Treatment Programs for Child Sexual Abuse Victims in Canada

A selected inventory of integrated programs that have been evaluated

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National Youth In Care Network
607 - 251 Bank Street, Ottawa, Ontario K2P 1X3, Telephone (613) 230-8945

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Family Violence Prevention Division
Health Canada
Tunney's Pasture
Ottawa, Ontario
K1A 1B4

Tel: (613) 957-2938
or
Toll-Free: 1-800-267-1291
Fax: (613) 941-8930

For TTY/TDD users: (613) 952-6396
or Toll Free: 1-800-561-5643

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We would like to thank all of those individuals and organizations that responded to letters sent out across Canada searching for integrated treatment programs that have been evaluated.

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M. Catherine Ryerse,
Researcher/Project Manager
February 1993

Introduction

While many treatment programs dealing with child sexual abuse have tended to focus on either the offender or the victim, integrated treatment models involving the victim, family members, adult survivors and offenders have been developed to address the problem. Evaluation models have been incorporated into a number of programs in an effort to assess the effectiveness of an integrated approach in the treatment of child sexual abuse.

The purpose of this project was to identify and describe service models that have been evaluated, or are currently being evaluated, or that demonstrate an innovative and comprehensive approach in the treatment of child sexual abuse. Our aim was to identify approximately twelve programs to be included in a selected program/service inventory of integrated treatment programs.

The objectives of the project were to identify quality integrated program models and services for the treatment of child sexual abuse in each province and territory; to prepare a selected Canadian inventory of integrated treatment program models for dealing with child sexual abuse; to share and disseminate descriptions and information on integrated program models; to encourage the provision of high quality integrated treatment programs and services through the development of the inventory and information sharing; and to promote the development of quality integrated programs and services for the treatment of child sexual abuse.

Through a mahout to 500 individuals, organizations and government departments involved with child sexual abuse treatment services, it was discovered that very few programs that meet the above criteria exist in Canada. While many more services exist for specific client groups (e.g. victim or offender), these services are not coordinated in such a way as to provide for other family members in a complimentary fashion. Services, therefore, are "sporadic and piecemeal in approach... Many vulnerable children and families fall between the cracks in existing service systems. These cracks are created, not only by the scarcity of service resources, but also by the confusion and lack of coordination among the services that do exist."[1]

In addition, of those programs that employ an integrated or coordinated approach, few have incorporated an evaluation component. Different models do exist, but it is not known which of these is most effective responding to child sexual abuse. Based on correspondence that we received from across the country, either no coordination efforts have been attempted or scarcity of financial resources has prevented treatment programs from evaluating services to clients.

This project identified eight integrated treatment programs (involving at a minimum services for the child victim and non-offending parent) that have been evaluated in some way. Evaluation focused on treatment outcome and/or service approach. One of these programs, the Programme de traitement des enfants abusés sexuellement (PTEAS), Centres de services sociaux Laurentides-

[1] Child Sexual Abuse in Rural Community Settings: The Implementation and Evaluation of a Coordinated Service Model. Demonstration Project. Child and Family Research Group, Faculty of Social Work, University of Manitoba (1991).

Lanaudiere, 617, boulevard Curé Labelle, Blainville (Québec), J7C 2J1, telephone (514) 430-9250, was not included in this listing because the final evaluation report was not available at the time of printing.

Program and evaluation reports for the seven remaining programs were obtained and summary descriptions were extracted. For those interested in reviewing the complete reports and obtaining further information, we recommend that you contact each program or organization listed.

Peterborough Sexual Abuse Treatment Network[1]

CONTACT

Peterborough Community Forum on Child Abuse
380 Armour Road, Suite 245
Peterborough, Ontario
K9H 7L7
Telephone: (705) 748-0256
Fax: (705) 748-2081

BACKGROUND

Based on the Task Force suggestions to the Peterborough Community Forum on Child Abuse, in October 1985 a core group of agencies established agreements to provide a network of sexual abuse treatment services. These agencies were Family Counselling Service, Kawartha-Haliburton Children's Aid Society, Kinark Child and Family Services and Peterborough Youth Services. Since that time, three primary treatment agencies (John Howard Society, Lindsay Community Mental Health Centre, and Tri-County Behavioral Services) and two collateral organizations (Peterborough Civic Hospital and Kawartha Family Court Assessment) joined the network.

The Treatment Sub-Committee was formed with representatives from each of the member agencies. The major goal of this sub-committee was to develop a coordinated network of high quality sexual abuse treatment programs within the three counties of Peterborough, Victoria and Haliburton.

CLIENTELE

Nearly 80% of the Network's clients were 18 years of age or younger. About 60% of the clients were victims, and nearly 20% were non-offending parents. About one-quarter of the clients were under an order from either the Child Welfare Court or Criminal Court.

Nearly half of the referrals were for validation, and about one-quarter were for counselling/therapy for victims of sexual abuse. The other main reasons were: support for the non-offending parent in coping with the abuse and in strengthening the parents' ability to protect the child; assessment; support for the family and behavioral problems.

One of the central concerns about a Network approach was the possibility of lengthy delays between the time of referral and the time service began. Overall, the Network was able to deliver services to more than half of its clients within one week of referral, to nearly three-quarters within one month, and to 90% within three months.

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[1] "An Evaluation of Peterborough Sexual Abuse Treatment Network" Arnold J. Love, Ph.D., October, 1991. Copies of the full evaluation report are available from the above contact. **Information and excerpts taken directly from the evaluation report.**

OBJECTIVES

An analysis of treatment goals showed that the most frequently set goals were: to validate if child abuse had taken place; to have the victim resolve feelings and issues about the abuse; to provide support and education about sexual abuse; and to protect the child from further abuse.

SERVICES

The Peterborough Sexual Abuse Treatment Network model proposed multiple levels of service, and it included the following key components:

- ∇ individual and/or group therapy for victims, sibs, non-offending parents and offenders
- ∇ marital and family counselling
- ∇ a combination of treatment and protection/criminal justice intervention

Network clients used the following services the most often: agency assessment services (58%); counselling (49%); sexual abuse investigation (45%); group work (24%) and crisis intervention (21%). Out of fifteen direct services, Network clients received a median of two services or an average of 2.5 services. Each client received an average of 25 hours of direct service.

With respect to indirect services, the majority of clients received three types of indirect services most frequently: internal conferencing (60%), screening (59%), and referral (49%). Each client received on average 16 hours indirect service time.

Support services were crucial for the functioning of the Network. More than 80% of the cases involved both telephone support and report writing, and nearly half required consultation. Transportation, client networking, and child care were also important support services. Service providers spent an average of nearly 28 hours per client on support services.

EVALUATION

Dr. Arnold J. Love conducted the evaluation of the Peterborough Sexual Abuse Treatment Network over a three year period, from 1987 through 1990.

The major purpose of the evaluation of the Peterborough Sexual Abuse Treatment Network was to evaluate the overall effectiveness of the treatment Network to deliver high-quality, coordinated sexual abuse treatment services. Other purposes included describing accurately the clients actually served and the components of the Network's delivery system, and evaluating the effectiveness of the Network's treatment programs according to the perceptions of clients and service providers.

Methodology

Program Coverage. Evaluating program coverage means measuring the characteristics of the actual participants in the program and comparing them with those of the intended client population. This identifies problems that may be caused, for example, by potential clients rejecting the program or by bias in the referral or intake process.

Service Delivery. Evaluating service delivery focuses on developing accurate descriptions of the program activities which are intended to help clients achieve positive change. In this way, implementation evaluation helps guide program development and improve program performance. It also increases program accountability by providing various stakeholders (e.g. boards of directors, funding bodies, executive directors, community members) with information whether or not the program is being delivered as planned, thereby helping them make informed decisions about program design and policy direction.

The evaluation was divided into the following three phases:

Phase I. Description of Network and System Linkages

The description of the network and systems linkages was obtained through a review of written materials and minutes, participation in selected committee meetings, and interviews with key informants at the start of the evaluation period. Feedback was also obtained from the workers and clients involved in the Network. Concise program descriptions were collected from each participant agency.

This phase culminated in an analysis and synthesis of major issues facing the Network that was presented to the Peterborough Forum Board as an oral presentation and as a written report. Standardized descriptions of program components at the start of the Network approach were complied, and they were used to track the changes in the services over the evaluation period.

Phase 2. Detailed Descriptions of Clients and Service Delivery

To provide a detailed description of clients and the delivery of services, data were collected for a six-month period beginning in January, 1989. These data provided descriptive information about the characteristics of the clients; the types of services provided through the Network; goals of service and service modalities used; the linkages among services and their sequence; and staff time used to provide services.

These data were collected through two data collection instruments designed specifically for this study: (a) Client Referral and Services Summary, and (b) Record of Services. The forms were completed by the primary worker in each agency for each person in the project who received service during the target data collection period. This information was supplemented by a retrospective analysis of data available before the Network approach began.

Phase 3. Evaluation the Effectiveness and Feasibility of the Network Approach

A systems analysis by the evaluator was utilized. The Peterborough Treatment Model involved four major functions: Protection and Crisis Response; Treatment Services; Coordination; and Education.

