planning to keep her baby. She talked of her plans excitedly and without regret. At the point where she accepted that she was actively planning to keep her baby Bonnie became increasingly interested in discussing her relationship with her mother. This was frequently introduced by acknowledgements that she would be a different type of parent than her mother had been. After several weeks of this Bonnie began to accept my challenges to consider factors that influenced Sara's parenting. Bonnie felt she could forgive her mother but realized she must also still approach a relationship with her cautiously. When discussing her mother the only emotion that was ever brought out seemed to be pity on one occasion. Bonnie felt sorry for Sara because she was living with a man that Bonnie felt was a derelict. Bonnie made the connection that her mother's lack of self esteem and her struggle with alcohol led to poor decision making. Bonnie presented a paradox of being very mature in her understanding of this situation but naively hoping that some "prince" would come rescue her Mom.

Bonnie allowed a gradual approach to the subject of sexual abuse and

her experiences. For the most part she was in control of the discussion of sexual abuse but would tolerate some probing.   A probe stood an equal chance of being received with a terse response to deflect the topic or inviting some level of introspection. The first time I offered a video that dramatized one family's experience of incest, Something About Amelia (Hanley, 1983), Bonnie accepted but with a safety plan in place.   Bonnie agreed to watch the movie but warned me that she could only stay for 20 minutes of the session because of another commitment. With this control given to her Bonnie showed the courage to approach a difficult subject. Bonnie then surprised herself and me by staying for an hour past the original deadline she had set.   Bonnie watched the movie intently. She became fidgety after the character in the movie made her disclosure but this was the only display of anxiety. Bonnie was able to talk about some of the dysfunctional characteristics of the father - daughter relationship in the movie. The movie was Bonnie's first opportunity to share someone else's experience of abuse. Afterwards she was engaged in a discussion about common after effects experienced by and seen in incest victims.

After the 7 week break Bonnie came back in the mind frame with which she had started therapy , i.e.," my abuse happened a long time ago so what's the big deal" ; "it doesn't bother me". At this point she added a new variable that I had not heard before. Bonnie said it did not bother her to talk about the abuse as it was behind her. The only part that bothered her about it was trying to understand why someone would want to be sexual with a young child. She accepted the information I gave her about different explanations put forth regarding causation of sexual abuse of children.   I kept her on the subject and gently challenged her perception that the abuse did not bother her anymore . I suggested that she may have issues to work through regarding the aftermath of the abuse because in her case, as in many, the family's reaction had the most lasting effect on Bonnie's experience of sexual abuse. Bonnie recognized that her family, although they say they believe her disclosures, had been unable to support her or protect her. She acknowledged that it was difficult to accept this knowing that they still were friends with one of her offenders. For the most part she felt her family preferred to avoid the subject and she had come to accept

this. She described confusion around the love/hate relationship she has with her mother but did not link this to any of the abuse issues.

THERAPEUTIC STEPS

Bonnie was very cautious about letting herself get too involved in the therapeutic process or in establishing a relationship with the therapist. Letting her set a slow and disjointed pace was somewhat frustrating but seemed to be the only way to make this endeavour safe for her. Patience and flexibility, with limits, seemed to make this a workable relationship. Bonnie was less ambivalent towards therapy once my role was clarified. It was paramount that Bonnie understood that my position was neutral regarding whether she gave the baby up for adoption or whether she would choose to raise the baby. Bonnie felt safer discussing her parenting options, plans, and concerns once she realized that this would be supported by the therapist as a mature way to resolve a "normal" struggle. Bonnie and the therapist addressed issues that any young, first time parent should spend time considering. As more trust developed the therapist could confront and challenge Bonnie with information that indicated that parenting was potentially an even more difficult task for someone coming from her background. Present parenting concerns were intertwined with historical concerns about how Bonnie had been parented by Sara. This approach to family issues made this topic safe for Bonnie. Approached from other directions Bonnie had been reluctant to discuss her mother. Bonnie was encouraged to examine how Sara's parenting had effected Bonnie and her brothers. Some problem solving was then done around specific, difficult situations that the family had been through. This involved rescripting these events with Bonnie. She was given the control to make the parental decisions and developed concrete, appropriate alternatives. This exercise reinforced for Bonnie that she had the opportunity and knowledge to parent in a different manner than Sara.

Bonnie seemed to manage the anxiety that sexual abuse produced with strong defense mechanisms of avoidance and denial that she had practised over the years. Bonnie clearly wanted to believe that the experience was long behind her and that it did not evoke strong feelings for her. Her curiosity for

78

information about sexual abuse indicated that there were issues she wished to work on just under the surface of her detached presentation. Bonnie was especially interested in material regarding other people's experience of childhood sexual abuse and offender's motivations. Information was shared with Bonnie on these topics through discussion, written materials, and video presentations. Bonnie's enthusiasm for getting to work when she did show up coupled with the number of times she did not show up seemed to indicate the struggle she continued to have in approaching the subject in any steady fashion. The only way to manage her anxiety seemed to be to allow her to proceed at her own pace while gently prompting her. It was unclear whether the intimacy of the relationship bothered her as much as the subject of abuse. The two factors probably worked together at some level to make trust very slow in developing. If one kept in mind the reluctance that this client showed initially it was felt that success occurred in this area as some headway was made. Bonnie could clearly articulate her inability to trust people. Her hesitancy to commit to treatment was further evidence of the struggle she had with trust issues. Wheeler and Berliner (1988) describe that what begins as an experience with one person becomes the basis for overgeneralized responses to many. Bonnie had learnt to approach all relationships with caution and the therapeutic relationship was no exception. The reliable, safe, and predictable relationship that the therapist continually offered to Bonnie hopefully provided an alternative model that competed with her negative expectations.

The socially learned responses of maladaptive beliefs, behaviors, and attitudes that Wheeler and Berliner (1988) label the second major pathway to postabuse maladjustment, were difficult to uncover with Bonnie. She never felt safe enough to disclose any of her beliefs about the sexual abuse except for those that were socially appropriate. Bonnie said all the right things about placing blame on the offender and understanding a child's inability to give consent. It was hypothesized that Bonnie presented an intellectual understanding of abuse issues that ignored the underlying maladaptive components that caused her much pain. This unacknowledged material continued to influence her beliefs, behaviors and attitudes.

This experience in treatment hopefully demystified the process of

therapy for Bonnie. Bonnie seemed to initially believe that she could be magically transformed through treatment. She always wanted me to direct and set extensive agendas for each meeting. Over time Bonnie became more comfortable with the idea that she would determine how we spent our time although I would always have several suggestions to prompt and guide her work. Expecting this input from her made her a more active and responsible participant. Bonnie was not allowed to get away with "just putting in her time" to prove something to her CFS worker. Bonnie was surprised that I did not respond to the demands she initially placed on me to orchestrate all aspects of treatment. When given some choices to make as to how we would proceed Bonnie at first tried to "wait me out" through silence. The therapist modelled that the silence did not make me uncomfortable and that she was still expected to make some decisions. This was done in a gentle and playful way so that Bonnie felt safe coming out of her defensive, withdrawn posture. There were many indicators that Bonnie enjoyed our relationship despite her predisposition to hate therapy.

The effects of the sexual abuse for Bonnie seemed to be clustered in the stigmatization and betrayal categories proposed by Finkelhor and Browne (1986). Bonnie was deeply betrayed by her mother and other family members inability to support her. Bonnie needed a great deal of support to ventilate emotions around this betrayal. Once Bonnie developed more comfort in expressing anger about this situation it was expected that grieving the loss of supportive relationships with family members would be a significant therapeutic focus. "A strong therapeutic alliance and improved self-concept may be prerequisites to catharsis because the expression of emotions may be very threatening or terrifying" (Courtois and Sprei, 1988, p.288). As Bonnie did not have these prerequisites in place it seemed positive that she had at least been able to recognize and label her anger towards these people. Another effect of betrayal that Finkelhor and Browne (1988) consider is extreme forms of dependency. People worried that Bonnie's relationship with Jack was one of great dependency because he was considerably older and they had been together for sometime without making a real emotional connection.

80

In my work with Bonnie this did not seem like a problematic area as she presented that she was capable of independent thought and action. She did not seem overly reliant on Jack and seemed to protect her own interests. Bonnie had so few supports in her life it did not seem beneficial to challenge Bonnie's perception of this relationship, regardless of what other people in her life believed.

The traumagenic model suggests that poor self esteem, a sense of differentness, and isolation are related to the stigmatization that victims are subject to or perceive (Finkelhor and Browne, 1988). Alcohol abuse is considered a secondary problem associated with these feelings. Bonnie's cognitive and emotional orientation to the world seemed to be based on a sense of being different from other people. This sense of differentness along with the fear of intimacy and inability to trust, results in isolation. "Isolation in cyclical fashion fosters these same effects while contributing to lowered self-esteem and intense loneliness" (Courtois and Sprei, 1988, p.288). Bonnie could acknowledge that she was at times escaping her isolation through the use of alcohol. She could tolerate some challenging regarding the usefulness of drinking as a coping mechanism but only as it effected her choice to raise a child. This would be an area for further work at some time. Preliminary work to break through Bonnie's sense of isolation around her abuse experience was accomplished through sharing other people's experiences in videotaped materials.

Bonnie seemed to appreciate being encouraged and allowed to be the expert on her own experiences and decision making. This presented a precarious situation when the topic was Bonnie's commitment to further treatment. The therapist did feel that it was necessary to gently challenge Bonnie's perception that she had not been effected by her abusive childhood and did not require further treatment. Bonnie's decision to stop treatment was respected however and it was reinforced that she knew what was best for herself regarding continuation at that specific time. This allowed Bonnie to continue to be the expert but it was qualified by the therapist as an appropriate decision only on a short term basis. A break at this time may have been developmentally appropriate as

81

Bonnie needed to consolidate her energies as she adjusted to first time parenthood. Bonnie was encouraged to seek treatment again in the future because clearly there were issues of victimization and abandonment that had not been resolved. At the time of termination it seemed imperative not to undermine Bonnie's understanding that treatment could be non-threatening and client controlled by challenging her too much around these issues. It was necessary however to remind Bonnie the success that she had met with, while of great magnitude for her personally, was realistically only the beginning of a long journey.

MEASURES

EDUCATIONAL SCALE

	T1	T2
CORRECT	16	16
WRONG	5	3
MISSED	0	0
OTHER	0	2

ROSENBERG SELF ESTEEM SCALE

T1	T2
17	23

IMPACT OF EVENTS SCALE

	T1	T2
AVOIDANCE	24 (MED - HIGH)	25 (MED - HIGH)
INTRUSIVE	14 (LOW)	22 (MEDIUM)

Bonnie went from 5 wrong items to 3 wrong items on the educational scale. This indicated that she had some knowledge about sexual abuse before treatment began and this improved more over the course of treatment. Of the three she had wrong at T2, two were the same questions that were wrong at T1. Bonnie still believed that abuse was committed mostly by strangers and that teaching children about their bodies was not helpful in preventing abuse. At T1 she felt that abuse victims did not act out sexually with other children but at T2 she said this sometimes happens.

Bonnie started treatment with a score of 17 of a possible 30 on the Rosenberg Self-esteem scale. This is just above the mid-point of 15 but as no norms are provided by Moran and Eckenrode (1992) it is impossible to know how this compares to other results. Of the four clients reported in this summary Bonnie scored the second lowest on this measure at both testing points. At the end of treatment Bonnie's score increased 7 points. This score, 23 of a possible 30, was considered medium-high. The improvement was a sign of success in our work. There were no dramatic switches in her answers except for two questions that went from negative opinions to positive and one that went from positive to negative. At T1 Bonnie disagreed that she was a person of worth and agreed that she felt useless at times. These changed at T2. At T1 she felt she was able to do things as well as most people but strongly disagreed with this at T2. If Bonnie was thinking in terms of physical capabilities it may be because she had just given birth a week prior to completing this scale. For 5 questions her opinion changed to a stronger degree of self - acceptance, i.e. agreed became strongly agreed. These subtle changes over a wide base of questions accounted for the overall improvement in Bonnie's self-esteem as measured by this scale.

For the Intrusive subscale of the Impact of Events Scale Bonnie initially scored 14 of a possible 28. This low score indicates that intrusive reactions occur infrequently for Bonnie. Bonnie increased from a low rating to a medium by the end of treatment, scoring 22 at T2. It is interesting that her avoidance subscale remained virtually identical for

83

both testings at a medium-high level, scoring 24 and 25 of a possible 32. This indicates that Bonnie frequently avoids certain ideas, feelings, and situations that could be associated with the trauma of childhood sexual abuse. The change in scores on the intrusive subscale indicated that ideas and feelings about the abuse were becoming more intrusive to Bonnie. This could suggest that perhaps treatment had opened up some doors for Bonnie that made some of her avoidance coping mechanisms less successful. For someone displaying Bonnie's level of denial about the impact of her abuse the increase in intrusive thoughts may actually be positive.

SUMMARY

It was quite clear that in Bonnie's family there was a blurred generational boundary as well as evidence of role confusion. Her mother saw Bonnie as a competitor for male attention when the abuse was disclosed. Sara seemed to judge Bonnie as a peer rather than as a child. Sara's choice to stay with the offenders rather than protect her daughter is strong evidence that Sara was not able to parent Bonnie. The physical abuse that first brought the family into contact with CFS also supports this conclusion. Parenting seemed to interfere with Sara's own needs being met. Sara could not operate in the parental role and chose to abdicate her parenting rights. Even as a "visiting parent" Sara had a difficult time maintaining a functional parent / child boundary. Bonnie learned quickly not to trust this relationship or expect much of Sara. Bonnie was able to explore these boundary disturbances and it helped her gain some insight about her mother's perspective and behaviors.

It was difficult to assess the meaning that the abuse might have played in Bonnie's family as she shared little about the context of her experience. Her choice of the word rape may imply that her first abuse experiences were aggression or rage based exchanges. Bonnie did not present the same ambivalence that other clients presented towards their offenders. This may also help to rule out that the abuse was based in expressions of affection that Larson and Maddock (1986) describe.

84

Bonnie made many small gains over the course of her sporadic treatment. Bonnie practised problem solving skills and seemed to become more confident in making her own decisions. Acquiring and strengthening problem solving skills is one area that can reduce feelings of powerlessness and isolation (Wheeler and Berliner, 1988). Bonnie's self image was enhanced by breaking through some of her feelings of isolation and fostering continued individuation from her family. The growth in Bonnie's self-esteem also allowed Bonnie to acknowledge her betrayal and start directing her anger at the appropriate sources. This emotional release was a very hesitant expression that will need to be facilitated further. Hopefully this positive preliminary experience will make future ventures into treatment enticing for Bonnie.

CHAPTER SIX : CASE STUDY TWO - CARMEN

PRESENT SITUATION

Carmen was a 15 year old female who immigrated to Canada three years ago from South America. She had lived in Winnipeg for one month with her step - mother Maria and her half - sister Laura (4 years). Carmen attended an innercity high school and spoke English quite well. Maria did not understand English and Carmen had become the family interpreter outside the small Hispanic community in which Maria interacted. Carmen's father, Paulo, was in jail in Vancouver and she had not seen him since the abuse was discovered three months ago. Carmen's paternal grandparents and several uncles were in Montreal. Carmen's birth mother, Pauline, remained in South America.

ABUSE HISTORY

When Carmen was twelve she was brought to Canada to live with her father. She later disclosed that the sexual abuse started shortly after her arrival. This continued for three years, first in Montreal, then Winnipeg, and Vancouver. In March the abuse was disclosed accidentally when it was discovered by her step-mother. Maria walked in unexpectedly and saw Paulo having intercourse with Carmen. Maria took Carmen and Laura with her to a shelter the next day. Carmen had not seen Paulo since that day. Some of the abuse took place in the bedroom that Laura and Carmen shared. There were concerns that Laura had witnessed sexual abuse but there were no indicators or disclosure that she had also been victimized. The family was living in Vancouver at this time and remained there in the shelter for two months. They now lived in Winnipeg but Carmen may have to return to Vancouver for her father's trial. Maria was appropriately protective and supportive of Carmen and placed responsibility on Paulo. There have been concerns raised however that she may not be consistent in her support and was assigning some blame to Carmen.