The evaluation concentrated on the first three functions. The effectiveness of each function was analyzed by the evaluator through assessment of written materials and conference minutes; information from data collection instruments; agency and network statistics; and interviews with key informants. Data included the following: extent of client participation in the Network and its component programs; profiles of the clients participating; extent of client involvement in individual, family, and group programs; timeliness and adequacy of assessments; timeliness and relevance of program response; waiting lists; numbers and types of information/training sessions held; costs of the overall program in terms of staff time; and factors internal and external to the program that supported or constrained the Network approach. This phase also involved interviews with service providers, clients, referral sources and community key informants.

EVALUATION RESULTS

Treatment Effectiveness

Twenty-one (57%) of the 37 clients who gave informed consent were interviewed. The 21 clients were drawn from all six primary treatment agencies. Three-quarters of the clients felt that the provider helped a great deal, and the remaining clients felt that they had helped some-what. The next question asked clients if they could deal with their presenting problems now after receiving help through the Network. Two-thirds felt definitely that they could, and the remaining clients felt fairly certain they could. When asked if they still needed help with their problems related to sexual abuse, about half felt they needed help and the other half felt they did not need further assistance. Three-quarters of the clients said they would definitely recommend the Network service to a friend, nearly 20% said they thought they would, and only 5% said they did not think so.

Clinicians completed ratings for 27 of the 37 clients (73%) who had given informed consent. The perceptions of the clinicians were very similar to those of the clients. Clinicians also felt they had helped three-quarters of the clients a great deal, and they had helped the other clients to some degree. They felt the majority of their clients (about 80%) could deal with their presenting problems after receiving help through the Network; but, in contrast to the client ratings, they did not think that 20% of the clients could cope with the problems resulting from child sexual abuse.

Clinicians felt they had achieved the major treatment goals as well as they expected for over 90% of the clients. They felt they had achieved the goals better than expected, however, in only about one-third of the cases, whereas three-quarters of the clients rated the goal achievement as better than expected. When asked if they felt their clients still needed more help with their problems,

once again clinicians were less optimistic: they felt 61% of the clients still needed help, whereas 48% of the clients felt the same way. Whatever the differences in ratings, the perceptions of both clients and clinicians are clear: the Network services have helped clients with their sexual abuse problems, but the majority of clients still need some ongoing assistance to cope with the aftermath of abuse.

Network Effectiveness

At the conclusion of the evaluation period, interviews with key stakeholders documented their perceptions about the overall effectiveness of the Network approach, including its strengths and areas needing improvement.

Strengths: First of all, they felt that a major strength for the Network approach was that it made child sexual abuse a community problem, rather than an isolated problem served by a single agency. This permitted greater coordination of services and consolidation of scarce community treatment resources. It also allowed better networking that reaches beyond the primary service providers to collateral treatment resources (e.g. physicians, YWCA Crossroads) and other community service sectors (e.g. education, Big Brothers/Big Sisters).

They felt that the Network approach enabled improved access to services. It also stimulated innovated services such as the Parent Education Program and the Adolescent Sex Offender Program at Kinark, the Preventive Education Project with the Board of Education, the Child Witness Program started by the John Howard Society, the Adults Molested as Children program at Family Counselling Service, the Crisis Support Services of the C.A.S. and the development of special materials for the protection of developmentally disabled clients by Tri-County Behavioral Services.

The key stakeholders felt that the Network approach provided the opportunity for better funding for training and greater training and consulting opportunities by pooling resources. It also afforded monthly contact with peers to discuss problems and receive support. The key stakeholders also felt that the Network approach produced better connections with the legal system, including workshops and training for the legal community and closer ties between the legal community and the Network.

Areas for Improvement

Despite their overall satisfaction with the Network approach as an effective way to deliver sexual abuse treatment services, the stakeholders felt that the potential of the Network had not yet been achieved.

The stakeholders noted a number of gaps in service. These included the following: lack of services to children under age five; crisis support services and rapid response services; unreliable start times for groups; long waiting lists for some services; some programs enroled beyond

capacity; female victims who received therapy from male therapists although they preferred female therapists; limited resources for developmentally disabled clients; lack of education regarding child sexual abuse; support for group home parents; and a limited range of Network services in Lindsay and Haliburton.

Other areas for improvement included : reducing worker burnout; developing closer cooperation among network members; providing timely advice and support to clinicians; updating the sexual abuse protocol; revising intake and referral process; setting guidelines for referrals that sidestep the Network; resolving the role of the Network Coordinator and the mandate of the Treatment Sub-Committee; increasing support services, such as transportation and child care; and improving linkages with the legal and law enforcement services.

Comparisons with Other Treatment Programs

Evaluative information was compared between the Peterborough Network, Bruce-Grey (Bruce County C.A.S., a regular staff model and Grey County C.A.S., a network model) and the Sexual Abuse Treatment Program (SATP) of the Metro Toronto Children's Aid Society. The comparisons showed that the network model and specialized sexual, abuse treatment program produced similar high level of client satisfaction with services, as well as similar levels of effectiveness as judged by clients and clinicians. In terms of efficiency, the Bruce-Grey study judged the network to be more efficient, when compared with services delivered by regular agency staff. The Peterborough Network and specialized Toronto SATP evaluations found that both programs delivered nearly the same amount of hours per client, but the way the time was allocated differed radically. The SATP spent nearly twice the amount of time in direct service than did the Peterborough Network; and as might be expected in a network approach, the Peterborough Network spent nearly equal amounts of time in direct service and in support activities and coordinating services. For a given amount of time per client, both approaches showed similar positive levels of effectiveness but they achieved those results in different ways. The SATP approach depended on a highly skilled and highly trained small group of treatment specialists, whereas the network model trained a larger group of clinicians and other persons in sexual abuse treatment, and relied on the commitment of the network partners to deliver services in their areas of expertise.

The results of these evaluations indicate that the decision to choose a network approach versus a specialized treatment program approach also must consider policy directions and practical concerns. For the Peterborough community, both sets of factors strongly favour a network approach or a hybrid model at this time.

Child Sexual Abuse in Rural Community Settings: The Implementation and Evaluation of a Coordinated Service Model[1]

CONTACT

Director, Child and Family Services Research Group
School of Social Work, University of Manitoba
Room 512, Tier Building
University of Manitoba
Winnipeg, Manitoba
R3T 2N2
Telephone: (204) 474-9798
Fax: (204) 474-6663

BACKGROUND

The project was developed to respond to gaps in services and a lack of empirical knowledge of treatment and delivery model outcomes. This research program addresses the fact that there is a lack of appropriate services for the client population and that existing interventions are few, sporadic and piecemeal in approach with no systematic follow-up or evaluation. In addition, the project identified the need to address these problems in rural communities where both population and services are spread out across a large geographical area.

CLIENTELE

All cases of child sexual abuse reported to the Child and Family Services of Central Manitoba and to Child and Family Services of Eastern Manitoba were eligible for inclusion in the study. Inclusion criteria for the project included: a case involving an alleged offender who is either a member of the victim's family or who has been acting in a position of trust in the role of parent or caregiver to the child; a victim aged no more than 18 years; and a case where the allegations have been either "determined" or "probable". All children and their families who met these criteria and who agreed to participate in the study were included in the service delivery phase of the project from February 1, 1989 to January 31, 1990. Those families who did not consent to participate in the study received the regular, ongoing services provided by Child and Family Services.

[1] Demonstration Project, National Welfare Grants, Health and Welfare Canada (1991). Child and Family Services Research Group, Faculty of Social Work, University of Manitoba. E. Adkins, Ph.D., C. Psych & B. Trute, Ph.D., R.S.W. Co-principal Investigators. G. MacDonald, M.A. Project Coordinator. K. McCannell, Ph.D., C. Herbert, M.D., C.C.F.P., F.C.F.P., E. Hill, M.S.W., D. Scuse, Ph.D. Co-Investigators. **Information and excerpts taken directly from the Demonstration Project Final Report.**

THEORETICAL FRAMEWORK

Although professionals working with sexually victimized children and their families aim to provide safe and effective intervention and treatment, "system-induced trauma" often occurs. Agencies tend to respond to sexual abuse in an isolated way, with a low level of inter-agency cooperation. Thus, the process of intervention often creates confusion and works against the goals of protecting the child and the laying of appropriate charges against the offender. Both clients and service providers are left feeling frustrated, angry and alone. Family members feel "suspended", are unclear of what will happen next, who will be involved, what they are to do, and how to understand the process they are involved in. The investigative process compounds the social and psychological damage.

Many human services, from child welfare to police, medical services, mental health and crisis centres, maintain some jurisdiction in responding to child sexual abuse. Individuals involved in different areas of the investigation may work at cross purposes, with different priorities and perspectives on the child sexual abuse situation. These different mandates can create a powerful intrusion in the life of children and their families with different professionals enquiring in a repetitive, yet seemingly uncoordinated manner.

"Crisis intervention theory" informs us that focused and immediate services are needed to assist victims of crisis situations. In many child sexual abuse situations, the prolonged investigative period can result in a protracted state of "institutional trauma" in which families recoil from the tension and confusion they associate with outside professionals disrupting the stability and security of the family. Many families totally close themselves to the outside world becoming "emotional fortresses". This circumstance makes it particularly hard for mental health practitioners to reach those families to provide the necessary long-term treatment that is required in situations of child sexual abuse.

The typical treatment process in situations of child sexual abuse is "linear", consisting of 3 stages: assessment, intervention and therapy. Different professional domains are often involved at each stage. Conflict over the course and focus of therapy can arise among the treatment providers. In addition, treatment providers who represent a cross-section of professional backgrounds tend to have very different belief systems regarding what constitutes an appropriate intervention. In rural areas, the vast distances between communities and farms exacerbate the issues of resource coordination and communication between professionals involved in these cases.

Both practical experience and research findings suggest that collaboration among agencies increases the effectiveness of an intervention. This would include coordinating activities among police, criminal justice, health care and child welfare systems. It would also include the facilitation of communication between these human service sectors, those providing treatment and members of the incestuous family.

The intent of this project was to implement the Pacific Coast Model (Herbert, Grams and Trute,

1986) in a rural region within the Province of Manitoba under the sponsorship of a local child welfare agency. A coordinated investigation and early treatment approach to the problem of child sexual abuse was developed to serve families with a disclosure of child sexual abuse in their local rural area. The approach included encouraging local service providers to collaborate in developing the following services: individual therapy for any, or all, members of the family; group therapy for victims, non-offending parents and offenders; dyadic therapy when appropriate; and family therapy, with or without the inclusion of the perpetrator of the sexual abuse. Local community human service personnel were trained in the coordinated approach as it applied to their involvement in child sexual abuse cases. Educational workshops and training sessions were organized to help different professionals understand each other's perspectives, attitudes and service resources.

Many of the staff involved in offering treatment were people who were already employees of the sponsoring child welfare agency or of other human service settings in the local rural area. The project did not include the involvement of urban-based professionals with expertise in child sexual abuse who would act as temporary consultants to the existing service providers, offer advice as to service direction, and then leave service providers on their own. The intent was to facilitate local community involvement in the design and implementation of a coordinated service plan, to strengthen local service providers in all aspects of child sexual abuse service delivery over a three-year period.

OBJECTIVES

1. To design and a deliberate, methodical, integrated a deal with child sexual abuse through all stages of investigation and early treatment, including:

    a) Initial education of and consultation with community professional involved with child sexual abuse with a view toward helping them understand each others' perspective in service delivery to facilitate a collaborative approach to case management;

    b) Training of child protection workers and other community service providers in methods of clinical intervention with families and individuals where child sexual abuse has occurred. This included consultation in group, individual and family therapy approaches;

    c) Implementing the role of Treatment Coordinator. The Treatment Coordinator "consulted with child welfare protection workers, the police, physicians and professionals associated with the system to develop an intervention and treatment plan that included therapy (when appropriate) for the victim, the offender, the non-offending parent, and siblings. Therapy could include individual, group and family approaches, depending on what was indicated for each identified case" (Herbert, et al., 1986). The Treatment Coordinator facilitated the identification of

a Case Manager for each case identified as requiring treatment for child sexual abuse;

d) It was the responsibility of each Case Manager to coordinate the various treatment providers involved with a child and his or her family. The Case Manager would ensure that treatment resources were applied as they were required in a systematic treatment plan (within the service resource constraints of the local community). The key here was to mobilize existing treatment resources at the time they were most appropriate in the treatment plan.

2. To develop a prototype service design that was relevant to rural locales. This included development of key inter-agency components as was required in a coordinated rural service system for the treatment of child sexual abuse.

3. To develop a set of standardized service and client system tracking forms that were used before, during and after treatment. These forms provided ongoing service monitoring through the collection of standardized service information.

4. To ensure detailed recording and analysis of a family's progress through the coordinated services with measures obtained at key intervals throughout investigation and treatment processes.

5. To ensure the selection of a geographical comparison area that was closely matched with the test area on a number of variables, including population and human service characteristics. Information was gathered that included services delivered and families served by the Child and Family Service agencies in the test and comparison areas. This allowed for some key comparisons of the investigative and treatment differences consequent to the introduction of a coordinated treatment approach.

SERVICE PROVIDERS

This project was designed to investigate the effectiveness of a coordinated multi-agency treatment approach to the complex problem of child sexual abuse within rural community settings. The overall goal of the project was to create an integrated model of service delivery in the area of child sexual abuse, by bringing together a diverse group of social service agencies in a rural area and assisting them to develop a shared sense of purpose and direction in the handling of these cases.

Specific areas of intervention included the creation of a formal multi-agency team, the bridging of legal-investigatory and treatment activities, the reduction of fragmented, individual agency based service delivery and the promotion of open and routine communication between service providers involved in each case of child sexual abuse.

Seven components were identified that were essential to the creation of a coordinated approach:

1. the establishment of a "Treatment Coordinator" position in the geographic locale containing the service network;

2. the garnering of commitment from senior managerial levels of all key participating agencies;

3. the holding of initial planning meetings with all parties involved in human services tied to child sexual abuse (i.e. CFS protection and treatment workers, police, Crown Attorneys, judges, probation workers and physicians);

4. the scheduling of formal, routine meetings with all local service providers involved in child sexual abuse cases;

5. the establishment of a Parent Support Worker (PSW) position to provide immediate crisis counselling services to "non-offending" parents at the time of the disclosure of child sexual abuse;

6. the coordination of services through key steps including inter-linked police and child welfare investigations, the introduction of PSW services and the designation of a Case Manager;

7. the development and implementation of a coordinated systemic intervention plan by a Case Manager in consultation with the individual therapists, group therapists, marital therapists and/or family therapists also involved with the family. The Treatment Coordinator who coordinated services related to child sexual abuse in the geographic area monitored the activities of each Case Manager and provided guidance to them regarding treatment planning for each child sexual abuse case.[2]

Agencies participating in the project included: Child and Family Services of Central Manitoba, Child and Family Services of Eastern Manitoba, Community Mental Health, Eden Mental Health Centre, Community Corrections, South Central Committee on Family Violence, Mental Retardation, and Police.

Child and Family Services assumed a central role in the development and implementation of the coordinated services. Child and Family Services of Central Manitoba was the sponsoring agency for the project and, as such, played an important part in promoting the research - in the local community, amongst professional groups and at provincial departmental levels. The pivotal

[2] For a thorough discussion and description of the process followed for each step, and a discussion of factors that hindered or advanced coordination efforts, see the Demonstration Project Final Report (1991).

position of Treatment Coordinator was filled by the supervisor of the Child and Family Services team in the test area.

EVALUATION METHODS

Information was collected for test and comparisons groups in four areas: management information system, treatment outcome measures, professional attitudes regarding child sexual abuse, and follow-up interviews.

Documentation for the information system included: a registration form containing socio-demographic information; an intake form detailing information about the victim, the perpetrator and the circumstances surrounding the abuse incidents; a service contract record designed to collect information on all service encounters that are "significant" to a case; and a medical assessment form used by physicians to document information related to an allegation of child sexual abuse.

Treatment outcome measures included: the Impact of the Event Scale to assess the level of post-traumatic stress at three time intervals; and at intake, the brief version of the Family Assessment Measure (III); the UCLA Revised Loneliness Scale; a social network/social support assessment form; the brief version of the Marlow-Crowne social desirability scale; the Child Behaviour Checklist; and the Colorado Child Temperament Inventory.

Other measures recommended for use by child therapists when appropriate included: the Child Attitude Toward Father Scale, the Child Attitude Toward Mother Scale, and the Child Depression Inventory.

Professional attitudes toward child sexual abuse were measured through a survey administered to service providers (child and family service workers, community mental health workers, probation and police).

Follow-up interviews were conducted with workers and clients to explore their perceptions of the effectiveness of treatment and the impact of the project.

A two-stage data collection strategy was employed to collect service impact measures from parents of sexually abused children. Stage one involved the collection of data during the early crisis period linked to the disclosure of the abuse. This first phase of data collection was framed as the period during which "Parent Support Services" were delivered. Essentially, the Parent Support Services created an opportunity for a project staff person to enter the life of the family, build trust in parents, and assist them in the resolution of the family crisis tied to the disclosure of sexual abuse. It also created a bridge into the family that allowed for the early collection of research information at the onset of service. The Parent Support Services were delivered on average over an eight week period. At the termination of the Parent Support Service a second collection of research measures was completed which offered pre-treatment and post-treatment

assessments of the period surrounding the "Crisis of disclosure." This also provided a set of measures at the onset of the coordinated treatment approach in the test community and at the onset of regular services in the comparison community. A final set of measures was collected at the end of the research project. This was on average ten months after services had been initiated for a victimized child and her or his family.

Of the 70 disclosures of intra-familial or trusted third party sexual abuse in the two study communities, 46 families agreed to participate in the research project and completed written, informed consents. At "time one" (T1 - onset of investigative services and Parent Support Services) parents from 34 families completed pre-treatment measures. At "time two" (T2 - termination of Parent Support Services) parents from 29 families completed "early" treatment measures. At "time three" (T3 - completion of term of project) parents from 23 families completed "final" post-treatment measures.

Because a closely consistent Parent Support Services intervention was applied in both study locales during the early treatment phase, research findings were merged as one homogeneous group for analysis of service impact. This was a TIM comparison. Next, a review was made of service impact on families at the onset and at the termination of services comparing the test and comparison areas to explore differences that emerged as a result of the "coordinated service approach. This was a T1:T3 comparison. Finally, a review was made of Tl:T2:T3 findings for key indicators of service impact.