FAMILY HISTORY

Carmen's family history took several sessions to gather because it was complicated by many instances of people adopting and deserting children. The cultural differences were at times difficult to comprehend also. Carmen was born to Paulo and Pauline in rural and remote Bolivia. Paulo and Pauline had another child, Antonio, one year after Carmen. When Carmen was two her parents divorced. At that time Paulo immigrated to Canada with his half brother "A". Paulo took Carmen from Pauline before he left for Canada. He arranged that Carmen would be raised by his parents in a small village. Antonio remained with Pauline. Carmen grew up thinking that her grandparents were her parents and that her four uncles were her brothers. These uncles (B,C,D,and E) are 3 to 17 years older than Carmen and she described being very fond of them. Carmen was not told of her real mother or father until she was between 8 - 10. She was told that her father was living in Montreal and remembered writing him some letters. Her grandparents would tell her to ask him to send money. She explained that this may have been to help pay for the medical care she needed. Carmen recalled that as a child she was often sick but was unsure what kind of illness this would have been. Carmen was told that her mother had not been taking care of her very well so it was decided it would be better that she live with her grandparents. Carmen does not have any clear memories of visiting her mother before she was 12 years old. Paulo took Carmen to visit her before she left for Canada. She had a vague memory that she may have met her mother one or two times prior to this but it had not been explained to her yet that this was her mother . When they visited before leaving for Canada, Carmen remembered thinking that Pauline seemed very nice and that it may have been nice to live with her.

Carmen described her grandfather as mean especially when he had been drinking. He would insult people and sometimes became violent with his wife. Little is known about this as Carmen remained quite vague about her life with her grandparents . Carmen's grandmother was described as being somewhat nurturing and protective of Carmen.

When Carmen was 12 years old her father appeared and announced his intention of taking her to Canada. Paulo returned to Canada ahead of Carmen

and she was sent to go live with Maria's (his new wife) parents in the capital of the country for 5 months, to await her departure. The move was necessary as Carmen needed to be near the Immigration Offices. Her Uncle "B" also lived with this family as he was also emigrating. While they were staying there, Carmen's uncle had an argument with Maria's family. The argument was never resolved and the uncle ended up taking Carmen with him to live with friends for the final month before emigrating.

When Carmen arrived in Canada she went to live with Paulo, Maria, and their infant Laura, in Montreal. Shortly after her arrival the rest of Paulo's family immigrated to Montreal. The grandparents wanted Carmen to continue living with them and a custody battle ensued. Paulo was awarded custody and was so angry with his parents that he would not allow any visitation. All contact between Paulo and his parents became strained. They were in Montreal for two years then Paulo, Maria, Carmen, and Laura moved to Winnipeg (1 year) and then Vancouver (less than 1 year) to distance themselves from these other relatives. When Maria left Paulo she decided to return to Winnipeg because she had a good friend there. This is Maria and Carmen's only connection in this area.

Maria and Paulo were married for seven years and had one child together. Maria had a 10 year old child from another union who was being raised by her parents in Bolivia. Maria described Paulo as an alcoholic who became physically aggressive at times. He physically assaulted her on one occasion. He would often slap Carmen as part of a roughhousing kind of play that would leave Carmen in tears. When the abuse was discovered, Maria decided right away that she would have to leave Paulo to keep the girls safe. Maria felt she had an obligation to provide a family for Carmen although they were not really related. Carmen said that she got along well with Maria and called her Mom. She did confide that Maria could be very short tempered and was often hard on her about doing housework and chores properly. The shelter in Vancouver had passed along information to CFS in Winnipeg that indicated concerns regarding this family. Observers worried that Carmen provided excessive child care for Laura and that Maria was at times blaming Carmen for what happened with her father. Carmen did not share these concerns.

PRESENTING CONCERNS and ISSUES

A CFS intake worker referred Carmen for counselling services as soon as the case was transferred from a Vancouver agency because Carmen expressed interest in treatment. The social worker did not intend to work with this family on any ongoing basis as they presented no protection concerns. The concerns that Maria may be inconsistent in her support of Carmen and that Carmen was shouldering too much of the child care responsibilities in the family were passed on from crisis shelter workers in B.C.

Carmen was interested in learning more about what sexual abuse is and why it happens. She recognized that she was still sorting things out and probably still in crisis. She was eager to have support while these topics were opened up and expressed motivation to get started right away. Carmen was very focused on her own response to the sexual abuse and did not see family issues as an area of concern at this time.

The therapist agreed with Carmen's concerns and was pleased to have such a motivated client. It was hypothesized that Carmen would also have issues related to being separated from her family of origin. It was felt that Carmen might test Maria's commitment to raising her. There also seemed to be a sense of isolation related both to being victimized and being in a foreign country. Carmen presented lingering self-doubt about her part in the abuse. An underlying need to process what this all meant to her relationship with her father seemed to be present.

Developmentally Carmen seemed to be focused on defining herself in relation to her new living arrangements. This presented a need to build a strong attachment while at the same time start achieving some independence. She did not present as struggling with sexuality or peer relationship issues.

PROCESS

Carmen came for 15 sessions including her intake appointment. There were also 2 joint sessions with Maria and her therapist. The joint sessions were conducted in Spanish. Carmen and the other therapist interpreted for me and Maria.

Carmen was easy to engage because she was very interested in

receiving treatment. She was open to the therapeutic process as she was still in crisis over the recent discovery of her abuse and the ensuing life changes. Carmen would have liked to take part in group treatment also but she was referred to the Clinic after the group had finished. Carmen attended her weekly appointments regularly without exception. Carmen approached generalized issues regarding sexual abuse from the very beginning of our work together. It remained difficult for her to approach more personalized issues regarding the abuse. This seemed to bring out a great deal of affect with which she was not comfortable.

ISSUES and THEMES

The work Carmen and I did together seemed to centre around her relationship with Maria and how this could impact on her future. Maria seemed to be giving mixed messages about her commitment to parenting Carmen. Once some trust was established between us Carmen felt comfortable exploring how Maria's inconsistency impacted on her. In the beginning Carmen was reluctant to mention struggles with Maria. The first time she spoke of their arguments it was a tearful conversation. Carmen was carrying around a lot of guilt about disrupting Maria's marriage to her father. She felt obligated to go along with whatever Maria decided in her life as she faced total abandonment if Maria did not want to parent her. By the time we had our joint sessions Carmen felt comfortable pushing Maria to clarify her position on the family. Carmen had also looked into what the realities would be if Maria did go back to her father or gave up on Carmen. Hearing options that were available to her relieved a lot of anxiety over her future. This seemed to encourage her to communicate her needs better to Maria instead of conceding all the time. This development also caused more conflict in the relationship between Carmen and Maria. Carmen was increasingly able to focus on the developmentally appropriate stage of defining herself outside the family home. Maria had never contended with this adolescent behavior before. In our sessions we decided to call Maria by her first name instead of Mom. This title had been forced on Carmen when she immigrated and felt very deceitful to her. Carmen felt empowered by this designation but elected only to exercise it in the privacy of our sessions.

As we explored what resources and supports Carmen had available to her it became very obvious how isolated she was from the rest of her family. We explored the potential of these family members to be supportive to her at any level. Next we problem-solved around how to contact the few that were identified as potential supports . In the course of doing this Carmen shared a lot of information about physical and emotional abuse by other family members and the strained communication between many family members.

Intermittently Carmen would use the sessions to ventilate feelings about her father and explore how this relationship had become abusive. Carmen had no confusion about loyalty to her father and was very angry with him. Contact between Maria and Paulo over the phone or through the mail seemed to instigate Carmen bringing him up in session. Occasionally the fear he evoked in her would also be brought up but Carmen had a harder time sharing this emotion. With support Carmen voiced her confusion about Maria's position towards her father and a secret fear that Maria would reconcile with him. She connected this to her suspicion that Maria still held her responsible for the sexual relationship with Paulo.

Exploring Carmen's relationship with her father provided many opportunities to increase Carmen's knowledge about sexual abuse in families. Carmen was very eager for this information. She progressed from a basic understanding of dynamics and effects of child sexual abuse to making quite sophisticated insights and observations about her situation. Carmen also sought out information on sexuality and decision making. This was a difficult area to address with her as the cultural differences she experienced became very evident. The patriarchal framework that her culture provided was difficult to integrate with information about sexual decision making based on equality in a relationship. This issue was further compounded by the misinformation about sexuality that her victimization had created. It seemed positive that Carmen recognized the gap she had to straddle on this topic and she continued to explore her concerns in this area. Discussion around the dynamics of abuse helped Carmen let go of the parts she still felt were her responsibility. She also needed a lot of specific information around why victims do not tell of their abuse as this seemed to be a source of tremendous self-doubt and punishment.

91

Intellectually she came to understand that her isolation was a major source of her compliance. She struggled however to consistently forgive herself for what she continued to feel had been her mistake, not telling anyone about her problem.

THERAPEUTIC STEPS

It was easy to form a therapeutic alliance with Carmen as she was eager to form a relationship. The therapeutic relationship served as a model of a reliable, safe, and predictable relationship that was reciprocal rather than exploitive (Wheeler and Berliner, 1988). Carmen seemed intrigued by my position in life as an independent, educated woman. Carmen had not really had much opportunity to connect with people outside of her family. Carmen was empowered by being accepted into an environment outside of the confines of the Hispanic immigrant community in Winnipeg. This was balanced by the empowerment she seemed to experience in sharing her culture with me. The interest I took in her culture seemed to point out to her areas that she was the expert on and highlighted information that she had never considered valuable before. In empowering Carmen it was important to strike a balance between the two cultures in which she lived. It would not have been therapeutic to empower her in a way that sent her home to challenge everything about the reality in which she lived. Carmen had a nice way of understanding the balance she would feel comfortable with in this area.

It was important in our work together to be patient when there were language difficulties. Carmen was so eager to please people she would sometimes present that she understood when she really did not. This became less frequent as our work progressed and her comfort level increased. On the few occasions where we were both frustrated by language barriers it was crucial to work through them and not compromise. It was feared that compromises would set a standard for communicating on a level that was mediocre rather than really communicating with each other.

It was seen as a sign of success in our work that Carmen felt comfortable backing away from abuse issues when she felt out of her comfort zone. It was easy to push Carmen a bit more than the other clients as she was more open to

approaching the abuse from the beginning. It was helpful for the therapist to be reminded that she too had her limits even if her pace was considerably faster than the others.

It was unfortunate that Carmen could not take part in group treatment as it was difficult to break through the sense of isolation that she felt. Video materials were useful in sharing information from other survivors but this was really just a starting point for addressing the isolation and stigmatization that Carmen described.

Carmen responded very well to encouragement to take care of herself between our sessions. She was assisted in thinking of self nurturing activities that she would find relaxing, pleasurable, and positive. It helped her to realize that the work we were doing together was difficult and that she expended a great deal of energy being too hard on herself. The nurturing exercises were useful in forcing Carmen to consider her own needs and seemed to reenergize her in a healthy way.

The traumagenic framework that Finkelhor and Browne (1988) proposed would describe Carmen in all of the four areas that they outline. The two strongest areas of difficulty for Carmen were her sense of powerlessness and betrayal. Carmen was overwhelmed by her inability to stop the abuse and much time was spent challenging her to develop a better understanding of why she was so powerless. Carmen had many negative and faulty beliefs around this topic. Courtois and Sprei (1988) point out that the "recognition that they are beliefs rather than facts allows for a reexamination and a determination of which ones continue to be applicable and which can be discarded" (p.288). Acknowledging and reviewing the factors that made her totally dependent on her family helped to empower Carmen.

Carmen had two specific fears that also contributed to her sense of powerlessness. Carmen was fearful and anxious that her father would show up and get her someday or that Maria would reconcile with him and leave her stranded. Carmen worried that the decision to live away from her father might be out of her control. This allowed her sense of powerlessness to grow. Carmen was very open to examining these issues and made real progress in addressing her fears. A specific strategy for coping with the unlikely event that

her father would attempt to get to Carmen was developed. This first required that the therapist elicit detailed information from her regarding the nature of her intrusive thoughts and the source of her anxiety. This information was then restructured to create a scenario that Carmen felt she could exercise control over. The new situation ended with her either conquering or avoiding her offender. She fluctuated between the two possible endings and was not pressured to accept only a "conquering" outcome. Avoidance was considered an equally protective response. This intervention provided Carmen the opportunity to improve her problem solving skills and was part of enhancing a positive self image (Wheeler and Berliner, 1988). Feeling able to manage both of the scenarios she feared allowed Carmen to regain some power and move away from her perception of herself as a victim. This may have contributed to the dramatic increase in Carmen's self esteem indicated by the formal measures.

Carmen was betrayed by her father in that he sexualized their relationship and also because he took her away from the family she had grown up with. She was moved from pillar to post by a man who promised her a better life and presented that he was acting in his daughter's best interests. Carmen suffered grave disenchantment and disillusionment upon coming to Canada that Finkelhor and Browne (1985) outline as connected with the experience of betrayal. Not allowing her to have contact with her grandparents and previously with her mother were difficult issues for Carmen to process, perhaps as difficult as the abuse itself. Carmen was very angry with her father and was encouraged to ventilate these feelings. Carmen did not feel safe expressing this anger around Maria so it was important to develop a management strategy for when she was at home. Carmen also was supported in grieving the loss of the relationships with her mother and grandparents. Carmen was encouraged to reminisce about these people. This is part of the normal process of mourning and considered necessary for recovery (Wheeler and Berliner, 1988).

Carmen needed extensive educating about child sexual abuse to counter the maladaptive beliefs and attitudes her experience had

94

engendered. This was achieved through the sharing of written and video materials as well as discussion. A great deal of time was spent discussing the issue of responsibility and sorting through the areas for which Carmen felt she should carry the responsibility. It was important to identify her perceptions of behaviors that she believed made her responsible (Wheeler and Berliner, 1988). Throughout our time together we looked at the choices she made and the reasons behind those choices over and over. Educating around her own sexuality and decision making was undertaken in order to decrease Carmen's vulnerability to further abuse. "Understanding the concepts of consent and mutuality, defining readiness to be sexually active, knowing the reasons why people are sexual, and assisting in the formulation of a personal set of beliefs assist in placing the abuse experience in perspective" (Wheeler and Berliner, 1988, p.244). An indication of success in this area came when Carmen could recognize the dangerous dating situations in which a friend of hers was taking part. Wheeler and Berliner (1988) refer to this as "becoming knowledgeable about pre-abuse warning signs" (p.242). Carmen became better able to make better decisions regarding her own safety while balancing this with her need to form relationships with appropriate males.

Carmen was sad that our work together was short lived when it was time for our termination. She was eager to continue in treatment and had no hesitation in agreeing to continue with another graduate student. An introduction to the new therapist took place in one of our last sessions together. This was done to provide support for Carmen in the transition to the new therapist.

MEASURES

EDUCATIONAL SCALE

	T1	T2
CORRECT	12	15
WRONG	9	4
MISSED	0	2
OTHER	0	0

ROSENBERG SELF ESTEEM SCALE

T1	T2
10	17

IMPACT OF EVENTS SCALE (IES)

	T1	T2
AVOIDANCE	20 (MEDIUM)	23 (MEDIUM)
INTRUSIVE	21 (MEDIUM)	14 (LOW)

Carmen started with a very low score on the educational scale in comparison to the other clients in this report. At termination Carmen made 5 fewer mistakes and scored 15 of a possible 21. Carmen also left out 2 questions at this time. The 4 items that were wrong at T2 were also wrong at the initial testing. She felt it was true that most offenders are strangers and are mentally ill or retarded. She also believed that offenders stopped abusing children once they were caught and that the victim is strange as abuse rarely happens to other children. Carmen was allowed to ask for clarification on the wording of these questions and on the other scales because it was felt that she had a disadvantage of recently learning English as a second language. The

other respondents were not allowed any clarification of the questions.

On the Rosenberg Self-esteem scale Carmen scored the lowest of all four clients reported here, scoring 10 of a possible 30. This was considered a low score as it fell considerably below the mid-point of 15 but the problem of having no norms for this scoring system again made this result difficult to interpret. At the end of treatment Carmen rose to a score closer to the mid-point, making a 7 point improvement. Six of the ten answers changed from a negative to positive appraisal by the end of treatment while four remained the same. The most dramatic shift was from rating that she strongly disagreed that she had good qualities to agreeing that she did have a number of good qualities. Carmen continued to rate herself negatively on whether she had anything to be proud of, the amount of respect she felt for herself, and agreed she still felt useless at times.