CONCLUSIONS[3]

The findings of this demonstration project suggest that a coordinated approach to service delivery in rural locales, which seeks to create a collaborative inter-agency approach in the investigation and early treatment of child sexual abuse, can be beneficial to child victims and their family members. It appeared that more treatment service resources can be mobilized, less stressful investigative circumstances can be created, and that psychological distress in parents can be more readily eased by a coordinated model of service delivery.

However, the implementation and maintenance of a coordinated service system to deal with situations of intrafamilial child sexual abuse is not without significant cost in the time and energy of the service providers. This project witnessed an escalating service demand as more cases were identified than had been the norm in the area, and as professionals were called upon to dedicate more time than would usually be allotted to each case. The increased time per case was tied to the numerous collateral contacts that were required with other human service professionals holding a mutual involvement or service interest in each case. The service pressures on child welfare investigators and on other community treatment providers seemed to rise in intensity as more collaborative effort was required and as closer collegial scrutiny of service delivery was

[3] For detailed evaluation results and analysis see the *Demonstration Project Final Report 1991*

maintained. The message that was clearly communicated from this research experience is that the coordinated approach is more beneficial but is *not possible to maintain without some increased cost in professional service resources*.

This demonstration project served to identify and highlight the essential service components of a coordinated treatment model in Canadian rural communities. These included the need to draw together local agencies in a shared, collaborative planning process that was based on the premise that coordinated services must be fundamentally implemented, monitored and maintained by line-level service providers. These are the key actors in such integrated systems. Further, commitment needed to be developed in senior administration of each of the participating agencies; be it child welfare, mental health or police. These administrators could sanction and support the efforts of their line staff or they could sabotage inter-agency activities through the tightening of resources or the limiting of their staff participation (e.g. through the size of caseloads that needed to be maintained or through the prohibition of travel to attend collaborative community planning meetings). At a higher political level, it is also important to secure support from provincial government departments to ensure inter-departmental bridging created which facilitates key policy elements such as investigatory guidelines that require inter-disciplinary assessments or the identification that child sexual abuse is a service priority that warrants departmental attention (e.g. that child sexual abuse is a legitimate "mental health issue" that deserves involvement of the Department of Health or that it is a high priority criminal justice issue that should be given special attention by Crown Attorneys in the Department of Justice). The design of a coordinated treatment system needs political support most profoundly at the "grass roots" of local communities. However this support must be developed at various points of service authority up to senior provincial departmental levels (in the case of Manitoba: involving the Departments of Health, Family Services and Justice).

At the local community level, it seems that three fundamental components need to be created for a coordinated service system: a Community Treatment Committee, a Treatment Coordinator and Case Managers. First, a Community Treatment Committee needs to be formally structured to provide a forum for community service planning by participating agencies. It is within the scope of the Community Treatment Committee to provide opportunities for the sharing and understanding of differing professional ideologies in regard to the handling of child sexual abuse situations.

It is vital in a coordinated system to have one person identified as the local "traffic cop" for all identified cases of child sexual abuse. This person acts as the Treatment Coordinator and has formal responsibility for seeing that there is a planned and smoothly functioning bridge between those that do the investigative work and those that can provide treatment services. The Treatment Coordinator ensures that the Community Treatment Committee meets regularly to maintain inter-agency communication and service collaboration. The Treatment Coordinator works to secure a Case Manager for each treatment situation linked to an abused child and monitors the functioning of each Case Manager.

Although practice supervision for individual treatment providers is provided by their home agency according to their discipline's standards and protocols, the Case Manager must monitor each case to be sure each treatment provider is meeting their commitments within a systemic treatment strategy. This means that every abused child has a comprehensive treatment plan involving them and their family members, and that treatment is delivered in a thoughtful, sequential manner that is appropriate to the circumstances of each case of child sexual assault.

The coordinated approach can be viewed as including three service phases which are not mutually exclusive and which may overlap sequentially. These are; the disclosure phase, the investigative phase and the treatment phase. The disclosure phase is that period of time that is tied to the crisis of disclosure of the sexual abuse that is marked by the realization that this is a family in which children are not protected (internal threat) and that this is a family that is under investigation (external threat). A Family Support Worker was a valuable preventative mental health resource during the disclosure phase that was of modest service cost.

The investigative phase was that period of time during which evidence was collected in regard to whether the allegation of child sexual abuse could or could not be substantiated. A critical feature of the investigative phase was the service interface between child welfare and police investigators. This was the most challenging component to create in the coordinated model. It was clear that these two professional groups hold conflicting ideologies in regard to intervention in situations of child sexual abuse that is tied to their difference service mandates. They key aspect of this professional difference seems tied to attitudes regarding the priority of treatment versus punishment in responding to child sexual abuse.

It was during the treatment phase that it was most important to maintain high inter-disciplinary congruence in regard to a shared ideology of treatment. Because the bulk of the treatment providers shared a "family systems view" of intervention, collaborative case planning was more readily achieved. Because the bulk of the treatment providers appreciated the need for sequential and multi-modal therapies (e.g. individual counselling, group sessions, dyadic interventions and family therapy), there were few professional skirmishes over treatment plans. The challenge seemed to be less in putting together a shared strategy of intervention and more in finding the necessary basic clinical resources that were necessary to adequately help abused children and their family members.

Charlotte County Intrafamilial Sexual Abuse Program - ISAP[1]

CONTACT

Mental Health Commission of New Brunswick
14 Portage Street
St. George, New Brunswick
E0G 2Y0
Telephone: (506) 755-6411
Fax: (506) 466-2433

BACKGROUND

Charlotte County is a rural, geographically diverse area in southwestern New Brunswick with an overall population of 27,000. This number is spread throughout scattered small towns and villages as well as remote island communities; the challenge has always been to provide services which are both accessible and equal to those services offered in more urban settings. ISAP is being developed in response to the needs of incestuous families in this rural area where resources are scant and unspecialized.

ISAP began accepting referrals in April, 1989 and the first treatment groups for teen victims, non-offending parents and offenders began later that month.

Based on recent research on the short- and long-term effects of child sexual abuse and the dearth of treatment available for victims of extra-familial abuse, ISAP has expanded the definition of its target population to include those families in which the offender is a trusted person or person in authority (i.e. neighbour, friend, minister, etc.).

SERVICE PROVIDERS

The majority of ISAP staff are employees of Community Mental Health Services and the Department of Education, Extra-Mural Hospital, Department of Solicitor General and trained consumers of ISAP itself. One innovative example is a student nurse who completed part of a course requirement by co-leading an adolescent group.

OBJECTIVES

The major objectives of ISAP are:

[1] The Evaluation of an Integrated Treatment Program for Victims Of Incest: The Charlotte County Intrafamilial Sexual Abuse Program — ISAP by Joan Hollett, M.A., L.Psych. March 1991. **Information and excerpts taken directly from the evaluation report**.

1. To set up a comprehensive treatment program for families in which sexual abuse has occurred. The focus of this program is on the needs of the victim and family reconstruction to the fullest extent possible.

2. To develop and model a treatment plan that is portable to other rural areas. Development of ISAP combines adaptations of accepted treatment approaches, such as those of Giarretto (San Jose, California) and Anderson and Mayes (Calgary, Alberta), with innovative ways of reducing the trauma experienced by rural families involved in abusive situations.

3. To promote a coordinated, multi-disciplinary, multi-agency effort by encouraging and training professional volunteers as ISAP staff.

4. To evaluate the effectiveness of ISAR Evaluation proceeds interactively with program development.

DESCRIPTION

At present, the majority of cases are referred by Family and Community Social Services. However, with the distribution of the brochure, it is anticipated referrals will come through other sources (i.e. family doctor, education, justice, self-referral).

An Admissions Committee determines whether the referred family meets the criteria for participation in ISAP and the ISAP family file is set up.

An Individual Family Therapist is assigned and provides individual therapy to all family members and guides the family through the program.

A Family Guidelines Meeting is scheduled as soon as possible to inform all family members of what has occurred, what the consequences are likely to be, and the treatment process is outlined. This meeting is scheduled by the family's individual therapist and is attended by the family, therapist and referral source (if appropriate). Guidelines for this family are signed by each family member and the therapist and copies given to the family. The ISAP Participation Contract is a also signed by each family member.

How the disclosure and substantiation of child sexual abuse is managed initially, largely determines the chance of a successful outcome in the Crisis Group. The group is designed to help the non-offending parents and the offender deal with the changes brought about by this crisis.

Victims, offenders and non-offending parents are referred to appropriate groups by the individual therapist. At least one of the co-therapists should complete the Pre-Group Interview Summary with the perspective group member. The ISAP confidentiality form is signed at this time. Groups

include: Teen Victim's Group; Kid's Victim's Group; Non-Offending Parents' Group; Offenders' Group; and, Adult Survivor Group.

As individual family members progress in treatment (through on-going individual and group therapy) relationship issues are addressed in dyadic counselling (i.e. non-offending parents/victim, offender/victim, offender/siblings, victim/sibling and marital). Dyadic counselling is the responsibility of the family's individual therapist.

The family's individual therapist also decides when/if family therapy is appropriate. The timing of all therapies depends upon the victim's progress in treatment. The final stage of treatment involves reconstructive family therapy, where possible, and all family members organize themselves around prevention of re-abuse.

ISAP family files are not closed, relapse prevention is an important part of the program and family members are encouraged to view ISAP as an available personal resource.