On the intrusive subscale of the Impact of Events Scale, Carmen started with a score that was consistent with the mean score of 21 of a possible 28 (Horowitz, Wilner, and Alvarez ,1979). This indicated that she was in the mid-range compared to other samples in describing how frequently ideas and feelings about her abusive experience were registered. At the end of treatment Carmen's score decreased 7 points to 14. This indicates that Carmen was able to exercise more control over the intrusive experiences. This was considered a sign of success in our work together. The avoidance subscale fell within the medium range on both testings with only a difference of 3 points between the initial and termination test scores. This indicated that Carmen was putting the same amount of energy into avoiding thoughts about the abusive experience. It is difficult however, to avoid ideas and feelings when they are being stirred up and examined each week by going to treatment. She was perhaps having more success controlling the intrusive thoughts as we had worked specifically on managing flashbacks and developed safety plans regarding recurring fears. This new level of control would fit with Carmen's verbal description of how her experiences were effecting her at the beginning and termination of treatment.

97

SUMMARY

Carmen's family seemed to struggle with boundary disturbances in several areas. The boundaries around the family seemed to be quite fluid. Family membership changed with great frequency and sometimes little explanation was provided. Generational boundaries seemed somewhat appropriate as Maria took a protective stance when the abuse was disclosed. There did seem to be times however when role confusion allowed Maria to contemplate Carmen's responsibility in the abuse and when Carmen became the caretaker in the family. Generational boundaries were obviously disturbed between Paulo and his children. Societal boundaries were also maintained very tightly by Paulo in attempts to isolate Carmen. Being in a foreign country also exaggerated this boundary disturbance as the isolation was both self-imposed and culturally imposed. This made family members extremely dependent on each other and decreased the possibilities of Carmen getting help. If this abuse had not been accidentally discovered it is likely it would have continued for many more years.

The sexual abuse in this family seemed to be based in what Larson and Maddock (1986) would describe as an aggression based exchange or possibly rage based. In both of these processes the offender is seen as using sexualized anger to deal with frustration and disappointment in other areas of his life. He dealt angrily and at times violently with Carmen. It is unknown if his motivation was to get back at someone else in the family that he really wanted to hurt, as is outlined for aggression based exchanges, or if he was acting on existential rage and long term frustration. The latter corresponds with the rage expression process (Larson and Maddock, 1986). It is highly possible that he had a childhood history of abuse that is believed to contribute to this outcome.

Therapy seemed to provide Carmen with a safe environment in which she could approach abuse related material. Talking about the abuse in a matter of fact way helped the memories lose their capacity to arouse "out of control" feelings (Wheeler and Berliner, 1988). Ventilating both anger and grief were new experiences for Carmen and had to be

98

strongly supported and encouraged. Carmen worked really hard to put words around aspects of the abuse that still made her fearful. This produced a tremendous amount of anxiety for her and was approached at the pace she set. Carmen was such an experienced caretaker it seemed difficult for her to give herself permission to take care of herself. Self-nurturing exercises were very valuable with this client. Restoring or enhancing an adolescent's sense of competency is also an important part of recovery from the effects of abuse (Wheeler and Berliner, 1988). Carmen became increasingly competent in a variety of areas over the course of treatment. The educational scale indicated that her knowledge base had increased. Carmen was more successful in communicating her needs to Maria and continued to become appropriately assertive in this area. Carmen developed a wider support network and her social skills became more age-appropriate.

Carmen really responded to the therapeutic environment and it was suspected that this relationship may have been one of the only where an adult was "reliable, safe, and predictable" as well as "genuinely interested in her welfare" (Wheeler and Berliner, 1988, p.242). Over our four months together Carmen's sense of isolation was broken and the therapeutic environment fostered increased self-acceptance, self-awareness, and independence.

CHAPTER SEVEN : CASE STUDY THREE - DEBBIE

PRESENT SITUATION

Debbie lived in foster care with Fran and her son Dallas (7 years). They lived in an apartment two blocks from the Clinic. Her sisters, Kim (13 years) and Mandy (5 years), were together in a foster home while her brother, Michael (10 years), was in a seperate foster home. Debbie had no visiting with her mother or siblings at this time. Her mom, Shelley, was 33 and lived in Winnipeg. Child and Family Services had permanent guardianship of all four children in this family. Shelley's second husband, Pete, was in jail but was to be released in September. Debbie had just completed Grade 6 in an inner city elementary school. In the fall she would start Junior High in a suburban school. Debbie had been working with another student therapist from March to June and had also taken part in the group that I co-faclitated from April - June.

ABUSE HISTORY

Debbie and her siblings were taken into foster care in 1989 after an investigation found that Michael was a victim of chronic long term sexual abuse by Pete. This came to light because Michael was sexually acting out with children in the neighbourhood. It was suspected that the girls had also been victimized but no disclosures were made at that time. There were concerns raised that the children may have been sexually abused by multiple offenders including their mother. The children's descriptions about what went on in their home lead people to believe that the children were used as sexual toys for the adults that went in and out of the home. After coming into care Debbie disclosed to her worker that she had been sexually abused by Pete. One of the crueller events she disclosed was Pete inserting a frozen wiener in her vagina. Debbie was also aware that her brother had been sodomized by Pete.

Debbie and her siblings had witnessed a lot of physical abuse of their mother by both of her partners. Shelley's first husband made a point of having the girls watch their mother being beat up. The children were also encouraged to call their mother a whore and other derogatory names.

In the children's first placement Debbie would become physically

abusive to other children and adults when she felt she had to protect her little sister. Debbie also had terrible nightmares when she first came into care, sometimes as many as 8 per night.

Shelley had not been supportive of the children's disclosures or the concerns presented by CFS. She chose to stay with Pete when the children went into care and has tried to influence the children to recant their disclosures.

FAMILY HISTORY

Shelley's first husband, Matt, was 12 years older than her. They married when she was 18 years old and were together for nine years. Matt spent five or six of those years in prison. He was imprisoned for break and enters, drug possession, and manslaughter. Matt is the father of the first three children while Mandy is a product of the second marriage. The first child, Kim , was born when Shelley was 20 years of age. Debbie and Michael followed in the next two years. Debbie was 4 or 5 when Matt left the family. Her only memories of this man were of him beating Shelley and that she did not like him.

Shelley's second marriage was to Pete and they have been together for six years. With Pete around the family home turned into a hang out for friends to drink and use drugs. There were always lots of extra people in the home, especially men. On the day that the children were apprehended and placed into the care of CFS a party was in progress. The police attended the home with a social worker and there was quite a scene. The party goers tried to obstruct the apprehension and the children were dragged out of the house. Debbie insists that the police were too rough with her and said she bit one of them in self-defence.

The children all went to the same receiving home at first but were later separated into individual foster homes. Debbie had been with Fran for just over a year. Fran was a specialized foster home chosen to meet the very significant emotional needs Debbie presented. In a psychological assessment Debbie was found to be dysphoric. She remained very loyal to her mother and missed her siblings very much. Debbie seemed to feel hopeless about ever returning home. Debbie would become angry and frustrated when she felt helpless. Debbie has had many difficulties relating to peers at school. She had been

101

very manipulative with other children and at times resorted to violence to get her way.

The entire family went through a psychological assessment by Dr. Eric Ellis as part of the CFS investigation. In his opinion there was evidence that suggested that Kim and Debbie had received some adequate parenting in their early years but this was not the case for Michael and Mandy. These two both had significant developmental delays which called into question the adequacy of parenting and environment. Dr. Ellis described Shelley as distant and emotionally constricted.

TRANSFER INFORMATION

When Debbie first came to the clinic in March she worked with Luvia Treftlin. She was transferred to my caseload in late June when Luvia left the Clinic. She had been encouraged to attend therapy by Fran and was open to trying it out. With Luvia, she attended regular weekly appointments that were extended from 1 to 1.5 hours at Debbie's request. This evolved into 1 hour spent in the playroom and .5 hour spent in a regular interview room. Debbie was very eager to do dramatic work and play therapy with Luvia so this was facilitated in the playroom. Luvia started the custom of walking Debbie home after sessions. She lived very close to the Clinic but had safety concerns that lead to this arrangement. Debbie was also very eager and willing to participate in the group treatment segment.

INDIVIDUAL WORK WITH LUVIA

Debbie came into her sessions with a very high energy level and wanted to be physically active. The playroom gave Debbie the opportunity to address abuse issues in a way that felt safe to her. She would create different abusive situations for dolls in the playroom and set herself up as their rescuer. Debbie would play the part of the policewoman that chased offenders away or the mother that kept people from killing her children. She also dramatized scenes where a mother sexually abused children. Debbie's role often included physically caring for children. Debbie was not ready to address her own abuse directly. She steered clear of this subject and other issues related to her family.

In their work outside the playroom Debbie preferred to discuss her relationship with Fran and peer problems.

GROUP PARTICIPATION

Debbie attended 6 of 8 group sessions. She was eager to attend the group and came in with a very high energy level. The topics that were presented to the group and the ensuing discussions clearly agitated Debbie. Her behavior became very difficult to manage at times and was often disruptive to the rest of the group in the beginning. Debbie was very demanding of attention from the group leaders and the other girls. The group had some success in providing feedback to Debbie that helped her monitor her own behavior. On a few occasions it was necessary for group leaders to discuss the problems that her behavior created for the group privately with Debbie. The situation improved considerably after the control battle that Debbie created with the group leaders was diffused. This happened in the first two sessions. Things seemed to escalate for Debbie again however, near the end of the group and she chose not to attend the last two sessions.

One of Debbie's biggest complaints about the group format was that we did not have each girl tell their story of abuse. Debbie could not see that she was expecting the other girls to do something that she herself was not prepared to do. Debbie would sometimes refuse to take part in activities in the group and would try to distract the others while she sat and watched. Debbie refused to spend time doing journalling in the group but did sometimes accomplish this in her individual sessions.

The group experience may have been premature for Debbie as it caused a great deal of anxiety for her at times. Debbie could have benefited from a lengthier opportunity to experience some success in individual therapy before attempting a group setting. The experience was not without positive aspects however. The other members were very tolerant of Debbie's difficult behavior for the most part and but also helped Debbie by providing feedback regarding the social appropriateness of her behavior. Debbie really wanted to belong to the group and sought approval from other members. The sense of belonging that she was able to achieve at times "may go a long way toward reducing her

103

sense of isolation and increasing her feelings of adequacy and self-esteem and her trust in others" (Knight, 1990, p.203). Debbie also took great pride in helping out the group by always assisting in preparing the snack and helping to clean up at the end of session. This was an important part of group membership for Debbie because she did not contribute a great deal to discussions or activities, where others made their mark. The group still provided Debbie with "factual information, social support, and an opportunity for emotional interaction with peers" (Herman and Schatzow, 1984, p.614). Although this experience was sometimes stressful to Debbie it was considered valuable in breaking through her sense of isolation and beneficial to her ongoing healing.

PRESENTING CONCERNS

Debbie's CFS worker hoped that treatment would increase her ability to talk about abuse related issues and ventilate feelings around the loss of her mother. It was expected that this would help to decrease her acting out behaviors.

Debbie was interested in learning more about sexual abuse and talking about her foster placement. Debbie also appreciated having a one on one relationship with an attentive adult.

PROCESS

Although Debbie was transferred to my caseload in late June circumstance (summer camp) and miscommunication lead to our first appointment taking place August 1. We had seven sessions together between August and October. Debbie was then transferred to another student who would be with her through the fall and winter. Debbie was aware of the short term nature of our work when we started. It was decided that because she was already familiar with me from participating in the group, I would carry the case until a longer term arrangement was available.

Debbie attended her weekly sessions regularly. For the most part they remained at one hour and were always spent in an interview room. She did not push for the play room and I did not suggest it as this had not been offered to

the others included in my practicum. We would bring simple activities into the interview room such as coloring supplies or board games. This insured that the focus of the entire hour was not on sitting and talking. That model of interaction would have been difficult for Debbie to participate in for an entire hour. The activities were simple enough that they did not have to distract from discussion. Two different videos were also used in our sessions, Something About Amelia (Hanley, 1983) and Incest : The Circle of Healing (Millican, 1979). Debbie had seen both of these before in group but requested to see parts of them again. Debbie also brought in a family photo album to one session that was helpful in facilitating discussion around family issues.

ISSUES and THEMES

Debbie was prepared, right from the first session we had together, to discuss the physical and emotional abuse that Pete inflicted on her and other family members. With a little encouragement she was able to label feelings that went along with these events. She spoke directly about her brother's sexual abuse but spoke in generalities about her own. In our fifth session Debbie was clearly worked up about something. She kept suggesting that there were some things she really had to get working on and share with me although she did not feel ready to do this. After some encouragement and exploration it became clear that Debbie was feeling pressured by Fran. Fran had told her that she needed to get working on her issues and start behaving better if she wanted to stay in her specialized foster home. This lead to clarifying and reiterating that in our work I expected her to only share that with which she was comfortable. I suggested that perhaps we could explore ways to make her feel more comfortable getting into the harder issues. This gave the control over our pace back to Debbie and seemed to relieve the anxiety she was feeling. Debbie then felt safe enough to disclose a more pressing concern regarding safety planning for Pete's upcoming release from prison. Debbie was clearly fearful that Pete would seek revenge against her in a violent way as she felt she had helped send him to prison. While this was being addressed she let herself disclose some scary memories of Pete showing a sexual interest in the children as soon as he moved in with their mother. She also disclosed that adult sexual

105

activity took place in front of the children in the home. In this same session Debbie sought information to help her understand if she had the potential to be a sexual offender. Her fears were based on the concerns that have been raised about her caring for younger children.

On the day that Debbie was feeling pressured to get going on her abuse issues she requested that we watch the Incest: The Circle of Healing (Millican, 1979). She was so wound up she could not stay with the movie for long and we watched very little of the show. At the next session she was more settled and took great interest in the characters in Something for Amelia (Hanley,1983). Debbie asked very thoughtful questions about the material presented in the show and was able to draw some comparisons to her own life.

Debbie was open to exploring the conflicting feelings she had towards her mother as long as it did not sound like criticism of her mother. The confusion Debbie felt towards her mother was evident many times in our work. Debbie would pour out memories of being hurt and neglected by Shelley. Then in the next breath she still planned to run away as soon as possible to go live with Shelley. Debbie acknowledged that, although she sometimes wished she had a different mother, she still loved Shelley. In the beginning this was the closest Debbie ever came to acknowledging pain or anger associated with how she had been parented. She was not angry that Shelley had been unable to protect the children or had chosen to stay with Pete. She explained that Shelley could not stand up to Pete and could not leave him because she loved him. Debbie could not tolerate any discussion that probed these choices Shelley had made or Shelley's behavior since the disclosures about abuse. After several sessions Debbie expressed anger towards her mother but it was specifically over the choice of a new boyfriend disliked by Debbie. For a moment she seemed to judge her mother in a more accurate light. This carried over into our last session when Debbie again talked about the confusion about loving and hating her mother as we reviewed our work together. She surprised me by being able to express that there were things to be mad about with Shelley. Debbie also understood that it was acceptable to feel this way. She could now see that it was very important that Shelley believed her children and not put them at risk in the future.

Another theme that often came up was concern about her younger siblings. Debbie would put a lot of energy into worrying about the placements of her younger brother and sister. This seemed to allow her to take the focus off of areas in her own life that were creating problems at times. It was also a sign of attachment that she longed to be able to visit with them. The natural longing was exacerbated because she had no understanding of why visiting was not being planned for the family. There was some ambivalence towards Kim and acknowledgement that they had a difficult time getting along. It was unclear whether she would visit Kim if given the opportunity. The younger children were her primary interest .

Debbie seemed to be at a developmental stage that brought on a great deal of self-appraisal and she focused on this frequently. Debbie seemed to recognize the tough image she had projected to her Grade 6 classmates and talked about changing her image. She hoped to make a fresh start in the new school for Grade 7 and redefine Debbie. Debbie used me as a sounding board to assess other people's perceptions of her at times. She could not believe that the kids at her new school thought she was pretty, funny, popular and athletic. After some discussion she could accept the athletic label but wanted to discard the others. A few weeks later she reported that someone had called her a slut at school but she did not provide any context to this remark. This of course raised many questions about Debbie's ability to relate with boys in a non-sexual manner as her home environment had been so sexualized. Debbie insisted that she had not developed any interest in boys yet and seemed to have a hard time imagining that she ever would.

Debbie also could do some introspection about her relationship with Fran. She described that Fran was the only person she had ever trusted. We talked about behaviors and situations that proved to Debbie that Fran could be trusted. When Fran suggested that perhaps her home was not the proper placement for Debbie it left Debbie quite shaken. The magnitude of Debbie's reaction to this discussion indicated the strong attachment that had formed to Fran. Debbie's desire to please Fran, although it created a higher level of anxiety for herself, indicated that she did not want to have to consider another placement. Debbie preferred to approach problems in the relationship from the

perspective of what Fran was doing wrong and could rarely consider her own contribution to situations.

THERAPEUTIC STEPS

Therapeutic movement with Debbie all seemed to evolve around letting her set the pace that we would approach issues on and avoiding control struggles with her. In our first meeting through the group we got off on the wrong foot by engaging in a power struggle. This soured our relationship for the first half of the group sessions. The pride we shared in working past this tenuous starting point proved to be a joining factor later in our work. When Debbie was approached with a clear focus on avoiding control issues, she was much easier to engage. Debbie would sometimes try to bait people to see if they would get into an argument with her. Her other trusted strategy was to manipulate and test situations to see what level of response she could elicit from people. She had tried this out a few times with the therapist and found either no fight or clear limits for her behavior when necessary. Once these outcomes were established as predictable Debbie seemed able to move away from these destructive tactics. It was important for the therapist to respond firmly only to the behaviors that presented overt concerns, such as a question of safety, and learn to let other obnoxious behaviors run their course. A differentiation needed to be made between these two categories of behaviors that was clear and consistent for both Debbie and the therapist. This clarity allowed a healthy relationship to develop between therapist and client that was not burdened by unproductive power struggles.

Debbie seemed to feel comfortable with the agreement we had that we would acknowledge that we worked together because of her abuse history but it would be approached at her pace. There were frequent fluctuations in her willingness to approach issues related to the abuse. On a few occasions, she would surprise me by leading us into abuse related material from other topics that had seemed unrelated. At other times Debbie would take the encouragement I gave her to move into these areas with little hesitation. She could stay focused on these topics for different amounts of time depending on many factors, both obvious and covert. If Debbie seemed reluctant to stay with

an abuse related discussion she was given the freedom to approach and avoid the topic as she felt necessary. There were also some sessions where Debbie would deflect all invitations to get into any issues and would sidetrack for long periods of time. Debbie was in a very agitated state when she was feeling pressured by her foster parent to "get going" in her therapy. It was obvious that clarifying her freedom in approaching subjects actually freed her up to do more work that day than the threat she had been trying to operate under. This clarification also encouraged her to keep going in treatment with a third therapist when previously she had been suggesting that she needed a break.

Debbie received extensive educational information regarding sexual abuse both through the group and her individual work. Straightforward information helped clarify responsibility attributions and gave Debbie a more realistic explanation for what had happened in her family. Information around causality remained difficult for Debbie to comprehend. She felt most comfortable with an explanation that her offender was "sick". This belief resisted all efforts at modification and all alternative explanations were ignored. The resistance encountered with this specific belief was consistent with the theory that some childhood messages are deeply entrenched and will not suit restructuring (Courtois and Sprei, 1988). Debbie felt safe enough to disclose concerns she had about her part in the abuse and faulty beliefs around this could be examined. Debbie was then challenged to discard the beliefs that were no longer applicable. Developing more appropriate and educated beliefs about her abusive childhood was intended to increase Debbie's self-esteem. Debbie became increasingly comfortable with this form of intervention and eventually shared one of her most painful beliefs. Debbie was frantic about the potential she felt she had to be a sexual offender. She trusted the therapist enough to question information that Fran had provided her about the possibility that she may become an offender. This was a sensitive area as the therapist did not want to undermine Fran but wanted to help Debbie have a realistic understanding of where this concern comes from. It was important to encourage Debbie that this was a behavior she could have control over while not minimising the need to be aware of everyone's potential for abusive behavior.

Debbie did not show a great deal of affect during our sessions. She discussed difficult issues in a detached manner. The only exception to this was the fear that was evident when she talked about Pete. This fear was expressed so dramatically it seemed possible that it was exaggerated. The therapist did not share this hypothesis with Debbie or confront her in any way. All the concerns she raised regarding Pete were given ample attention. It was felt that any attempt to challenge her on the accuracy of her perceptions could have closed off this important subject prematurely. This would not have been helpful to Debbie at this time. The fears she raised were clarified and operationalized where possible. As the fears became more concrete Debbie and the therapist could problem solve around each issue. A safety plan developed out of this exercise that was shared with Fran and Debbie's CFS worker. This seemed to increase Debbie's sense of safety and self-efficacy.

Debbie's concerns about visiting her family were addressed both through advocating on her behalf and empowering her to be her own advocate. On two occasions I discussed with Debbie's social worker how visiting would be therapeutic for Debbie. As visiting was clearly something that CFS would have to take into consideration in their case planning, Debbie was encouraged to keep bringing it up with her worker. It was discouraging to both Debbie and myself that a visit did not take place until September and visiting was not committed to on any regular basis. The concerns regarding visiting with Shelley needed to be considered as a seperate issue. We reviewed the available information that supported why Shelley did not have visitation with Debbie to try and help her understand CFS's position.

The eroticized environment that Debbie grew up in would be expected to have had a profound influence on sexual attitudes that Debbie acquired. There was little evidence of this, however. Debbie was not sexually acting out at this time and seemed to be able to distinguish (in discussion) between abusive and non-abusive sexual behavior. As she enters junior high school and developmentally becomes more of a socializer, sexual acting out may be anticipated. The only symptomatic behavior that would fall into the traumatic sexualization (Finkelhor and Browne, 1988) category was the anxiety that sexual information created in

110

Debbie. In the group, sexual topics frequently seemed to coincide with Debbie engaging in disruptive behavior. This may have also been related to wanting to impress her peers in the group forum. The anxiety was present in the individual sessions as well but was exhibited in less problematic ways.   Individually, Debbie would show her discomfort through increased fidgeting and irritability when sexual topics arose. This seemed to subside over the course of individual therapy but remained a problem in the group setting. Debbie was provided with feedback about this behavior and taught appropriate methods of self-control.

Debbie showed a real need to control both the therapeutic and outside environments. This would be classified by Finkelhor and Browne (1988) as a psychological impact of the state of powerlessness the abuse created for Debbie. Debbie was allowed complete control within the interview room and did not abuse this arrangement. In other parts of the Clinic or when we would walk home it was necessary to set limits for Debbie. This again may have been related to needing to impress any one that Debbie perceived as an audience. Setting consistent limits around the Clinic hopefully helped Debbie practise responding to situations that she could not exercise complete control over. Debbie challenged some of the limits and needed to be reminded of the roles of adults and children. Treating Debbie like a younger child was necessary at first until she showed that she could monitor her own behavior more appropriately. This entailed giving Debbie a choice between a limited number of options. This gave her a sense of control and helped avoid power struggles while still operating within prescribed boundaries. For example, Debbie would be given a choice whether she would like to bring in activity "a","b", or "c". Debbie would not be allowed to go in the playroom and look through all the materials as she would spend half the session engaged in this decision. A limit would also be set that the activities she chose stayed for the entire session. There would be no going back and forth out of the interview room to exchange materials. These limits were necessary as Debbie initially was in and out of the interview room for frivolous reasons. Debbie was still allowed to leave the room

once to use the bathroom or to get a drink. The frequency of this needed to be monitored by the therapist at first but later was put in Debbie's sphere of responsibility. Debbie made better choices regarding her own behavior over the three months that indicated an increasing ability to exercise self-control. She became less unruly in and around the Clinic and her social skills seemed more age appropriate. Within the therapeutic environment of the interview room Debbie's ability to display age appropriate social skills was often related to the material being worked on at any given time. Debbie was allowed a great deal of freedom to physically express her anxiety. Debbie would change seats frequently in the interview room and once conducted a portion of our session with her body in a chair and her head on the floor. The therapist would encourage Debbie to express these feelings in words while this was occurring. This remained very difficult for Debbie. The physical agitation was something she could acknowledge and this was seen as a starting point for future emotional expression.

Debbie had many issues related to betrayal that needed to be resolved. She was supported in labelling and expressing feelings around the betrayal by the abusers and the lack of support by her mother. Debbie also felt betrayed by the CFS worker that was not planning visits and I advocated for her on this point. Debbie was more comfortable sharing negative feelings related to her worker than feelings about her mother but made some progress with this issue. Debbie was very young to be expected to differentiate from her mother. As she matures and appropriately separates from her mother she will have much anger and grief to experience regarding this relationship. This would be a continuing area of work for Debbie.

As Debbie continued to be very anxious about approaching abuse related material it could be concluded that the treatment process had not gone very far with her. The level of anxiety that Debbie exhibited had however, clearly decreased from the first session to our last. Although there was very little discussion of direct abuse issues, it was felt that a trusting base had been established. From this base we discussed

sexuality occasionally but more often focused on the relationship struggles Debbie had with her mother and foster parent. Debbie was encouraged to problem solve for herself. All of her efforts in this area were supported and praised especially those that presented alternatives to violence. Debbie seemed to appreciate the expectation that she was capable of taking care of some of her concerns herself. Her sense of competency was enhanced by expecting her to choose appropriate means of solving conflicts and expressing her needs. Debbie was challenged to appreciate the pugnacious attitude that she presented to the outside world. With encouragement and support she recognized where this tough persona had come from. Examining and acknowledging the many factors in her home that forced her into the role of protector allowed Debbie a better understanding of her response to abuse. She talked sadly of incidents where she had to fend for herself and the other children. We reframed toughness as a coping mechanism that had served her well in her home environment but was becoming problematic in environments where it is not necessary, i.e., Fran's home and school. Working to enhance her self-image gave Debbie the opportunity to experience more positive interactions with peers and adults. This may in turn reduce the frequency of conflict in Debbie's relationships. Debbie was given practise in evaluating situations where she would need to differentiate between small concerns and bigger concerns through structured rehearsals with the therapist. This was done to help Debbie assess when a situation called for assistance from appropriate adults. It seemed important that a young adolescent like Debbie with a history of being parentified clearly understand that she could still expect assistance from caring adults. The therapist frequently reiterated that while she was being coached to solve her own problems more effectively this did not imply or necessitate complete independence. It took a lot of encouragement to have Debbie imagine or practise how she would be assertive in letting people know when she needed help. This intervention met with more success when Debbie could be worked into a playful mood. Hopefully continued practise in these skills will contribute to a decrease in her acting out behavior.

MEASURES

EDUCATIONAL SCALE

	T1	T2
CORRECT	18	17
WRONG	1	1
MISSED	0	0
OTHER	2	3

ROSENBERG SELF ESTEEM SCALE

T1	T2
24	30

IMPACT OF EVENTS SCALE

	T1	T2
AVOIDANCE	16 (LOW-MED)	25 (MED-HIGH)
INTRUSIVE	8 (LOW)	10 (LOW)

On the educational scale that Debbie wrote at the time of termination she had only one wrong answer as well as two "maybe's", and one "sometimes". The alternatives of maybe and sometimes were written in by Debbie and were not actually offered as possible responses. The one incorrect response on both the pre and post test was to the same question. At both times of testing Debbie felt it was true that most offenders are mentally ill or retarded. Her "maybe" answers were in response to whether children who have been sexually abused will ever lead normal lives and that most children disclose the abuse right away.

She responded that children are confused about their feelings towards the offender sometimes. This seemed to be an issue that Debbie was just beginning to explore near the end of our time together.

On the Rosenberg Self esteem scale Debbie initially scored well above the mid-point of 15 with a score of 24. This indicated a healthy level of self-acceptance and fit with Debbie's confident presentation. At the end of treatment Debbie surpassed this high starting point by scoring the highest possible level on the scale, 30 of a possible 30. She answered in a strong positive direction for each and every question. This may reflect Debbie's discomfort with focusing on difficult issues and perpetuate her desire to see everything in only the most positive ways. If this measure was to be believed it indicated that she did not struggle or falter in any area of self-acceptance. It is my belief that this is what Debbie would like people to see in her. In reality it seemed that Debbie struggled with many painful feelings about herself and experienced a great deal of self-loathing. These more sensitive aspects of Debbie's character seemed to be hidden just under the surface of a carefully cultivated confident presentation. The six point increase from the first test period to the second may indicate that she was becoming more proficient at telling people what she thought it was they wanted to hear. This would have been the fourth time that Debbie had completed this scale as it was also used with her previous therapist. It could also indicate that Debbie was becoming increasingly comfortable with herself as a person. An increase in scoring on this scale would have been expected as Debbie's behavior seemed to indicate positive growth in self esteem. It is difficult to accept that the six point increase in scores holds any true meaning when the scores on both tests presented suspicious results in the first place.

On the intrusive subscale of the Impact of Events Scale Debbie scored very low at both times of testing. A score of 8 at T1 and 10 at T2 indicate that Debbie was rarely bothered by intrusive experiences related to the her history of childhood sexual abuse. All answers in this category at T2 reflected that intrusive experiences were never a problem except for

115

the question related to reminders of the experience. Debbie indicated that reminders "often" brought back memories of the abuse. At T1 Debbie had answered "not at all" to the same question. This is the only indication that ideas or feelings were becoming increasingly intrusive. On the avoidance subscale Debbie scored below the mean at the initial testing. Her score fell halfway between the mean and the low. At the end of treatment Debbie's score rose nine points to 25 of a possible 30. Debbie recognized that she was more actively avoiding certain ideas, feelings, and situations. The mean for this scale is 21 so her score falls between the mean and the high. At both times of testing 28 out of 30 questions were answered with only the most extreme ends of the scale provided, that is, either "often" or "never" with nothing imbetween. This is consistent with Debbie's black and white or concrete approach to life. Debbie seemed to exaggerate or minimize things and rarely presented any middle ground. These scales were completed during the termination session which may have increased her emotionality. Debbie's affect seemed somewhat exaggerated regarding our termination and this may have influenced her answers.

Debbie's measures for the end of group treatment were used as her initial measures (T1) in our individual work together. This made sense as the testing coincided with the point of transferring the case from the departing student.

SUMMARY

Debbie's family was characterized by boundary diffusion between members and invited friends. Members were not allowed any autonomy and were expected to follow the lead set by the Shelley's partners. The disturbed personal boundaries within the family produce dysfunctional interactional patterns that become "rigidly structured into the behavior of family members, producing a lifestyle directed at overcoming a pervasive sense of intrapersonal and interpersonal emptiness" (Larson and Maddock, 1986, p.30). The high level of sexuality and the abuse of drugs and alcohol in the home may have evolved as methods to cope with this

116

emptiness.   Boundaries between child and adult generations seemed nonexistent.   Debbie seemed to take on adult roles that nobody else was fulfilling and became a parent to anyone who needed one. Shelley competed with her children for attention and provided very little parenting to her youngest two children.   Shelley chose to ignore the needs of her children by staying with their offender.   Shelley did not move back into an adult position even after the children were removed from her care. She showed very little initiative to maintain a relationship with her children since they went into foster care. The few times she did have contact with the children it was obvious that she could not exercise any consistent adult-child boundaries.   Asking the children to recant their allegations is a good example of how Shelley expects her children to meet her needs.

The abuse in this family seemed to be based in an erotic - exchange process where all relationships are somewhat eroticized if not outright sexual (Larson and Maddock, 1986). There was little concern for privacy around parental sexual relations and some suggestion that other adults were taking part in a variety of public sexual behaviors in the home. Even food was seen as having erotic potential in this home.

The therapeutic environment gave Debbie an opportunity to increase her self-awareness, self-acceptance, and her independence. These are some of the most important aspects of therapy with abuse survivors (Briere, 1989).   The therapeutic relationship provided a good model for Debbie of a reciprocal, safe, and predictable relationship (Wheeler and Berliner, 1988). This was a type of relationship that she had rarely seen. Debbie's decision to continue with yet another therapist gave me great optimism that the groundwork that had been laid in our work together would serve her well in her continued efforts to make sense of her abusive past. An important area to address in further work would be increasing Debbie's comfort level regarding expression of difficult emotions. As a strong therapeutic alliance and improved self-concept are sometimes considered prerequisites to the necessary emotional release (Courtois and Sprei ,1988) this may be a task for longer term therapy with this client.