The Adult Survivors Group is an important component of and resource for ISAP. Many non-offending parents are, themselves, victims of child sexual abuse. Referral to the Adult Survivors Group helps them deal with past trauma while, concurrently, learning to cope with the crisis in their immediate families.

Community Involvement

The community linkages which support ISAP are critical to its' growth and development. Obstacles to treatment implementation in an emergent program are more likely to be environmental than internal, ISAP developers were careful to ensure that community and professional education and support proceeded interactively with program development.

Linkages with a number of professional agencies and community groups resulted in ISAP being launched into a positive, informed community environment. This network included, ISAP Review & Planning Committee, ISAP Community Support Group, Mental Health, Evaluation of ISAP, Interagency Child Abuse Committee, Justice, and Family & Community Services.

ISAP has recently developed a Resource Centre which responds to community based requests for information about child sexual abuse.

EVALUATION (OUTCOME)

From 1988-1990 critical evaluation procedures became a routine part of ISAP operation. The documentation of internal program process is a function of the biweekly meetings of the ISAP Review and Planning Committee; profiling participants is a routine task for the family therapist/caseworker; and staff recognise that data collection and description is an essential precursor to program replication. Because ISAP is staffed by volunteers, there is often a wide

variability in documentation. Tolerance for individual differences in group leaders did not result in information loss at series end. However, leadership style and group composition did preclude assessing outcome of the 12-week series based on delivery of the didactic component of each session. Nonetheless, a number of standard clinical assessment instruments were tested with these ISAP participants. Some demographic characteristics of these families are as follows:

Characteristic		(#) Clients	%
Age of Victim	1 - 9	(3)	10
	10 - 12	(6)	19
	13 - 18	(22)	71
Sex of Victim	Female	(24)	77
	Male	(7)	23
Relationship	Father	(12)	27
	Stepfather	(6)	13
	Uncle	(5)	11
	Brother	(1)	2
	Stepbrother	(2)	5
	Grandfather	(5)	11
	Mother's boyfriend	(3)	(3)
	Cousin	(1)	2
	Other (includes offenders outside of family)	(10)	22
Number of perpetrators to child victim	Abused by 1	(21)	68
	Abused by 2	(6)	19
	Abused by 3 or more	(4)	13

The Moos Family Environment Scale — FES

The variables include: Cohesion (the degree of parental consistency, one's identification with a family unit, and non-chaotic family interaction); expressiveness (the degree to which the various family members feel they can speak freely on a wide range of topics and feelings); and conflict (the presence of verbal and physical conflict and aggression in the family).

The FES was administered to Teen Victims' Group I and their parents in the non-offending parents group. The results illustrate a similar, shared perception of a dysfunctional family. This social and situational context provided by the family is an important variable not often assessed in child sexual abuse studies.

The Piers-Harris Self Concept Scale

The Piers-Harris Self Concept Scale was administered pre and post to Teen Victims' Group I (n=7). Results showed no significant change on the total score or on any of the subscales for the 12-week group period. The Piers-Harris was also administered, for clinical purposes, to 16 teen and pre-teen victims as they were admitted to the program. Baseline mean scores were in the slightly below average range.

The Tennessee Self-Concept Scale - TSCS

The TSCS was administered pre and post to Teen Victims' Group 11 (n=6). Results showed no significant change on the overall score or any of the subscales for the 12-week group period. At pretest, the TSCS was administered to 9 teen victims; mean scores were in the below average range.

Results from the Piers-Harris and TSCS suggest that sexually abused teens did not perceive themselves as having particularly low self-esteem, as assessed with standardized, self-report measures. The general lack of significant findings may reflect the inadequacy of these instruments in tapping the emotional problems of sexually abused children. However when the results were graphed the Piers-Harris and TSCS total scores and subscales all showed a positive trend at the end of each 12 - week group series. These instruments were tested with two different groups of children and yielded very similar results. Given these trends, no significant findings in the area of self-esteem may mean that twelve weeks is an insufficient period of time to affect reliable change.

The Multi Score Depression Inventory for Adolescents and Adults — MDI (Berndt, 1986)

The MDI was also administered pre and post to Teen Victims' Group II (n=6). Results showed no significant change on the total score. However two of the ten subscales did show important changes from pre to post. The children experienced a significant decrease in Social Introversion [t(10,6)=2.29, p.045] and a decrease approaching significance on Irritability (p,.057). It may be that these MDI subscales are sensitive to changes attributed to group participation over a 12 - week period.

A child scoring high on Social Introversion is likely to feel socially withdrawn and isolated, a child scoring high on Irritability is likely to be irritable with a quick temper and intolerance of others.

The author of the evaluation, Joan Hollett, was also involved in a study to examine the efficacy of group treatment for adult survivors of child sexual abuse (Nind, 1991). Subjects were identified from the files of the Charlotte County Mental Health Clinic. Those who agreed to participate were randomly assigned to treatment and waiting list control groups. A battery of tests were administered, pre and post, including the Tennessee Self Concept Scale (Fitts, 1964); The

Beck Depression Inventory (Beck, Rush, Shaw and Emory, 1979) and the CES - Depression Scale (Radloff, 1977). There are three significant results following the 15 - session group treatment. The CES - Depression Scale showed a significant decrease [f(1,6)=7.78,p,.031, as did the Beck Depression Inventory [f(1,6)=6.18,p,.05]. On the Tennessee Self-Concept Scale one subscale, Self Satisfaction, showed significant improvement [f(1,6)=6.18,p.05]. Treatment group scores approached significance on the overall positive score [f(1,6)=4.7,p,.07] and the Social Self subscale [f(1,6)=4.77,p,.07]. The waiting list control group showed no important gains from pre to post.

RESEARCH

The research design and methodology has recently been amended with the focus now on a process as opposed to outcome model. The primary aim of the research is now to evaluate and monitor this effort to marshall and co-ordinate existing community resources to ensure that victims of incest and their families receive treatment. As well, it would feed back appropriate research data (collected at 6 - month intervals from participants) to inform and refine the various therapeutic modalities.

METHODOLOGY

1. A data base will be established to collect basic socio-demographic and sexual abuse history on ISAP families. The instrument to be used will be the family profile form which is contained in the ISAP family file. This file will also contain referral and admission forms and a progress chart which documents the use by various family members of specific program functions. We were able to pilot this system during the formulation stage and currently maintain skeleton files on 70 victims.

2. A second database will be established to collect and maintain process and implementation data. Information such as how ISAP operates; what services are offered and used by whom, which staff members provide specific program components; how program policy decisions are made; and what participants and staff members observe and experience will be collected from ISAP Review and Planning Committee Minutes, Group session reports, and final group reports. We have also been able to pilot this system and, in co-operation with group leaders, have designed a group session report which satisfies the needs of research and group leadership.

3. The systematic gathering of information about program implementation and program process also utilizes some of the instruments described above. As well program participant data will be collected by surveys administered on a bi-yearly basis to [program participants. This process evaluation will place more emphasis on collecting information about staff recruitment, training and supervision; staff turnover and burnout; and the use of community and consumer volunteers. On going training, both for

professional staff and volunteers, will be expanded to include anyone interested in delivering services to ISAP families. In this way we hope to increase our pool of volunteers and inform the community. Feedback from this group will help guide program development and strengthen community involvement.

4. There are inherent problems in attempting to unravel what program components work best with which participants. Every effort is made to tailor ISAP therapeutic resources to the needs of the family. Efforts to "unpack the black box of treatment" must be balanced against the volunteers' aversion to completing forms-Effective communication between researcher and group leaders is necessary and the treatment model will be described more in detail as regards to specific therapeutic modalities. However, content analysis of the family therapists' files and the final group reports would yield valuable information about duration, intensity and types of treatment. This activity would be contingent upon the request for funding for a research assistant being approved.

SUMMARY

ISAP process data will describe how ISAP operates; what services are offered and used by whom; which staff members provide specific program components; how ISAP policy decisions are made; what participants and staff members observe and experience; and the actual cost of ISAP This data will establish whether the intended service is actually being offered and help understand why ISAP affects certain participants differently. ISAP process data will also document the program's internal organization to allow replication to other rural areas.

Treatment of Child Sexual Abuse within a Comprehensive Service Model: Evaluation Report #3[1]

CONTACT

Community Action Centre
225 Watt Street
Winnipeg, Manitoba
R2L 1S6
Telephone: (204) 944-4353
Fax: (204) 944-4506

Knowles Centre Inc.
2065 Henderson Highway
Winnipeg, Manitoba
R2G 1P7
Telephone: (204) 339-1951
Fax: (204) 334-4173

BACKGROUND

In 1986, North East Winnipeg Family and Child Extended Social Services (NEW FACESS) and Knowles Centre Inc. embarked on a strategy to provide treatment to young victims of sexual abuse, young perpetrators of sexual abuse and the families of the young victims and perpetrators. A program proposal was developed based on the values shared by the two agencies.

The Sexual Abuse Treatment Program (SATP) began providing individual and group therapy for sexual abuse victims and mothers of sexual abuse victims in June of 1989.

Funding for this program is obtained through private sources and overall administration is conducted by the executive director of Knowles Centre and the area director of Child and Family Services East Region.

CLIENTELE

Non-offending Mothers

1. Must be the non-offending mother of a sexual abuse victim who is protected, safe and not in unsupervised contact with the offender.