CHAPTER EIGHT : CASE STUDY 4 - ANNA

PRESENT SITUATION

Anna was 13 years of age when she was referred to the CRC by her Child and Family Services social worker. Her mother Wendy was divorced from her father John since 1986. Anna lived in a group home with 7-8 other adolescent females at the time of referral. Anna attended Grade 7 at a local junior high school. Anna had been at the group home for just over one year but had been in and out of foster care for the last four years. Anna's brother, Bill (17 years), had just recently moved out of their mother's home. Bill lived with his girlfriend and their infant son. Anna's other brother, Carl (16 years), was still living with Wendy. Wendy's second husband Mac was currently serving time in prison for physically assaulting Wendy. Anna was aligned with her father and her paternal grandmother at the time of referral. On her frequent absences from the group home it was strongly suspected that she was being harboured by these people. CFS continued to have protection concerns regarding the relationship between John and Anna and allowed only supervised access (office visits and limited, monitored phone calls). John had talked about pursuing custody of his daughter but had not formally set this in motion. Anna had a very strained relationship with her mother and had not seen her for many (4-6) months. The family lived in a duplex where Wendy's mother occupied the main floor suite and Wendy had the upper level.

ABUSE HISTORY

In December of 1986 Anna disclosed that her father was sexually abusing her. Her two brothers witnessed this abuse at times. John was immediately charged and asked to leave the family home. Wendy appeared to be supportive and planned to divorce John. She remembered suspicious incidents with Anna and John since Anna was five years old. Wendy had suffered her own abuse from John, physically, sexually, and emotionally. Wendy also had a history of sexual abuse in her childhood.

In September of 1987 the trial was held for John's charges of assaulting Anna. John was found not guilty. Anna's testimony was described as very

believable by the judge but she was confused about when the abuse had occurred.

In November of 1989 Carl disclosed that he was also sexually abused by John. Carl refused to talk about this abuse with anyone because he did not want to go through what Anna had been through.

In March 1990 Anna was seen masturbating the family dog and Wendy responded by having her hospitalized for three weeks on a psychiatric ward. Anna then went through an assessment at the Manitoba Adolescent Treatment Centre. At that point Anna recanted that her father was a sexual offender and alleged that her mother filled her head with those ideas when she was too young to know better.

.   In September of 1990 Carl felt safe enough to share his disclosure of sexual abuse by John with the CFS social worker.

In October of 1990 Anna made a new disclosure and claimed it was actually her brother Bill that assaulted her from 7 - 12 years of age.

In February 1991 Anna was referred to the CRC.

FAMILY HISTORY

Wendy and John lived as a family until the abuse was disclosed in 1986. Bill was adopted while the other two are their natural children. Wendy was an emotionally needy person with recurring mental health problems, before and after the marriage. As a father and a partner John was described as cold and excessively strict. Carl had threatened to run away or kill himself while they were living together because of John's cruel treatment. After John left the home all three children reported that they were happier and had minimal contact with him for a year. Some level of contact was established in December of 1987 and this seemed to have a noticeable negative effect on the children. Anna's behavior began to deteriorate and become increasingly problematic. Carl was hospitalized for psychiatric treatment. Since the separation John had maintained a campaign to discredit Wendy as a mother and harassed the family from a distance. Sometime in this time period Wendy went through a phase of befriending street kids and giving them shelter with her family.

Wendy (40 years) and Mac (25 years) started a relationship in June

119

1987. Mac had a lengthy criminal record, a history of severe physical and sexual abuse as a child, and an addiction to alcohol. By September 1987 this relationship was extremely abusive and Wendy made a suicide attempt. The family environment became increasingly chaotic and both sons presented as suicidal and depressed. Little is recorded in the CFS file until May 1989 when the family entered family therapy at Children's Home. At this time Anna and Carl were placed in foster care for three months to help the family stabilize. In August 1989 the children returned home, Wendy was deemed increasingly self-sufficient and the CFS file was closed. In November 1989 the case was re-opened when Wendy was hospitalized for suicidal thoughts and depression. A severe physical assault by Mac, that was interrupted by Carl, precipitated the hospitilization. In February 1990 Mac and Wendy married. Anna was hospitalized shortly after this (the dog masturbation incident) then placed in foster care again. Anna continued to be aligned with her mother at that time. She ran away from her placement frequently to return to Wendy's home. In October of 1990 Anna switched her allegiance to her father and became focused on clearing his name and going to live with him. She made several appearances at police stations to make statements recanting her previous disclosure. Anna severed her relationship with her mother. She was placed in care at a group home. Wendy was not considered as a placement option at this time because her home continued to be abusive and chaotic. CFS continued to only allow supervised access between Anna and her father as this relationship continued to be dysfunctional. Anna talked about her father like a boyfriend at times, he seemed to script how he wanted her to try and manipulate the system, and he fluctuated between babying her and courting her. Wendy became angry with CFS as time passed and withdrew from pursuing a relationship with her daughter. Wendy concluded that although she felt badly for how things had turned out for Anna, she felt helpless and unsure how to change the situation as long as Anna was rejecting her.

PRESENTING CONCERNS and ISSUES

Anna's social worker was concerned that Anna lacked social skills, she was displaying very sexualized behavior, and that she had an insatiable

appetite for adult attention. The worker felt that Anna could benefit from developing an understanding of her family's dysfunctional interactions and relationships. While doing this it might also be possible to address the protection concerns that John continued to present. It was also hoped that she would develop a better understanding of the sexual abuse that she acknowledged by her brother.

Anna's was interested in talking about her grievances with CFS, building her relationship with her non-offending brother, and achieving more freedom in her relationship with her father. Anna had no interest in her relationship with her mother and was clear that this was a very sensitive issue that she was not willing to discuss.

The therapist agreed to work with Anna on her issues and hoped that the social worker's issues could be incorporated as the work progressed. Anna had been hesitant to attend this initial meeting and had little commitment to therapy. Her apprehensions had subsided enough that she quickly identified that one hour per week may not be sufficient as she had so much to talk about. Anna also agreed to give the group treatment an opportunity for one session. She remained pessimistic, however, that a group experience could be useful.

Developmentally Anna was very focused on self-definition. She also seemed torn between getting nurturance from her family and proving herself as an independent entity. Her budding sexuality was a major concern to adults working with her. The confusion related to her victimization mixed with a need to appear independent and in control contributed to different types of inappropriate and dangerous sexual activity. Anna was definitely lacking in social skills. One example of this was the difficulties she had in maintaining peer relationships. Developmental issues were also compromised by her need to be aligned with one parent over the other.

GROUP PARTICIPATION

In the beginning Anna was unconvinced that the group experience was something in which she wanted to participate. Her opinion was effected by a bad experience with group work that was done at the group home where she lived. After a month of working together individually she agreed to give the

121

group a try, on the condition that she did not have to continue if she did not like it. Some obnoxious behavior by another member (Debbie) in the first session convinced Anna that she would not like to be part of the group. In her next individual session with me Anna indicated that she no longer had transportation to the group and would not be attending future group sessions. With some pushing she was able to clarify that the real problem was that Debbie's behavior had hurt her feelings. Anna acknowledged that leaving the group was her way of avoiding Debbie. Her objection was validated and plans were developed about how the group leaders would take responsibility for getting Debbie to behave more responsibly to other group members or not take part. Anna was also capable of understanding that Debbie was expressing her own anxieties about attending the group through her rude behavior. Anna was empowered by the consideration that perhaps she had some more appropriate coping skills to model for other group members when they were nervous. Being helpful to other group members is acknowledged as a significant therapeutic experience that can boost self-esteem (Knight, 1990). Anna agreed to give the group one more try and became a regular attender. This sense of having some importance to other members contributed to Anna establishing herself as a leader. She missed only one session and this was because she was absent without permission from her placement.

Anna seemed to feel safe in the group and took part in most discussions and activities. The only piece she opted out of was writing in journals at the end of each group. She did agree to spend time on this at the beginning of some of her individual sessions and proved to be very expressive in her writing. It was somewhat unexpected that Anna would become one of the leaders in the group. Her social skills were not as noticeably underdeveloped in the adolescents that made up the group. Her leadership actually helped move the group in a positive direction for the most part. There were exceptions when she would try to shock the others with graphic language or problematic behavior but she came to recognize that this only impressed the peripheral group members. Anna was more successful interacting with peers in structured activities and with the leaders present. The group provided a safe place for Anna to practise her social skills and it seemed that she struggled less with this

as time passed.   The group also provided a valuable peer group to Anna that helped break her isolated experience of sexual abuse and sexuality. Anna seemed to appreciate that everyone in the group, no matter how "cool" they seemed, had a great deal to learn about sexuality and that it was acceptable to struggle with this knowledge. Anna seemed to enjoy the freedom to get silly about sexual discussions without being reprimanded. It was often Anna's lighthearted comments that opened the girls to any discussion. Anna made many valuable contributions to the group. The group experience benefited Anna by providing "factual information, social support, and an opportunity for emotional interaction with peers" (Herman and Schatzow, 1984, p.614).

PROCESS , ISSUES, and THEMES

The process of Anna's treatment was difficult to unravel from the issues and themes. They are grouped together here for this reason although the other client summaries separate these categories.   Anna attended 20 sessions over a 7 month period so there was a great deal of material to sort through.

Anna's initial focuses were maligning both her mother and the group home staff and environment. She could not tolerate much discussion around issues with Wendy.   Anna was always eager to throw out a few barbs at Wendy, however, before she closed this off as a topic of conversation. Initially these were very concrete items like Wendy had too much sex, it was Wendy's fault she had failed Grade 5, and Wendy screwed her up by filling her head with the false abuse allegations against John. Anna distanced herself from this painful subject by saying she had no mother or she did not want Wendy to be her mother. At this point Anna had not seen or been in contact with Wendy for at least 4 months.

Anna would often move away from difficult subjects by focusing on all the injustices and inhumanities she suffered at the group home. She was reluctant to look at how she could act on any of her complaints but seemed to feel validated when she was allowed to ventilate as much as she wanted. After 8 sessions (where group home complaints were her main focuses) she agreed to have a meeting with her keyworker at the group home and myself. The purpose of this meeting was to support her in clarifying what her concerns were and to

help her understand what responses she could reasonably expect from the staff. This agreement was reached only after Anna was so worked up about how she was being treated at the group home that she let herself cry for the first time in session. At this point Anna also needed clarification about why she was attending therapy. She had reached the understanding that her lawyer had arranged for therapy to help her get back with her father. This was clarified and for the first time Anna was challenged around issues with her father. This included discussing what her father was actually doing to get her back and appropriate intimacy between fathers and daughters.

After the meeting at the group home Anna allowed the focus in treatment to move away from the problems in the group home. Anna was increasingly open to invitations from the therapist to talk about her family and was less prone to sidetrack into group home issues. On May 28 Anna watched the documentary Incest : A Circle of Healing (Millican, 1979). One segment featured abuse victims discussing their experience while another section focuses on non-offending partners (typically mothers) viewpoints in incestuous families. Anna was very interested in the first part of the documentary but indicated she wanted to go for a walk later in the session and was not interested in seeing the mothers' segment. She later requested to continue the tape and forgot about the walk. Anna then proceeded to pretend to fall asleep while the mothers spoke and remained sleep-like after it was finished. I talked about other girl's responses to the show and reviewed points the mothers had raised, hoping that Anna was taking it in at some level. Before Anna left she said some things about her mother that seemed to indicate she had been taking in most of what was being put forth. Anna said she could see the mothers' side in the story and that this made her understand and feel sad for her own mother. We discussed how her mother needed to focus on her own survival over the last few years as she was in an abusive relationship with Mac. Anna identified Mac as a scary person. Anna did not feel hopeful that she could establish a relationship with Wendy now though because " they had never really had a relationship". Anna forgot that Wendy used to be her parent of choice and only remembered that Wendy had never visited her in foster care. There was only one occasion after this session where Anna spent time wishing that she could

124

live with her father. This occurred in mid June. She talked longingly of living with John full time. Anna was also feeling desperate enough to consider some out-of-province relatives as an acceptable second choice if CFS would not approve placement with John.

In late June Anna surprised everyone by dramatically abandoning her alliance with her father. Anna left the group home without permission and arrived unannounced at Wendy's door after being on the run for several days. This produced a variety of new focuses for our work together. Anna's new agenda at that point was to live with her mother again. This was to be assessed as a possibility by her CFS worker, at the end of August. Wendy made it clear to Anna that she would only be welcomed home if she had made a lot of progress in therapy. Although Anna was not clear what exactly Wendy meant by this she approached therapy with renewed gusto. Anna became very focused on the issues surrounding her sexual abuse in a rushed and superficial manner. She was in such a hurry to "get over" her sexual abuse that she became somewhat non-discriminant in talking about it with people. Anna now acknowledged that both her father and brother were perpetrators and she had been sexual with the family dog. Anna was given the choice about continuing visits with her father or not. She acknowledged that seeing John made her feel like running away and lying for him and that would make it too difficult to see him.

The first issue that Anna presented after changing allegiance to Wendy was working through her feelings about being put into the hospital by Wendy several years ago. Anna reconnected with her favourite staff member at the hospital and came to see this as a positive part of her life. Anna acknowledged that going to the hospital had felt like some kind of punishment and it had never been acknowledged why Wendy had taken her there. Through conversations with her mother and work done in our sessions Anna came to see that Wendy had acted out of fear and ignorance as many people do when faced with a sexual problem. Anna was helped to understand that her own behavior was not weird or abnormal and that Wendy had acted in a way that she thought was helpful to Anna. Briere (1989) refers to this as normalizing the clients reaction to their abusive childhood experiences, or destigmatizing. Anna came to

125

forgive her mother for the hospitalization. She separated this from continuing to feel angry at Wendy for allowing Mac to be a higher priority than the children. Anna continued to struggle with this aspect of her situation and recognized that she felt abandoned by her mother. In early August Anna clearly felt that she was now ready to live with Wendy. She could tolerate little discussion that this may / may not happen as it also depended on Wendy being ready to parent full time.

When Anna felt comfortable approaching abuse issues the focus intertwined with sexuality concerns. It was apparent that Anna's ideas about sexuality had been severely impaired by her own victimization and a highly sexualized home environment. Anna still struggled with why her brother had chosen to be sexual with her. Despite ongoing efforts by the therapist to provide information to help resolve her questions, Anna continued to understand only a sexual explanation. She held out that he had fathered a child as proof that he was sexually active and insisted that he had always had plenty of willing sexual partners. Anna also showed the chaos in her own exploration of adolescent sexuality. This started with her testing the water with roundabout and vague comments about other people's sexual activities. She asked informational questions regarding birth control for "her friend" who thought she might be pregnant. Anna later disclosed that she had experienced non-abusive sexual experiences. She became very ambivalent and ambiguous about whether she had consented to sexual activity and whether it had been an age appropriate partner. Anna settled on the fact that she had said this guy could have sex with her but she had slept through it. Anna acknowledged that there was a time period when she thought all she was good for was sex and she did not care what happened to her body. Anna seemed to feel safe by putting this in the past and claiming to be in control of her sexuality at present.

In late August Anna saw her father for the first time since her change of allegiance. It remained inconclusive whether it was by coincidence that he had arrived at the same campsite that the group was using. It was also hypothesized by group home staff that Anna could have arranged this coincidence. When Anna first saw John she spoke with him briefly in the

presence of another group home resident. Anna then let the staff know what was going on and stayed in the staff's presence. She became quite worked up about her father coming to get her and assault her again. The staff were of mixed opinions whether this was real fear or dramatized. Anna's sexual acting out started to increase after this camping trip. In sessions Anna started focusing on problems with group home staff and peers again. At the very end of August Wendy declared she was not ready to parent yet as she was feeling "pretty messed up". Anna became very angry and left without permission for a two week hiatus from the group home. A placement review at this time acknowledged that she had become more open about her own sexuality and abuse issues since reconnecting with her mother. There was concern raised that Anna discussed the abuse issues without attaching any emotion to it at all. The staff also felt that she continued to have difficulty relating to men as she tried to sexualize all contact with males. Her relationships with staff had suffered since she started visiting Wendy again. While she was away from the group home Anna spent sometime with her father and grandmother at the Public Safety Building (P.S.B.) trying to clear her father's name. She had also run into Mac (who is now a friend of John's) and passed her Mom's unlisted phone number on to him. Wendy was furious with Anna as Mac then started harassing her over the phone. Wendy started to wonder if all the effort she felt she had put into reconnecting with Anna was for nothing. Wendy was unclear about whether she was still willing to work out a relationship with Anna at this point and continued to focus on her own needs.

When Anna returned from her leave she asked the staff that an appointment be set up with her therapist. She acknowledged her anger at Wendy and saw this as the trigger to her latest absence from her placement. She was forthcoming about meeting John at the P.S.B. but said that this episode of running away from her placement was different than the others as that was their only contact. Anna recognized that her Dad still had power over her. Anna felt that she had to stay away from John because she did not want to lie for him anymore. Anna was also more honest in discussing her own sexual activity that had transpired while she was living on the streets. After much discussion Anna could acknowledge that at some points being on the run had

127

been scary and that was why she had eventually returned to the group home. For the most part Anna had a real sense of bravado about the scary situations she described. Many of the events were clearly abusive and exploitive. Anna could not see the revictimization because she wanted to believe she had been in control.