2. The offender must be an individual who is known by the child and in a position of authority and trust with the child.

3. Must be able to admit that her child was indeed sexually abused.

4. Must be able to express some degree of willingness to talk to SATP staff.

5. Must have no serious psychiatric problem.

[1] Submitted by Erma Chapman Smith, Ph.D., February 1992.Copies of the full Evaluation Report are available. **Information and excerpts taken directly from evaluation report.**

6. Must not be chemically dependent.

Child

1. Must be a victim of sexual abuse by an offender who is known and in a position of authority and trust.

2. Must be able to admit that she/he was sexually abused and by whom.

3. Must be able to express some degree of willingness to talk to SATP staff.

SERVICE PROVIDERS

The Clinical staff within this program are social workers who obtain regular clinical supervision from psychologists with expertise in the area of child sexual abuse.

As part of the commitment to community involvement, SATP staff are prepared to train professionals who are already working with children and families to become group co-facilitators. Professionals wishing to volunteer their time are required to make a commitment of 5 to 7 hours per week for up to 30 weeks.

PROGRAM DESCRIPTION

SATP is a joint endeavour between Knowles Centre Inc. and Child and Family Services East Region. This community-based treatment is offered at the Knowles Centre counselling facility (individual) and the Child and Family Services (East) Centre for the Prevention of Domestic Violence (group). The Centre for the Prevention of Domestic Violence is an amalgamation of various programs previously offered by the N.E.W. F.A.C.E.S.S. Community Action Centre.

Engagement/Assessment Process

All referrals to SATP are accepted by staff at the Community Action Centre. These staff members are responsible for all initial assessments and carry this out in an engagement process. This process usually involves 4 - 8 individual interviews.

Group Therapy (Non-offending Mothers)

All groups are co-facilitated by two therapists. Non-offending mother groups are closed; all accept a maximum of ten members and run for approximately ten months. Mothers' groups are conducted one evening per week for two hours. The first hour within group is generally devoted to the provision of educational information which is presented by the facilitators and

occasionally, guest speakers. Topics include:

- ∇ the effects of sexual abuse on children
- ∇ sex role stereotyping - its relationship to sexual offenses
- ∇ understanding offender behaviour
- ∇ the "dysfunctional cycle"
- ∇ personal boundaries
- ∇ the impact of sexual abuse on childhood development
- ∇ relationships
- ∇ assertiveness
- ∇ grief and resolution
- ∇ termination

Group topics are often expanded upon and altered based on the identified needs of the group. Approximately one hour of each group is devoted to sharing time by group members.

Group Therapy (Children)

SATP offers several groups for children who are victims of sexual abuse. These groups include:

- ∇ (18 weeks) 8 to 10 year old female victims of sexual abuse.
- ∇ (24 weeks) 11 to 13 year old female victims of sexual abuse.
- ∇ (30 weeks) 14 to 17 year old female victims of sexual abuse.

All children's groups have a maximum of ten members, are closed and meet once per week at the Centre for the Prevention of Domestic Violence. Topics include:

- ∇ effects of sexual abuse
- ∇ the offender
- ∇ dysfunctional cycle
- ∇ family relationships

- ∇ Boundaries
- ∇ Personal safety and protection

Older children's groups are more discussion based, whereas younger children's groups are activity based.

Individual Therapy

The majority of individual therapy is conducted by Knowles Centre staff at the Knowles facility. Individual therapy is available for both mothers and children. Therapy is offered on either a short or long-term basis, depending on the client's goals for therapy and the time required to deal with these goals. The client is consulted regarding the frequency and time of appointments.

THEORETICAL FRAMEWORK

SATP staff provide service based on the following principals:

1. Protection and safety of sexual abuse victims is the beginning stage of treatment.
2. All children who have been sexually abused are negatively affected by this experience.
3. Children who are afforded the opportunity of group and individual therapy to deal with the traumatizing effects of sexual abuse are less likely to have short and long-term problems with family relationships, school achievement and community involvement.
4. Children are better able to cope in general if their care providers are supportive.
5. By offering treatment, support and education to non-offending mothers, their children will be given more support.
6. Contributing factors to child sexual abuse include sex role stereotyping an the objectification of women and children.

EVALUATION

The evaluation of the SATP was designed to address both the process and the outcomes of the project. Areas of focus for the third and final year of the evaluation were as follows:

- ∇ measurement of client growth;
- ∇ measurement of client satisfaction;

- ∇ objective measurement of the extent to which program goals were achieved;
- ∇ measurement of attitudes of agency staff and management, volunteers, regional abuse committee members and SATP staff toward the program;
- ∇ documentation of SATP governance, management and administrative processes and policies;
- ∇ answers to the questions "does it work? why, why not?"

Client Satisfaction

Clients were asked to complete a satisfaction rating scale when they finished their treatment and/or left the program. The evaluator forwarded by mail, with a postage-pal id, self-addressed return envelope, the satisfaction surveys. Different survey forms were used for youth and adult clients.

Since the response rates to the client satisfaction surveys were relatively low and since the respondents self-selected, the sample of clients cannot be considered representative of all SATP clients. Those clients who did respond to the client satisfaction surveys were generally satisfied with the treatment they received the program and, within the adult sample of clients, believed that their lives had improved in most of the areas targeted for change through group and/or individual treatment.

While only female clients responded to the client satisfaction survey during 1991, the decision to run group treatment for only girls who are victims of abuse and their mothers was made in response to limitations of human resources. Lack of resources to meet the needs of boys, siblings of young victims, juvenile offenders and non-offending fathers was a continuing concern.

Caseworker Attitudes

Since case workers were the only source of referrals to SATP, their attitudes towards the program were significant. The caseworkers attitude was developed by Knowles Centre's evaluation team in consultation with program staff Areas coffered awareness of the SATP program, if they had used the program, comparison with 1989 and 1990 program, the caseworker's perceived role of the program, strengths, weaknesses, effectiveness and overall satisfaction with SATP.

The improvements which were noted from 1989 to 1990 regarding ease of assessing client eligibility for SATP and in the extent to which time to meet with a client interfered with referrals to SATP were maintained through 1991. As well, fewer caseworkers seemed to be having difficulty with client ambivalence toward treatment in 1991 as compared with 1989 or 1990.

When caseworkers were asked to list strengths and weaknesses of SATP, they focused on the availability of treatment for various abuse client groups. Caseworkers reported that they were satisfied with the quality of the treatment but would like it to be available to a broader spectrum

of their clients.

Caseworkers who have used SATP appeared to be both knowledgable about, and satisfied with, the treatment program.

Regional Abuse Committee Attitudes

As part of the plan for the second and third years of program evaluation, regional abuse committee members were surveyed to determine their attitudes towards SATP. The regional abuse committee in northeast Winnipeg consists of representatives from a variety of community organizations, including three school divisions, community mental health, probation services, police and health services. As such, the committee can provide a measure of perceptions from the professional community regarding the impact and role of the sexual abuse treatment program. A questionnaire was developed by the evaluator based on answers to the survey during the Year 11 Evaluation. Areas included familiarity and program roles, role of the Regional Abuse Committee, strengths, weaknesses, effectiveness and overall satisfaction.

Only two-thirds of the members of the regional abuse committee, representing agencies external to the two organizations which sponsored SATP, indicated they were familiar with the program. While it was clear from responses to the survey that committee members did not feel it was their role to make referrals for treatment of individual abuse cases, the lack of familiarity with SATP among a third of the members was of note.

Strengths and weaknesses of SATP noted during the evaluation were similar to those expressed in the year 11 Evaluation by members of the regional abuse committee. Treatment services and competent staff continued to be seen as strengths of SATP. During the final year of the pilot project, the lack of a commitment for long term funding, and the possibility of the loss of the program, were also perceived as weaknesses. It would appear, then, that respondents perceived that clients received a quality treatment service, with the extent of service limited by available resources.

Management, Staff, Volunteers and Supervisor Attitudes

Personal interviews were conducted with 14 individuals. Respondents noted a large number of improvements in the program since the fall of 1990. In particular, individuals noted a better service to clients and an improved system of service delivery. Almost exclusively, areas of deterioration noted by interviewees concerned the relationship between the two sponsoring agencies. Unresolved differences in philosophies and values, lack of vehicles for cooperation and a worsening relationship among program staff were noted, not only as areas of deterioration, but also as weaknesses of SATP, areas of dissatisfaction and factors which detracted from the effectiveness of SATP.

Lack of adequate funding to meet client demands for treatment and lack of a secure funding base for continued service delivery were seen as weaknesses which impacted on SATP.

Increased efforts to include community volunteers in service delivery and increased presence through speaking engagements with community groups were reviewed positively.

Respondents seemed to agree on the roles for SATP: direct treatment services within northeast and, when available, greater Winnipeg; community education about abuse; consultation and training; and, a community-based program model for other agencies.

Evaluation of Therapeutic Intervention

For the final year of the SATP Evaluation, information about the impact of the program on individual clients was to be examined.