In the final review of our work before we terminated Anna made a realistic appraisal that she had been let down by both her parents in different ways. She seemed to appreciate that Wendy was feeling discouraged by her behavior of late but felt that this was a relationship worth working on in the future. Anna appreciated that she would like to have a relationship with her father someday. She was clear in her understanding that this would never be possible until he apologized and accepted responsibility for the sexual abuse and other manipulations. Anna presented some interest in continuing therapy with another graduate student but also expressed relief that this work was over for the moment. This seemed to indicate that she remained ambivalent about treatment and was not taken as a negative appraisal of our work together. The prospect of doing some therapeutic work that included her mother seemed to be what interested Anna the most at this time.

THERAPEUTIC STEPS

The most therapeutic aspect of the relationship that developed between Anna and myself seemed to be the positive regard that I showed for her. I accepted Anna as the expert on her situation right from the beginning and let her set a pace that she was comfortable with in addressing abuse issues. I did not focus on trying to prove that John had sexually abused her. Other helpers in Anna's life were forced to focus on the fact that John had sexually abused Anna as this created ongoing child protection concerns. Clearly establishing that I had a different role than other adults in her life was the first step in establishing trust with Anna. Advocating for Anna by talking to group home staff with her and writing a letter to her lawyer also helped to build a therapeutic alliance. Anna seemed more prepared to open up about her family after I acted on the requests she made for me to support her outside the clinic setting. Initially family topics were so threatening that even completing a genogram

128

together proved difficult. Anna was very guarded about information as innocuous as the ages of family members. Anna was not forced to provide information she wished to keep private at that time. This demonstrated to Anna that she was in control and the therapist would respect her pace. A few sessions later Anna accepted an invitation to complete the genogram and provided detailed observations about family members. Demonstrating that this activity was something that she had a choice about and waiting for an appropriate level of trust to develop facilitated the completion of the genogram. On one occasion I disregarded the pace that Anna had set for approaching abuse issues. I tried to invite Anna into considering why people recant abuse allegations and attempted to expose her faulty belief on this topic. I continued to challenge and confront her and eventually felt like I was digging myself into a hole. I was working on my own agenda of forging ahead on her abuse issues and failed to recognize that Anna was not prepared to entertain this subject yet. I came face to face with the tremendous oppositional energy that Anna put into other relationships with adults who were trying to help her. After this session I approached all challenges and confrontations in a gentler manner that fit my personal style more appropriately and met with more success. Confronting and rebuilding faulty cognitions were frequently used interventions that became increasingly successful as trust developed in the therapeutic relationship. Anna became more accepting of encouragement to take in other peoples viewpoints and information that allowed us then to dismantle faulty beliefs. Anna was so defensive with other adults that any information they tried to provide her was aggressively disregarded. Anna was constantly invited to take in new information. It varied a great deal from session to session how she would respond to these invitations and how long she could stay focused on topics if she took the challenge. It was important for her to be given this sense of control and demonstrated to her the therapist's ability to respond to her needs. Over the long run, the positive regard I showed for Anna, being willing to advocate for her, and giving her choices about how we would proceed, all contributed to Anna letting me into her world.

In the beginning it was also important to accept Anna's inability to discuss her relationship with her mother. Allowing her the freedom to ventilate

129

hostile feelings about her mother opened the door later to discuss the origin of these feelings. It was an important breakthrough in our work when Anna could acknowledge and describe how her mother had let her down and how this made her feel. The insight she later gained that both parents had let her down was the most rewarding indicator of success with Anna. This awareness was a sign of increasingly mature and independent thinking that Anna had not been capable of when we first started working together. Hopefully this was the first step for Anna towards a more realistic understanding of her situation. This understanding could serve as the foundation she would need to face the inconsistencies that both parents would continue to present in her life. Anna was beginning to define herself outside of what her parents expected her to be. This was a very healthy development as Anna had previously been trying hard to figure out what her parents wanted and was constantly manipulated into meeting their needs. Beginning to separate from parents was developmentally appropriate for a person Anna's chronological age but somewhat premature for Anna's level of emotional neediness. It would have been beneficial if Anna could have been supported and nurtured by her parents for a much longer time period. As her parents would not be capable of doing this hopefully Anna would be able to have these needs met in other appropriate ways while she struggled to develop an identity separate from her own parents.

      The most apparent effects of Anna's abusive childhood were inappropriate sexual behaviors and attitudes. The extensive information she was provided in both individual and group work regarding healthy sexuality sometimes seemed like a drop in the bucket compared to what would be needed. Anna seemed to take in the information and displayed a keen interest in sexual topics. She continued to display however, through her questions and behaviors, that it was very difficult for her to incorporate these new ideas against all the misinformation she possessed. Educating would definitely be a long term process for Anna. It was considered to be a positive sign that in the end she was less clandestine about her own sexuality and was asking more questions. The questions reflected that she was seeking out information to challenge some of the misinformation herself rather than waiting for the therapist to lead in this area. Along with the information that Anna was

provided about sexuality she was encouraged to be aware of different societal attitudes about sexuality. We attempted to formulate a personal set of beliefs around sexuality for Anna that put the abuse in perspective. It was important to emphasize issues related to consent and responsibility in these discussions as Anna continued to struggle with these concepts.

Anna's presentation seemed to mirror the negative self-image she harboured. Finkelhor and Browne (1986) would relate this to the stigmatization that child sexual abuse creates. For the first 5 months we knew each other Anna was unkept and dressed like a boyish hoodlum. She seemed to take very little interest in her appearance even when this exacerbated a skin condition she had. When Anna made the disclosure about her father she started to take a greater interest in these previously neglected areas and looked like a different person. The positive feedback this received was very encouraging to her. It would have been interesting to see if her score on a second self esteem scale would have reflected the visible changes in her self acceptance.

The other area that Anna seemed strongly affected by was the betrayal involved in her situation. Vulnerability to subsequent abuse and exploitation,depression, extreme dependency, impaired ability to trust, anger, as well as discomfort in intimate relationships were some of the behaviors that Finkelhor and Browne (1988) attribute to the betrayal of being let down by the offender and other family members. Anna exhibited all of these symptoms to some degree. When she was able to develop some compassion for her mother's position she seemed to feel less betrayed by her. This turning point then allowed for the more difficult work of processing the betrayal by her father. This was in the initial stages when our work ended.

In our 7 months together the process of therapy lent itself to anxiety reduction around the subject of sexual abuse. Anxiety was never completely dissipated and anxiety levels fluctuated a great deal from session to session. In general ,however, it was still felt that Anna became increasingly more comfortable with the subject and could tolerate discussing some of her memories. Therapy also started to chip away at some of the socially learned responses that Wheeler and Berliner (1988) describe. Anna was able to discard some of the maladaptive beliefs, behaviors, and attitudes that her

131

abusive history had fostered. She placed responsibility clearly on her offenders, she attempted to understand her offender's behavior, she acknowledged some of the vulnerable situations she had recently put herself in, and she had a better (although rudimentary) understanding of consent issues. Anna was able to express some feelings around her experience with her brother and later, her father. Anna was encouraged to label these feelings and learn to handle them in constructive ways. She appreciated this opportunity to talk positively about John as she did not feel free to do this anywhere else.

The therapist initially surprised Anna by giving her permission and encouragement to miss her father. With this freedom, Anna was then able to move away from her defensive stance regarding their relationship. Gelinas (1983) cautions that if loyalties are ignored they will operate as resistance to treatment. Anna then found it tolerable to question and challenge some of her father's actions and became increasingly objective in evaluating their relationship. When Anna took a healthier position and distanced from her father the shift paved the way for the rebuilding of Anna's relationships with Wendy and Carl. It seemed like Anna believed that Wendy could fill the large void in Anna's emotional life that withdrawing from John had created. It was frustrating for Anna that reconnecting with Wendy was really just a starting point and not the immediate solution that Anna had hoped. Anna's fantasy that Wendy would be able to provide all the support she needed was difficult to challenge at this point. It was feared that Anna would have taken confrontation on this topic defensively and the developing therapeutic relationship would have been jeopardised. This issue was left to run it's own course and Wendy proved on her own that she was not instantly ready to parent again. Wendy also fluctuated in her commitment to working through issues with her daughter and often put all the pressure on Anna to change. Wendy's behavior forced Anna to let go of her perfect family fantasy. This was a fortunate natural development as the therapist was not put in a position that could have been interpreted by Anna as a negative stance towards Wendy. Previously, Anna had slowly developed some comfort in examining her relationship with her mother. This lead to their reunification. Anna was also capable of continued examination of this topic after their "honeymoon period". When Wendy's

132

position was more evident Anna was able to continue experimenting with the expression of grief around the limitations of this relationship. It seems like the hopeful period immediately following their reunion was very confusing and disorienting to Anna. It also temporarily halted the treatment process. Anna could only be supported by the therapist during this time through their safe and predictable relationship. It was imperative to wait for a more appropriate time to continue the difficult work of developing a healthier understanding of her relationship with her mother.

In the time periods when Anna was open to exploring her relationship with her mother we normalized Wendy's responses to Anna. This was done by presenting information and challenging faulty cognitions about possible explanations for Wendy's behavior. Anna's faulty beliefs about her mother's behavior seemed to have an extremely negative effect on her self-esteem. The therapist encouraged her to think about many possibilities and expected Anna to reach her own conclusions. It was very important to determine the specific misinformation and faulty beliefs that were influencing Anna so that new information could be tailored to her needs. Developing an understanding of her mother's position that was not blaming or accusatory was an important therapeutic milestone. Anna previously seemed trapped between needing to believe that either she was a bad child or Wendy was a bad parent. The same educated understanding of attitudes and behaviors found in abusive families needed to be developed for Anna's belief system about herself. This all seemed to breakdown Anna's sense of isolation and differentness which can foster low self esteem and loneliness (Courtois and Sprei, 1988). This boost to Anna's self-esteem seemed to give Anna the courage to pursue a relationship with Wendy again after many months of estrangement. Shortly after this therapeutic development Anna showed up on her mother's doorstep. This also seemed to allow Anna to let go of the desperate attachment she had been maintaining with her father.

The dramatic shift in Anna's support system changed the course of our carefully nurtured relationship initially. As part of the plan to move home permanently Anna was being encouraged by her mother to complete her therapy. Anna attempted to "work out" all her abuse issues by quickly

acknowledging all the abuse in her past and openly analyzing her own sexual behavior. She became indiscriminant in talking about her abuse and in her sexual activity. Anna seemed strangely detached from both of these activities and discussed these areas with a noticeable lack of affect. It felt like Anna had dramatically moved away from the pace she had previously set regarding abuse issues and was moving at a rapid fire pace to please her mother. Her sexualized behavior and inability to connect any emotion with discussion of her own victimization indicated that now Anna was proceeding at a speed that she could not tolerate. It was difficult to remain engaged with Anna during this time period. She did not want to be challenged or confronted on the possibility that she may not be returning to her mother's home in August. She also avoided any probing about the change in her relationship with her father. Anna did not make herself available to discuss difficult issues until she was in crisis again. Anna was devastated in late August when it was determined that Wendy was not ready to parent full time. Anna reacted with her standard coping mechanism of running away. When she returned however there was an indication that Anna was beginning to include healthier coping mechanisms in her repertoire. Actively seeking out time with her therapist was seen as an indication of positive change. Anna came to her next session prepared to ventilate many difficult emotions regarding her mother. It was unfortunate that Anna's need to reconnect with the therapist came only weeks before our termination. It did provide the opportunity however to reach some understanding about this difficult time period with her mother. The last few sessions were also used to review with Anna all the hard work she had put into treatment and reinforce the positive changes that the therapist was observing. Although Anna still had a long way to go in her journey of healing she has taken many important beginning steps and her courage was applauded.

MEASURES

EDUCATIONAL SCALE

	T1	T2
CORRECT	17	-
WRONG	3	-
MISSED	1	-
OTHER	0	-

ROSENBERG SELF ESTEEM SCALE

T1	T2
21	-

IMPACT OF EVENTS SCALE (IES)

	T1	T2
AVOIDANCE	29.5 (HIGH)	-
INTRUSIVE	20 (MEDIUM)	-

Anna wrote the educational scale at the end of the group treatment in June. At that time she had three items wrong. Her measure for April has been misplaced so it is impossible to determine what her level of knowledge was prior to treatment. Like all the others tested Anna agreed that offenders were mentally ill or retarded. She disagreed that many children feel the abuse was their fault.   This possibly indicates a healthy understanding that this is not right, although the question was intended to indicate that this is a common reaction. The other item that Anna had answered incorrectly could fall into the same category in that true or false does not adequately satisfy the statement. Anna said it was false that abused children sometimes think they are ugly or look

different than other children (#16). The answer considered correct for this statement (true) indicates a frequent response but not all children will experience this reaction. In those instances "false" may be a more accurate answer and could indicate a child at a different point of resolution of their abuse. As mentioned previously, ambiguity proved to be an obvious fault of the wording chosen for several questions. It is interesting that Anna left out the item that questioned whether most children tell someone right away when they have been sexually abused. Perhaps this was an uncomfortable area to think about at that point in time as Anna was still spending time with and protecting her abusive father. Anna scored 17 of a possible 21. This indicated that Anna had a good knowledge base about common beliefs about sexual abuse.

On the Rosenberg Self-esteem scale Anna scored 21 of a possible 30, with 30 indicating the highest level of self esteem. As Moran and Eckenrode (1992) provide no indication of norms for this new method of scoring it is difficult to know what this represents when compared to other results. If a score of 15 is the mid-point in possible scores Anna has scored in a medium high area. Anna had only one question that fit the negative category of response. She indicated that at times she feels she is no good at all but saw the nine other areas in a positive light. This indicates a healthy level of self-acceptance that fits with the cocky, confident presentation Anna exudes but does not account for her self- destructive behavior and unkept appearance. It was difficult to accept the results of this scale as accurate in this case. Anna's behaviors and attitudes indicated a great deal of inner turmoil. Her confident presentation seemed to be a strained and exaggerated attempt to cover up a very low opinion of herself.

For the Impact of Events Scale Anna scored in the medium range of the intrusive subscale, 20 out of a possible 28. The mean for this subscale is 21. It was surprising that someone projecting so much denial about her abuse when she came into treatment would be experiencing this level of intrusive thoughts. Anna presented that everything was under control for her and that she had not been sexually abused by her father. At the time of testing Anna would have been using the sexual abuse by her brother as her point of reference. The scale would indicate that thoughts around this experience were fairly intrusive. Anna put so much energy into denying that she had been sexually abused by

her father it would be surprising if she was having intrusive thoughts about that experience. Anna scored much higher on the avoidance subscale, scoring 29.5 out of a possible 32. This seemed to fit with a victim that was trying to convince herself and others that she had not been abused. All 8 of the avoidance questions rated either "sometimes" or "often". This would indicate that Anna was actively and consciously avoiding certain ideas, feelings, or situations that could be associated with the abuse she had experienced. The test cannot measure the potential for or frequency of denial and repression as this does not occur at a conscious level. As part of Anna's experience was still being denied at this point this is something that must also be considered as an indication that the scale may underestimate both the levels of intrusion and avoidance for this client.

Anna's termination measures were never completed due to a variety of reasons. It had been planned that they would be completed at the last meeting scheduled at the Clinic where Anna was to meet the therapist that was taking over her case. This meeting was never accomplished as Anna was absent from the group home without permission and did not return while I was still at the CRC. When it became obvious that I would not officially terminate with her I dropped the measures off at her group home and asked that they send them along to me if/when she returned. An envelope and postage were supplied to the group home staff in order to accomplish this with minimal effort on their part. I never received any response from Anna.

SUMMARY

Anna's family had boundary disturbances in many of the areas that Larson and Maddock (1986) described. There was evidence that the adult/ child boundary was extremely blurred with both parents. The blurred boundary allowed the sexual relationship to exist between father and daughter. The role confusion that accompanies these blurred boundaries helps to explain why Anna protected her father and sometimes described him as a boyfriend. With her mother the blurred boundary gave Wendy the permission to use Anna as her confidante regarding her own emotional issues. Anna appeared to be a peer of her mothers. Wendy would probably need ongoing support and

guidance in order to assume more of a parental role with Anna. Individual counselling that would lead to dyadic work was recommended to Wendy for this reason. This was suggested when Anna first reunited with Wendy and again in August when it became apparent how unsure Wendy was in her commitment to parent Anna. Anna's blind loyalty to her father was a testimony to the enmeshment and overdependence found in incestuous families. Helpers were seen as intruders and were not allowed to penetrate the rigid boundary that Anna and John hid behind. Anna spoke of the common agenda she and her father shared and seemed programmed in her responses. John seemed in control of Anna when she first entered into treatment and she seemed incapable of independent thought. Anna relied on denial to "minimize the cognitive dissonance and emotional pain created by the intrafamilial abuse while maintaining the emotional dependency" (Larson and Maddock, 1986, p.30) she had with her father. At the end of our work together Anna had put some clear boundaries around her relationship with her father. She recognized that it would be difficult to maintain a clear boundary with him if she continued to see him. This contributed to her request to have visiting put on hold. It remained unknown if Anna would be able to maintain this position with her father as it was quite a drastic stance to take. She hoped to develop a healthier relationship with him in the future but was clear about the safety factors she would need in place first. As there was no indication that John would ever accept responsibility for his abusive behavior it seemed unlikely that Anna could have any level of relationship with her father and be true to herself.

In Anna's family it was difficult to establish one precise function that the incest served. At times the abuse seemed to be a means of "affection exchange" between adult and child generations. John would plan special outings with the children that gave him the opportunity to isolate them and engage them in sexual activity. There were also hints that the entire home atmosphere was somewhat sexualized and that the children were socialized to accept this atypical atmosphere. There was much discussion between generations regarding adult sexual behaviors that did not seem to bother anyone. This indicated the possibility of an" erotic exchange process" in the family. The abuse of Anna by her oldest brother seemed to serve a different

138

function than the abuse by her father. Anna's brother was aggressive towards her and at times restrained her. Anna had a real fear that he was capable of physically hurting her. This abuse could fall into an "aggression expression" functional category. Larson and Maddock (1986) describe that "an adolescent male may sexually exploit his younger sister in retaliation for what he perceives as abandonment or rejection by his father, whom he believes shows intense favouritism towards the girls in the family (which may itself have an incestuous element)" (p.38). Bill's abusive behavior may have been a response to his own long history of neglect and possible abuse. Larson and Maddock (1986) would put this in a" rage based" category. His actions were cold and calculated by Anna's descriptions and this is a factor in "rage based" families. Larson and Maddock's (1986) categories were useful in suggesting possible meanings the abusive experiences had to this family and individual members but far from conclusive. Speculating on possible functions in this family reinforced the belief that this was a very complex and dysfunctional family system. Anna continued to struggle with her own capacity to make sense of the abuse at the end of our work but this is not surprising as she did not or could not acknowledge being victimized by her father until many months had passed. Perhaps coming to some understanding about what happened with her father in the future would force her to reevaluate her abusive experience with her brother. Anna was still very confused as to why her brother had been sexual with her as it did not fit her understanding that abuse is only motivated by sexual needs. Looking at her father's possible motivations and other contributing factors may challenge her to move past a sexual explanation for both of her offenders. Larson and Maddock's (1986) functional categories provide much information for Anna to consider.

In the beginning of our work Anna identified very few supports in her life. She did not believe that anyone at the group home could be trusted and had trouble relating to peers at school. The friendships she valued appeared superficial and unhealthy. Her father, her grandmother, and her father's lawyer were the only people she felt were supportive of her position and capable of caring for her. We will never clearly know what influenced or caused the dramatic shift in allegiance for Anna as she could not consciously identify how

139

she had arrived at this point. It is hypothesized that therapy provided a safe and neutral environment for Anna to take in new information about sexual abuse in families. Anna was constantly being challenged by the therapist to incorporate new information into her thinking. Most importantly the therapeutic environment seemed to foster increased self-awareness, self-acceptance, and increased independence that Briere (1989) concluded were the most important aspects of therapy with abuse survivors. At the end of treatment it was hoped that Wendy would be a valuable support to Anna in the long run. At that time she was at least a more positive support for Anna than John. At the end of our work Anna had reconnected with a helper from the past that she seemed to trust. This person seemed to be a valuable support to Anna in the transition from her father's sphere of influence over to her mother's. It seemed apparent that this woman's warm reception to Anna gave her a much needed boost in her self esteem during this difficult time. Anna was able to engage in a more age appropriate manner with group home staff when we terminated. She continued, however, to be involved in manipulative and superficial peer relationships.

Several months after I left the CRC Anna came back to continue treatment with the graduate student I had offered to her previously. As I could not bridge the transition with the new therapist I had written Anna a letter to introduce them.

CHAPTER NINE : Personal Learning and Evaluation

GOALS

From the beginning it was hoped that this practicum experience would increase my skill in meeting the treatment needs of adolescents with mental health concerns. Although clients who had experienced sexual abuse within their families were the focus of the practicum it was expected that the skills learned could also be put to use with other presenting problems.

Working with survivors of sexual abuse and an extensive literature review of the subject was expected to increase my understanding of child sexual abuse. Developing an understanding of the vast array of effects that are attributed to the experience of childhood sexual abuse and family dynamics in incestuous systems were considered to be important foundations for any work with this client group. Developing appropriate interventions would also be researched and practised with particular attention paid to the needs of adolescents. This practicum hoped to establish a better appreciation regarding the possibility of unique treatment needs for this population.

It was also expected that planning the practicum would help me to define the principles of therapy that were important to me and provide an anchor for future work.

EVALUATION

Over the course of the practicum it became clearer that working with this client group successfully really meant meeting them where they were, i.e., on issues that were presently focused on.   I found that I needed to relax my initial expectations about how much time we would spend talking about the actual sexual abuse. This was a necessary precursor to accepting the pace that the client set or responded to. I quickly came to realize that the time we spent together was still useful treatment for adolescents who had experienced sexual abuse. Understanding that dealing with the seemingly trivial content at times was important groundwork for moving into the more difficult subject allowed me to take some pressure off myself to get clients moving faster than they were ready to proceed. Once some level of trust was established abuse related

material was allowed to weave in and out of each session. Another theme that was frequently focused on were issues related to loss of family or strained family relationships presented. The family issues the clients struggled with were for the most part the direct result of the family's response to the discovery of the abuse. It was fascinating to see how these two areas of concern, abuse and separation, would be interspersed and intertwined with the more generalized developmental issues that were confused for these girls. A great deal was learnt about encouraging clients to approach difficult subjects while also allowing them the freedom to decline these invitations. Clients also needed to feel that they could move away from the subject when they had had enough. They would also at times be encouraged to go past what they believed was their own capability. There is a real balance that must be achieved in these pursuits and I feel a stronger understanding for the description of therapy as both an art and a science. At times it was necessary to acknowledge to myself and to the client that I may have pushed too hard and been too eager to stay with an area that the client wanted to abandon. Of course the opposite was also true on occasion where the client could have been encouraged to go deeper into an area but was allowed to retreat prematurely. It was clear that establishing trust was the most important factor in being successful in setting the tempo of therapy and that this would be different with each client.

In my study of the subject of sexual abuse within families the most important development in my own thinking has been an increased ability to understand offenders and their role in the lives of the daughters I met. The separation and attachment issues that come up over and over again can only be understood if one accepts that the abuse was just one facet of very complicated personal relationships between victim and offender. For some victims there is a great deal of confusion to resolve about feelings towards their offenders and mourning the loss of healthy parts of the relationship. Without some empathy towards offenders it would have proved difficult to engage with the client around these concerns and they may have been misjudged as unimportant.

The other aspect of sexual abuse that has been clarified by this

142

practicum is that the most lasting after effect is not actually the abuse itself but the lack of support and loss of family that all my clients experienced. Treatment of a child abused in their family and supported throughout the process by trusted adults would seem to be a far simpler and more straightforward assignment. Trying to sort out the pieces after a child's family is shattered and the child ends up in isolation for speaking the truth is a somewhat daunting task that probably represents long term treatment needs. The treatment issues also need to be addressed at several different developmental stages over the client's lifetime. It is important to start working on whatever part of this the client is willing to join with the therapist around and not get hung up on meeting all their needs in their first experience of treatment. It was important to realize that for my clients having a positive experience in their first treatment opportunity would hopefully encourage them to seek further therapy as issues continued to present later in their lives.

In defining my own work it became apparent that both feminist and systemic principles guided my thinking and that these two views could be compatible. Allowing clients to be the expert on themselves and expecting them to be able to create their own solutions was especially empowering to adolescents because they do not get this response from many adults. They were also empowered by interventions that educated them by providing accurate information and in contact with other abuse victims. Systemic thinking was important to connect these young women with other significant people in their lives even if they no longer had relationships with them. Many of the adolescents had erased people from their lives that had deserted them or mistreated them. Clients gained a lot of insight from seeing how these people still affected them whether they liked it or not. Some supportive people that had been overlooked or left behind for a variety of reasons were also incorporated into our work by taking a systemic approach.

My clients taught me a great deal about adolescence. They were living proof of the humanistic belief that people are always evolving towards health. At times each of my clients demonstrated the exuberance of youth even though they had experienced much trauma in their lives. At other times their emotional turmoil was overwhelming and painful to watch. There was a real fluctuation

143

from session to session in their emotional presentation. A crisis in their environment on any level assured a more affective presentation in treatment. As expected there was a false maturity in these young women that comes from being given adult responsibilities too soon. It was difficult to separate this unnecessary maturity from the developmental task of separation that the girls were eager to accomplish and demonstrate. It was hypothesized that self-nurturing experiences would be very therapeutic for these girls. They were not open to obvious nurturing from caregivers as that seemed to make them feel "babied". It would be hoped that actively nurturing themselves would fill some of the voids in this area. Peers can sometimes do this for each other in adolescence but most of my clients did not have a strong peer group.

The need to separate and individuate are strong developmental influences in adolescence. The recovery from sexual abuse however necessitates reliance on strong emotional and environmental support. This is the crux of the matter in providing sexual abuse treatment to adolescents and accounts for some of their uniqueness as a client population. Developmentally, separation from family and differentiation are to be strived for. Time needs to be suspended for sexually abused adolescents in treatment however so that this developmental task can be put on hold. These adolescents need the opportunity to understand that it is a parent's responsibility to protect and support their children. Recovering adolescents still need the chance to feel this support and revel in it. Research suggests that adolescent maturity is gained within the context of progressive and mutual definition of the relationship between parent and child (Fishman, 1988). Ideally this relationship is maintained rather than abandoned and functional separation is achieved without alienation (Fishman, 1988). If the necessary support cannot come from parents, other appropriate adults must fill this need. Adolescents may resist attempts to nurture and support them but adults need to persist in offering this. Success in treatment seems to require environmental support for the adolescent.

The most important areas that my clients highlighted for me regarding sexual abuse were the strength of denial and the ambivalence victims feel towards offenders. Denial was fuelled by many contributing factors in my client's

144

lives. Loyalty seemed to be a major influence in determining the strength of denial. Denial for one client seemed to be an attempt to protect a relationship with an offender. In another client, where loyalty was not tied to their offender, denial was still understood as a function of loyalty. I came to believe that for some clients denial is a form of self- loyalty. A victim may believe that talking about the abuse will cause overwhelming emotions. The victim fears they will lose control of themselves unless these feelings are continually repressed. Denial then is a protective strategy motivated by the need to faithfully protect their own interests. This is what I choose to call loyalty to the self. This can present a strong obstacle to overcome in the therapeutic setting. Loyalty issues are also related to the ambivalence that victims present regarding their relationship with their offenders. It is important to examine these confused loyalties and not make assumptions about relationships. The client must feel that the therapist can respect their loyalties. If loyalties are challenged or disregarded the therapist may be regarded with distrust.

CONCLUSIONS

Many things were learnt in setting up this practicum that may be helpful to others in the future. The student had no idea how frustrating the referral process was going to be at the beginning of the practicum. Perhaps students should allow for an extensive recruitment period before they plan to concentrate on their clinical work rather than use up precious practicum time hunting down referrals. With the high rate of client drop out that can be expected it would also be beneficial to pursue referrals from many sources. The student would need to be clear that these referrals may never receive service but offer that they will be on a waiting list for the specific practicum. This waiting list could be transferred over to the referral system of the practicum setting when it was determined that these recruits were extraneous. This would be a viable alternative to aligning with one referral source that later does not produce the anticipated client volume.

The intake process of having the CFS worker attend the session with the client worked well. The amount of time that the CFS worker actually spent in discussion with both the client and the student at intake varied for each client.

Whether the CFS worker was present for ten minutes or fifty minutes it was an important transition point that needed to be accomplished in person. Some CFS workers needed more convincing than others that it was an important meeting for them to schedule even if it was for only ten minutes. For the most part as long as the therapist made the scheduling very flexible the CFS workers would make themselves available. Prior to the first intake appointments the student went to the CFS office to gather information from files for the initial referrals. This proved to be tedious and unnecessary. The files were difficult to make sense of as they contained masses of poorly organized material. It was also frustrating when time would be spent on this exercise and then the client would not attend an intake appointment. Family history was efficiently and sufficiently gathered through discussion with the client and the CFS worker, both jointly and individually. It was appreciated that CFS made these files accessible to this student but it would not be recommended that they be studied. Workers, familiar with where to access specific information, can provide copies of relevant assessments, evaluations, and summary recordings if necessary.

It would have been ideal if all clients could have taken part in the group treatment experience. As peer relationships are so essential to adolescent development the group experience probably provides the most relevant treatment model for this client group. The psychoeducational focus is appropriate for clients in all stages of recovery from childhood sexual abuse. Even the client that struggled with the the abuse material more than the others benefited in many ways from attending. It remained important for all group members to be involved with an individual therapist in conjunction with the group experience. Following this initial experience some members could probably move to a group with a therapeutic focus while others should be given the opportunity to attend another cycle of the psychoeducational group. This would require developing an assessment procedure to determine who seemed ready to process their abuse experiences in a group format.

Working with another therapist to facilitate the group was a useful learning experience. A certain comfort level must be worked towards so that open communication can take place. Without great effort and patience, planning sessions become difficult and unproductive. Time must also be

146

allotted for debriefing after each session. Important issues and subtle group developments were forgotten when the debriefing took place with much delay and irregularity. It would have been ideal if both therapists could allot some time immediately after the session. This was not possible for our situation as the therapists were also providing transportation home for the clients. Greater efforts could have been made to be stricter in our scheduling of debriefing in close proximity to the sessions even though the ideal could not be achieved. Working with someone that you do not know very well necessitates that clear expectations be established about the roles and functions that both parties will perform.

The interventions used in this practicum were very appropriate for this client group and felt comfortable to the therapist. Wheeler and Berliner (1988) provided many practical suggestions that fit with my own beliefs regarding recovery from sexual abuse. The theory base that Wheeler and Berliner (1988) connected all interventions with helped make me feel confident applying this approach.

REFERENCES

Adams - Tucker, C. (1984). Early Treatment of Child Incest Victims. American Journal of Psychotherapy, 353 (4), 505-516.

Allen - Meares, P. & Shore, D. (1986). A Transactional Framework for Working With Adolescents and Their Sexualities. Journal of Social Work and Human Sexualities, 5 (1), 71 - 83.

Asher, S.J. (1988). The Effects of Childhood Sexual Abuse: A Review of the Issues and Evidence. In L.E. Walker (Ed.), Handbook on Sexual Abuse of Children (pp.3 - 17). New York: Springer.

Augoustinos, M. (1987). Developmental Effects of Child Abuse : Recent Findings. Child Abuse & Neglect, 11, 15 - 27.

Bagley, C.R. & King, K. (1990). Child Sexual Abuse: The Search For Healing. London: Tavistock /Routledge.

Bagley, C.R. & Ramsay, R. (1986). Sexual Abuse in Childhood : Psychosocial Outcomes and Implications for Social Work Practise. Journal of Social Work and Human Sexuality, 4 (1-2), 33 - 47.

Bagley, C.R. & Thomlinson, R.J. (1991). Introduction : Understanding and Preventing the Sexual Abuse of Children. In C.R. Bagley and R.L. Thomlinson (Eds.), Child Sexual Abuse : Critical Perspectives on Prevention, Intervention, and Treatment (pp. 1 - 8). Toronto : Wall & Emerson.

Berliner, L. & MacQuivey,K. (1982). A Therapy Group for Female Adolescent Victims of Sexual Abuse. In R. Rosenbaum (Ed.), Varieties of Short-Term Therapy Groups (pp.2 - 27). New York: McGraw-Hill.