Development of Measures: Each measure which was developed or selected was designed to address specific client-based goals. These goals include:

(a) abuse does not continue;

(b) client has a developmentally appropriate locus of control, neither too externally nor internally directed;

(c) risk to self, in terms of behavioral manifestations of abuse, declines;

(d) client exhibits more appropriate sexual behaviour;

(e) behavioral manifestations of abuse decrease or disappear in client;

(f) child will have supportive family structure with appropriate adult-child boundaries and power relationships;

(g) client's and family members' ratings of family satisfaction increase; and,

(h) client will develop age-appropriate levels of self-esteem and self-worth.

For each goal, a specific instrument was employed in order to measure each client's progress, from time of entry (i.e. engagement) through treatment to termination and follow-up. The instruments used include: Child Behaviour Checklist; Nowicki-Strickland Locus of Control Scale; Piers-Harris Children's Self Concept Scale; Sexual Abuse Screening Inventory; Beck's Hopelessness Scale; Beck's Depression Inventory; Family Assessment Measure; Goal Attainment Scales; Therapists Judgement.

Summary of Youth Client Findings

The sample used for youth clients included 34 females ranging in age from 8 to 18 years old. On the basis of the clients growth information for youth the following indications were noted for client goals:

- ratings of risk by group leaders and individual therapists indicated that the risk of further abuse was not reduced during the course of treatment in SATP;

- on the basis of ratings by group leaders and individual therapists, it would appear that SATP clients felt that they had more control over events which occurred in their lives;

- on the basis of scores on the Nowicki-Strickland locus of control scale, enhanced feelings of internal control among SATP clients was not demonstrated;

- from the scores on the Beck Hopelessness Scale, it did not appear that clients' risk to themselves decreased during treatment;

- from average scores on the Sexual Abuse Screening Inventory, it appeared that, overall, SATP clients demonstrated a decrease in behavioral indicators of abuse, including a move toward more developmentally-appropriate sexual behaviour; the impact appeared to be related to the age of clients, with younger children demonstrating more of a change than older children;

- average scores on the Piers Harris Children's Self Concept Scale indicated that clients had a more realistic self concept after treatment than before treatment;

- average scores on group goal attainment scales were in the predicted direction, indicating that clients moved toward achieving the goals of treatment;

  average scores, however, reflected achievement which was less than the expected outcome at the end of treatment;

- on the basis of results from the Child Behaviour Checklist, it appeared that some improvement in functioning occurred for pre-adolescent clients, but not for adolescent clients;

- while average scores on the Family Assessment Measure all changed in the predicted direction from engagement to termination, the results could not be confirmed statistically; therefore, it could not be concluded that family functioning improved based on youth clients' ratings.

Adult Clients

For the purpose of measuring client growth during treatment, data was available for 45 non-offending mothers. At the time of engagement, SATP staff interviewed mothers and reviewed referral material from caseworkers. On the basis of these sources of information, staff recorded events of interest within the history of mothers of children who were sexually abused. The following percentages of adult clients were known, at the time of engagement, to have a history

described below:

- ∇ 38% of mothers had been physically abused as children;
- ∇ 36% of mothers had been sexually abused as children;
- ∇ 38% of mothers had been victims of either unspecified forms of abuse and/or had witnessed their mothers and/or siblings being abused, as children;
- ∇ 46% of mothers had been victims of spousal abuse;
- ∇ 23% of mothers had a history of drug and/or alcohol abuse;
- ∇ 41% of mothers had received prior mental health services; and,
- ∇ 21 % of the mothers had been reported to Child & Family Services previously for physical abuse of their children.

In addition to mothers' history, referring caseworkers noted mothers' degree of support for the victim of sexual abuse at the time of disclosure. Data was available for 18 mothers with the following results: 12 (67%) were judged to be supportive of the victim; 2 (11%) were judged to be ambivalent; and, 4 (22%) were judged to be not supportive of the victim.

On the basis of data collected from 45 non-offending mothers who participated in SATP, the following observations were made:

- ∇ it would appear from scores on the Beck Depression Inventory that mothers had lower levels of depression following treatment in SATP than prior to treatment;
- ∇ it would appear that mothers' overall functioning improved over the course of treatment, with mothers achieving the goals of. understanding the effects of sexual abuse; enhanced protection of her child; enhanced relationship with her child who had been sexually abused; and, facilitating peer support for change; and,
- ∇ it would appear that changes in family functioning, as measured by the Family Assessment Measure, did not occur.

Program Impact

In addition to outcome measures which pertain to individual clients, the extent to which program goals were met and the success of the collaborative service model were evaluated.

Estimates of Goal Achievement

Subjective estimates of goal achievement were included as an indicator of the extent to which program objectives are being met. Objective measures of goal achievement were included when available. The four objectives of SATP were:

1. to provide treatment services to 85 per cent of juvenile victims, juvenile offenders and their families;

2. to provide a treatment response within 15 days of abuse disclosure;

3. to demonstrate community awareness of the issue of child sexual abuse through increased levels of awareness of the problem, the services available and the gaps in service within northeast Winnipeg; and,

4. to have community members, who were not directly impacted by abuse, demonstrate their sense of responsibility through charitable donations to support treatment services.

Respondents to surveys and interviews were asked to indicate the extent to which they thought SATP was meeting each of its objectives, using a five-point rating scale. Average responses for each objective were calculated for casework supervisors, caseworker respondents, regional abuse committee members, management, staff and volunteers of SATP.

For the service-related objective of providing treatment to 85 per cent of juvenile victims, juvenile offenders and non-offending family members, ratings by survey and interview respondents and the service which is actually delivered indicated that some progress has been made toward achieving the goal, but the objective has not been met. Decisions made in response to the availability of resources determined that treatment was available primarily to school-aged female victims of sexual abuse and non-offending mothers of victims of sexual abuse. Within the past year, a closer working relationship between caseworkers and SATP staff has resulted in greater percentages of juvenile victims and non-offending parents being referred to SATP for treatment.

For the service-related objective of a treatment response within 15 days, both subjective ratings of response groups and counts of days between abuse, disclosure, referral to SATP and contact by SATP staff, suggest that this objective has not been met. If the present method were to remain, then a goal of a 30 day response time may be more realistic.

Less subjective measures of the goals of community awareness of child sexual abuse and charitable donations for treatment of sexual abuse were impossible to employ in light of the impact of the provincial campaign, as well as the loss of NEW FACES as a community-governed agency. Subjective ratings of these goals indicate that although some progress had been made toward achievement of each of these goals, the objectives were not met completely.

Collaboration

A unique facet of SATP was its structure as a collaborative venture in service delivery by a mandated child and family service agency and a non-mandated community treatment centre. As resources become scarcer, and needs in the community continue to increase, agency collaboration in service delivery has emerged as one solution to ensuring the optimum use of available dollars.

For observations related to SATP as a particular model, management team members, staff, resource centre supervisors and community volunteers for SATP were asked during their interviews about which elements of SATP facilitated and inhibited collaboration.

Collaboration among human service organizations is not only a difficult process, but involves time at an administrative level which may not always be recognized as a requirement for success. In any collaborative venture, direct service time will be reduced as compared with non-collaborative ventures in order to ensure efficacy of the collaborative model. Those involved in service delivery should all be aware of this need for non-direct service time and plan accordingly.

As a collaborative model, SATP demonstrated both the benefits and the pitfalls associated with theoretical perspectives on collaborative models. With more attention to planning for differences in values and philosophies, recognition of personal traits which enhance the process and time for meeting and documentation, the collaborative model used for SATP would likely be successful for the staff, as well as the clients.

RECOMMENDATIONS

1. Winnipeg Child and Family Services and Knowles Centre should make every effort to continue to provide the Sexual Abuse Treatment Program, with some modifications designed to address the specific difficulties associated with collaborative projects.

2. Funders of services to youth should provide sustaining support to a planned program designed to alleviate the effects of sexual abuse on children.

3. Service providers should consider the efficiency and effectiveness of providing treatment to victims of child abuse and non-offending parents when resources are limited.

4. Program developers and managers should include a continuing evaluative component in service delivery in order to provide information for extension of the program to new communities or different client groups and for refinement and enhancement of service delivery.

5. The use of volunteers from the community should be continued and, if possible, expanded.

The Marymound Model: A Sequential Approach to the Treatment of Male Adolescent Sexual Offenders and Sexual Abuse Victims[1]

CONTACT

Marymound, Inc. Family Resource Centre
349 College Avenue
Winnipeg, Manitoba
R2W 1M2
Telephone (204) 944-7400
Fax (204) 589-6061

BACKGROUND

Marymound, Inc. has operated a community-based Family Resource Centre in the core area of Winnipeg since 1984. The centre serves as an administrative site for a treatment foster care service and, subsequently, as a setting for the piloting of two abuse treatment programs.

In January of 1985, out of the preliminary work with clients placed within the treatment foster care program, two of Marymound's social workers identified the need to begin offering treatment groups for male victims of sexual abuse. By November of 1985, their interest and clinical experiences led them to identify and respond to the issues and concerns of male adolescent with histories of sexual offending. With a small sample, they were able to identify a particular client group in need of specialized services.

Efforts were made to institute these groups as a permanent community service offered by the Family Resource Centre by seeking and securing external funding. In December of 1986, grant funding was received from corporate and private sources. This enabled a pilot program for adolescent male victims and sexual offenders to be launched. It was further recognized, at that time, that in order for the program to develop and evolve to meet the growing needs of these adolescents and their families, permanent core funding was required.