Brickman, Julie. (1984). Feminist, Nonsexist, and Traditional Models of Therapy: Implications for Working with Incest. Women and Therapy, 3 (1), 49-67.

Briere, John. (1989). Therapy for Adults Molested as Children: Beyond Survival. New York:Springer.

Briere,J. & Runtz, M. (1988). Post SexualAbuse Trauma. In G.E.Wyatt & G.J. Powell (Eds.), Lasting Effects of Child Sexual Abuse (pp. 85 - 99). London: Sage.

Browne, A. & Finkelhor, D. (1986) Impact of Child Sexual Abuse : A Review of the Research. Ottawa, Ontario: Health and Welfare Canada.

Browne, A. & Finkelhor, D. (1986b). Initial and Long-Term Effects: A Review of the Research. In D. Finkelhor (Ed.), <u>A Sourcebook on Child Sexual Abuse</u> (pp.143-179. Beverly Hills, CA: Sage.

Burgess, A.W. , Holmstrom, L.H. & McCausland, M.P. (1978). Divided Loyalty in Incest Cases. In A. Burgess, A. Groth, Holmstrom,L. & S. Sgroi (Eds.) <u>Sexual Assault of Children and Adolescents</u> (pp. 115 - 126). Toronto: Lexington Books.

Butler, S. (1978). <u>Conspiracy of Silence: The Trauma of Incest</u>. New York: Bantam.

Conte, J.R. & Berliner, L. (1988). The Impact of Sexual Abuse on Children: Empirical Findings. In L.E. Walker (Ed.), <u>Handbook on Sexual Abuse of Children</u> (pp. 72 - 91). New York: Springer.

Courtois, C.A. & Sprei, J.E. (1988). Retrospective Incest Therapy for Women. In L.E. Walker (Ed.), <u>Handbook on Sexual Abuse of Children</u> (pp.270 - 307) New York: Springer.

Courtois, C. A. (1988). <u>Healing the Incest Wound: Adult Survivors in Therapy</u>. New York: W. W Norton.

Crowder, A. & Myers - Avis, J. (1990). <u>Group Treatment for Sexually Abused Adolescents: A Handbook of Interventions</u>. Guelph, Ontario: Guelph Wellington Counselling Centre.

Dolan, Yvonne. (1991). <u>Resolving Sexual Abuse</u>. New York: W.W. Norton.

Einbender, A.J. (1991). Treatment in the Absence of Maternal Support. In W. Friedrich (Ed.), Casebook of Sexual Abuse Treatment (pp 212 - 236). New York: W.W. Norton.

Everson, M., Hunter, W., Runyon, D., Edelsohn, G. & Coulter, M. (1989). Maternal Support Following Disclosure of Incest. <u>American Journal of Orhtopsychiatry, 59</u> (2), 197 - 207.

Everstine, D. & Everstine, L. (1989). <u>Sexual Trauma in Children and Adolescents : Dynamics and Treatment.</u> New York: Brunner / Mazel.

Feldman, R. & Stiffman,A. (1986). Mental Health Didorders in Adolescence: Issues and Prospects. In R. Feldman & A. Stiffman (Eds.), <u>Advances in Adolescent Mental Health</u>, Vol.1, Part A. Greenwich, Conneticut: Jai Press.

Finkelhor, D. & Browne, A. (1984). Initial and Long - Term Effects : A Conceptual Framework. In D. Finkelhor (Ed.), <u>Child Sexual Abuse: New Theory and Research</u> (pp. 180 - 198). New York: Free Press.

149

Finkelhor, D. & Browne, A. (1985). The Traumatic Impact of Child Sexual Abuse : A Conceptualization. American Journal of Orthopsychiatry, 55 (4),530 - 540.

Finkelhor, D. & Browne, A. (1988). Assessing the Long - Term Impact of Child Sexual Abuse : A Review and Conceptualization. In L.E. Walker (Ed.), Handbook on Sexual Abuse of Children(pp. 55 - 71). New York: Springer.

Fishman, H.C. (1988). Treating Troubled Adolescents : A Family Therapy Approach. New York: Basic Books.

Friedman, Spencer. (1988). A Family Systems Approach to Treatment. In L.E. Walker (Ed.), Handbook on Sexual Abuse of Children (pp.326 - 349). New York: Springer.

Friedrich, William (1990). Psychotherapy of Sexually Abused Children and Their Families. New York: W.W. Norton.

Gelinas, Denise. (1983). The Persisting Negative Effects of Incest. Psychiatry, 46, 312 - 332.

Giaretto, Henry. (1982). Integrated Treatment of Child Sexual Abuse: A Treatment and Training Manual. Palo Alto, California: Science and Behavior Books Inc..

Grace, Melanie. (1984). Crisis Intervention in Child Sexual Abuse. Unpublished masters practicum, University of Manitoba.

Green, A.H. (1989). Physical and Sexual Abuse of Children. In H. Kaplan & B. Sadock (Eds.), Comprehensive Textbook of Psychiatry IV(Vol. 2,5th ed, pp.1962 - 1970). Baltimore, Maryland: Williams and Wilkins.

Gomes-Schwartz, B., Horowitz, J., Cardarelli, A., & Sauzier,M. (1990). Child Sexual Abuse : The Initial Effects. London: Sage.

Hanley, W. (Writer), Rappaport, M. (Producer), & Haines, R. (Director). (1983). Something About Amelia [Film]. Los Angeles: Leonard Goldberg Company.

Haugaard, J. & Repucci, N.D. (1988). The Sexual Abuse of Children : A Comprehensive Guide to Current Knowledge and Intervention Strategies. San Francisco: Jossey - Bass Publishing.

Hazzard,A., King, H.E., & Webb, C. (1986). Group Therapy With Sexually Abused Adolescent Girls. American Journal of Psychotherapy, Vol.XL(2),213-223.

Healy, J.M Jr & Stewart, A.J. (1984). Adaptation toLife Changes in Adolescence. In P.Karoly & J.J. Steffen (Eds.), Adolescent Behavior Disorders : Foundations and Contemporary Concerns (pp.39 - 60). Lexington, Mass. : Lexington Books.

Herman, J. & Schatzow, E. (1984). Time-Limited Group Therapy for Women with a History of Incest. International Journal of Group Psychotherapy, 34 (4),605 - 616.

Hogan, Allan. (1990). The Integration of Feminist and Systemic Principles in the Treatment of Intrafamilial Child Sexual Abuse. Unpublished masters practicum, University of Manitoba.

Horowitz, M. , Wilner, N. , & Alvarez, W. (1979). Impact of Events Scale : A Measure of Subjective Stress. Psychosomatic Medicine, 41 (3), 209 - 218.

James, B. & Nasjleti, M. (1983). Treating Sexually Abused Children and Their Families. Palo Alto, California: Consulting Psychologists Press.

Janoff-Bulman, R & Freize, I. (1983). The Aftermath of Victimization: Rebuilding Shattered Assumptions. In C. Figley (Ed.), Trauma and It's Wake: Study and Treatment of Post-traumatic Stress Disorder (pp.15-36). New York: Brunner / Mazel.

Jehu, D., Gazan, M., & Klassen, C. (1985). Common Therapeutic Targets Among Women Who WereSexually Abused in Childhood. In M.Valentich & J. Gripton (Eds.),Feminist Perspectives on Social Work and Human Sexuality (pp. 25-45). New York : Haworth Press.

Kitchur,M. & Bell,R. (1989). Group Psychotherapy With Preadolescent Sexual Abuse Victims: Literature Review and Description of a Inner-City Group. International Journal of Group Psychotherapy, 39 (3), 285-311.

Knight, C. (1990). Use of Support Groups with Adult Female Survivors of Child Sexual Abuse. Social Work, 35 (3), 202 - 206.

Knittle,B & Tuana, S. (1980). Group Theapy as Primary Treatment for Adolescent Victims of Intrafamilial Sexual Abuse. Clinical Social Work Journal, 8 (4), 236-242.

Larson, N. & Maddock, J. W. (1986). Structural and Functional Variables in Incest Family Systems: Implications for Assessment and Treatment. In T.S.Trepper & M. Barrett (Eds.), Treating Incest : A Multiple Systems Perspective (pp. 27 - 44). New York: Haworth Press.

McGregor, B. & Dutton, D. (1991). Prevalence Rates of Child Sexual Abuse Within Populations Requiring Health System Intervention. In C.R. Bagley and R.L. Thomlinson (Eds.), Child Sexual Abuse : Critical Perspectives on Prevention, Intervention, and Treatment (pp.135 - 156). Toronto : Wall & Emerson.

Millican, Susan (Producer), & Katz, R. (Journalist). (1979). Incest : The Circle of Healing [Television documentary]. Winnipeg, MB: Canadian Broadcasting Corporation.

Mishne, J.M. (1986). Clinical Work With Adolescents. New York: Free Press.

Moran, P.B. & Eckenrode, J. (1992). Protective Personality Characteristics Among Adolescent Victims of Maltreatment. Child Abuse & Neglect, 16, 743-754.

Morison, S. & Greene, E. (1992). Juror and Expert Knowledge of Child Sexual Abuse. Child Abuse & Neglect, 16, 595-613.

Morrow, B.K. (1991). Attributions of Female Adolescent Incest Victims Regarding Their Molestation. Child Abuse & Neglect, 15, 477-483.

Offer, D., Ostrov, E. & Howard, K. (1981). The Adolescent: A Psychological Self - Portrait. New York: Basic Books.

Offer, D., Ostrov, E., Howard, K., & Atkinson. (1988). The Teenage World: Adolescents' Self-Image in Ten Countries. New York: Plenum Medical Book Co..

Peters, S.D., Wyatt, G.E., & Finkelhor, D. (1986). Prevalence. In D. Finkelhor (Ed.), A Sourcebook on Child Sexual Abuse (pp.15 -59). London: Sage.

Porter, F., Blick, L. &Sgroi, S. (1982). Treatment of the Sexually Abused Child. In S. Sgroi (Ed.), Handbook of Clinical Intervention in Child Sexual Abuse (pp.109 - 145). Toronto: Lexington Books.

Rencken, Robert. (1989). Bodily Assault: Physical and Sexual Abuse. In D. Capuzzi & D. Gross (Eds.), Youth at Risk : A Resource for Counselors, Teachers, and Parents (pp.71 - 96). Alexandria, Virginia: American Association for Counselling and Development.

Rist, Kate. (1979). Incest: Theoretical and Clinical Views. American Journal of Orthospsychiatry, 49 (4), 680-691.

Robinson, J. & Shaver, P. (1973). Measures of Social Psychological Attitudes. New York: Survey Research Center Institute for Social Research.

Roth, S. & Cohen, L. (1986). Approach, Avoidance and Coping With Stress. American Psychologist, 41, 813-819.

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

Russell, D.E. (1988). The Incidence and Prevalence of Intrafamilial Sexual Abuse of Female Children. In L.E. Walker (Ed.), Handbook on Sexual Abuse of Children (pp.19 - 36). New York: Springer.

Schaefer, S. & Evans, S. (1988) The Incest Continuum: A Conceptual Framework for Assessing Incestuous Dynamics and Behaviors in Families. Minneapolis, Minnesota: Unpublished manuscript.

Sgroi, S.M. (1978). Introduction: A National Needs Assessment for Protecting Child Victims of Sexual Assault, in A.W.Burgess, A.N. Groth, L.L.Holmstrom, & S.M.Sgroi (Eds.), Sexual Assault of Children and Adolescents (pp.xv - xxii). Toronto: Lexington Books.

Sgroi, S.M. (1982). Handbook of Clinical Intervention in Child Sexual Abuse. Toronto: Lexington Books.

Shapiro, S. & Dominiak, G. (1990). Common Psychological Defenses Seen in the Treatment of Sexually Abused Adolescents. American Journal of Psychotherapy, Vol.XLIV (1), 68-74.

Sink, Frances (1988). Sexual Abuse in the Lives of Children. In Martha B. Straus (Ed.), Abuse and Victimization Across the Life Span(pp. 82 - 106).Baltimore: John Hopkins University Press.

Sturkie, K. (1983). Structured Group Treatment for Sexually Abused Children. Health and Social Work, 8 (4),299-308.

Sugar, Max. (1986). The Structure and Setting of Adolescent Therapy Groups. In M.Sugar (Ed.), The Adolescent in Group and Family Therapy (2nd ed.). Chicago: The University of Chicago Press.

Summit, Roland. (1983). The Child Sexual Abuse Accomodation Syndrome. Child Abuse & Neglect, 7, 177-193.

Swan, R. (1985). The Child As Active Participant In Sexual Abuse. Clinical Social Work Journal, 13 (1), 62 - 77.

Swink, K. & Leveille, A. (1986) From Victim to Survivor: A New Look at the Issues and Recovery Process for Adult Incest Survivors. Women & Therapy,5, 2/3,119-141.

Thomlinson, R.J. (1991). A Review of Child Sexual Abuse Treatment Outcome
    Research. In C.R. Bagley and R.J. Thomlinson (Eds.), <u>Child Sexual Abuse :</u>
    <u>Critical Perspectives on Prevention, Intervention, and Treatment</u> (pp181 - 202).
    Toronto : Wall & Emerson.

Tramontana,P. & Sherretts, S.F. (1984). Psychotherapy With Adolescents: Conceptual
    , Practical, and Empirical Perspectives. In P.Karoly & J.J. Steffen (Eds.),
    <u>Adolescent Behavior Disorders, Vol. 3 : Foundations and Contemporary</u>
    <u>Concerns</u> (pp.282 - 302). Lexington, Mass. : Lexington Books.

Wachtel, A. & Scott, B. (1991). The Impact of Child Sexual Abuse in Developmental
    Perspective. In C.R. Bagley and R.L. Thomlinson (Eds.), <u>Child Sexual Abuse :</u>
    <u>Critical Perspectives on Prevention, Intervention, and Treatment</u> (pp.79 - 120).
    Toronto : Wall & Emerson.

Ward, Elizabeth (1984). <u>Father Daughter Rape</u>. London : The Women's Press.

Wheeler, R.J. & Berliner, L. (1988). Treating the Effects of Sexual Abuse on Children.
    In G.E. Wyatt & G.J. Powell (Eds.), <u>Lasting Effects of Child Sexual Abuse</u>(pp.
    227 - 247). London: Sage.

Wright, L., Everett, F. & Roisman, L. (1986). <u>Experiential Psychotherapy With Children</u>.
    Baltimore, Maryland : John Hopkins University Press.

Zayas, L. & Katch, M. (1989). Contracting With Adolescents: An Ego - Psychological
    Approach. <u>Social Casework,</u> 1,3 - 9.

APPENDIX ONE
EDUCATIONAL SCALE DEVELOPED FOR THIS PRACTICUM

THINGS TO THINK ABOUT, THINGS TO LEARN

Please read each of the following statements and circle True or False.

1. Many children make up stories about being sexually
    abused.   True   False

2. Most sexual abuse offenders are strangers.   True   False

3. Teaching children about their bodies (that they are
    special and they own them) is helpful in preventing
    child sexual abuse.   True   False

4. Most sexual abuse offenders are strangers.   True   False

5. The child who is believed when he/she reports
    sexual abuse has the best chance of recovery.   True   False

6. Parents should ignore an incident of sexual abuse
    because it is just a part of growing up.   True   False

7. Many children who are sexually abused feel guilty
    and feel that it was somehow their fault.   True   False

8. Only female children are sexually abused.   True   False

9. It is better to keep the secret of sexual abuse than to
    tell someone who cares about you.   True   False

10. Most offenders stop sexually abusing children after
    they get caught.   True   False

11. Children who have been sexually abused will never
    lead "normal" lives.   True   False

12. Once a child has been sexually abused they are
    more vulnerable to being abused again.   True   False

13. Children who are sexually abused are responsible for what happened to them. True False

14. Boys or girls who have been sexually abused sometimes act out what happened to them in a sexual way with other children. True False

15. Many children who have been sexually abused feel very angry. True False

16. Children who have been sexually abused sometimes think that they are ugly or look different than other children. True False

17. People who sexually abuse a child should admit that it is their fault and apologize to the child. True False

18. Most children tell someone right away when they have been sexually abused. True False

19. Children who have been sexually abused can be confused about whether they like or dislike the person that abused them. True False

20. Child sexual abuse happens so rarely it must mean that you are strange if it happens to you. True False

21. Mothers always know when their children have been sexually abused. True False

156