In March of 1988, based on the significance of the pilot years, the Child and Family Services Research Group, Faculty of Social Work, University of Manitoba, was approached to assist Marymound in accessing demonstration funding. A major financial contribution for the project was subsequently granted to Marymound by National Welfare Grants under its Family Violence Initiative. This allowed for the establishment of a 3.5 year clinical research project known as The

[1] Final Report, written by Linda Campbell, John Lussier, Gloria Vaughan-Jones, Kathryn McCannell and Ron Kuncewicz, in conjunction with Audrey Law Hosegood and Sarah MacKenzie (1992).
Information and excerpts taken directly from the Final Report.

Marymound Model: A Sequential Approach to the Treatment of Male Adolescent Sexual Offenders and Male Sexual Abuse Victims.

PROJECT DESCRIPTION

The Marymound Model demonstration project was designed to accomplish the following objectives:

1. To effectively treat male adolescent sexual offenders and male adolescent victims of sexual assault using a sequential model.

2. To implement and evaluate the use of family therapy within a sequential model.

This community-based approach to the treatment of male adolescent sexual abuse victims and male adolescent sexual offenders involved the sequential application of individual, group and family therapy over two separate 18 month periods. The sequencing of therapy followed an assessment-adjustment-adaptive path in which each segment built on the work accomplished in the previous stage. The treatment stages and their respective duration were fixed: Assessment (Phase I), one to four months; Adjustment (Phase 2), five to 12 months; and Adaptive (Phase 3), 13 to 18 months.

TREATMENT PRINCIPLES

Marymound's clinical value base can best be described as relationship-centered and humanistic, that is, committed to responding to the uniqueness of each person in as comprehensive a way as possible. Accordingly, Marymound has adopted certain general principles of treatment in order to frame our interventions with clients, whether they present as victim, offender, or as non-abusing family member. Briefly stated, these are:

1. Treatment is a developmental process: each individual is met at his/her level within his/her particular context.

2. Treatment is a process of empowerment: promoting the awareness that there are choices and that each individual is responsible for the choices that are made.

3. Treatment is needs-focused: proceeding from the understanding that needs are expressed through behaviours and that the primary goal of any interven-

   tion is to move past behaviour to reach the individual's needs, desires, emotions and thoughts. Behaviours change when needs are met.

4. Treatment is the acceptance of feelings: each individual is encouraged to become aware

of, express and own his/her feelings within the context of nonjudgmental relationships.

5. Treatment is focused on each individual's and family's strengths, gifts, skills and attributes.

6. Treatment is an individualized plan and process.

7. Treatment is the development and review of plans in consultation with the systems that relate to each individual.

8. Treatment is the recognition of and respect for the culture of the individual and his/her family, as well as their right to self-determination in such areas.

9. Treatment is in the "process": continually evaluating how it is impacting the client at any given time.

CLIENTELE

Male adolescent sexual offenders were admitted to the project if they were between the ages of 12 and 16 1/2 years of age and had sexually abused a child or adolescent. During Phase I, it was stipulated that their offense(s) had to be perpetrated against a male. This was later revised to include offenders who had sexually abused both males and/or females if the adolescents themselves had been victims of abuse. Adolescent male victims were admitted to the program if they were 12 to 16 1/2 years of age and had been sexually abused by a male. As became clear during treatment, several of the victims, as well as a number of offenders had also been abused by female adolescents and women. Individuals who did not meet the above criteria were not admitted into the treatment project.

Additional reasons for not accepting an offender referral included: denial on the part of the offender that he had committed a crime, the assessment that he would threaten public safety if treated in a community setting, and a concern that the offender's placement was counter-productive to the treatment process (e.g. offender residing with victim). Victims tended to withdraw voluntarily during the referral and intake process. In addition, several referrals were found to have located alternate treatment resources between receipt of the referral and intake.

EVALUATION

The evaluation designs that were used to assess the effectiveness of the family therapy intervention and determine the clinical outcome of the Model consisted of:

1. A pretest/post-test comparison of two groups of matched offenders and two groups of matched victims on several psychosocial variables. Only one group of offenders and one

group of victims were provided with the independent variable (family therapy).

2. A pretest/post-test comparison of two groups of matched offenders' risk of reoffending. Only one of the two groups was provided with the independent variable.

3. A longitudinal tracking study of the adolescents who were admitted to treatment in 1988. The focus of this component was the number of sexual offenses committed by the youths 18 months after they had completed treatment.

A precision matching technique was used to create two groups of offenders and two groups of victims who were compatible on key variables. These variables were selected on the basis of issues raised in the treatment literature and as a direct result of the practice experience gained by the therapists with the offender and victim populations.

The criteria that were used to match clients engaged in family therapy with those who were not engaged in family therapy (for offenders) were: family support, cultural background, prior victimization, level of responsibility for the offense at intake, object connection, prior treatment for offending, academic functioning, intergenerational abuse, and depression/suicidality.

The criteria that were used to match clients engaged in family therapy with those who were not engaged in family therapy (for victims) were: family support, cultural background, age at first victimization, academic functioning, intergenerational abuse, depression/suicidality, and substance abuse.

The pretest/post-test comparisons were based on clients' scores obtained from standardized and non-standardized psychometric tests which were selected to capture change on several relevant dimensions: depression, locus of control, self-concept, distorted beliefs, loneliness, social desirability, family functioning, family problems, and risk of reoffending. All the characteristics, with the exception of risk of reoffending were assessed on the basis of client self-report measures which were completed by the adolescents and/or their mothers during individual or group sessions. Clients' risk of reoffending was directly assessed by the therapists.

Information for the longitudinal tracking study was obtained 18 months post treatment for the adolescents admitted to treatment in 1988. The primary source for this information was the City of Winnipeg Police Department's Youth Division. A second source of information was the project therapists.

In addition to the above design components, empirical case studies were conducted on two matched offender cases and two matched victim cases. Data from the psychometric tests was combined with the therapists' clinical observations to produce detailed histories on these four youths as they progressed through treatment. Client feedback was also solicited after treatment using the Consumer Satisfaction Questionnaire-8 (Larsen, Attkisson, Hargreaves, & Nguyen, 1979) which was administered to the adolescents and their parents.

SUMMARY OF FINDINGS (Offenders)

Psychometric Measures

Based on the results from the Family Assessment Measure III(FAM) and the Family Problem Checklist, family therapy appears to have had some positive effects, especially in terms of the mothers' perceptions of family functioning. The adolescents who received family therapy also reported statistically significant improvements in the areas of Communication and Role Performance, two dimensions of family functioning measured by the FAM, and an increase in satisfaction with family issues.

For both the family therapy and no family therapy groups, statistically significant improvements were demonstrated with respect to depression. The adolescents' mean scores in both treatment groups shifted from the mild-moderate to the normal range of depression. Improvements in the area of self-concept were also identified for both groups, with the no family therapy group experiencing a statistically significant increase in the attribute.

The family therapy and the no family therapy groups were both rated by the therapists as being at a lower risk of reoffending at the end of treatment, although this drop was more marked for the offenders who did not receive family therapy.

These favourable outcomes do not appear to have been produced by the family therapy intervention itself In fact, the adolescent offenders who did not receive family therapy appeared to experience the greatest gains as a result of the 18 months of treatment. The t-test of mean difference between matched pairs supports this conclusion and indicates that the only significant difference between the family therapy and no family therapy groups is the increase in between the family therapy and no family therapy groups is the increase in distorted beliefs experienced by the offenders who received family therapy. The youths who did not receive the family therapy intervention experienced a statistically significant reduction in the number of distorted beliefs they held over the course of their involvement with the treatment project.

The limited impact of family therapy on many of the areas measured by the psychometric instruments is of considerable clinical and research interest. Of equal interest is the potentially adverse impact of family therapy on offenders' cognitions regarding appropriate sexual behaviour. Several issues emerge from these findings...

The first issue is a concern that the families themselves may have had difficulty supporting the offenders as they began to engage in the treatment project. Many of the families involved with the Marymound Model were also experiencing serious family difficulties. It is possible that creating the opportunity for short term family work only served to heighten the adolescents' sense of confusion and uncertainty as they were asked to participate in a concerted way with what in many instances was a dysfunctional family system. A second issue pertains to the duration and structure of the family therapy component itself, and the requirements of offender-specific

treatment in general. The final issue relates to adolescence as a developmental stage and the strain that conflicting demands may place on the family system.

Offending Behaviour

One of the most critical indicators of treatment success was the proven ability of the Marymound Model to prevent adolescent sexual offenders from reoffending sexually following termination with the project. To assess the effectiveness of the project in this important area, sexual offending behaviour was monitored during treatment and tracked for 18 months post-treatment for the 12 adolescents who completed Phase I of the project. For the 12 youths who completed Phase II, reoffending behaviour was tracked during treatment only.

Data from official and unofficial sources indicates that two offenders reoffended, one during treatment and one post-treatment. The juvenile who reoffended during treatment did not receive the family therapy intervention. The youth who reoffended post-treatment was engaged in family therapy along with his mother and siblings.

Empirical Case Study

Two matched offender cases were selected for analysis: Randy and Daryl.2 Based on clinical observations, and the results from the standardized and non-standardized scales and indexes, it is apparent that adolescent offender Randy, whose family was not involved in family therapy, fared better than Daryl at the end of treatment.

non-standardized scales and indexes, it is apparent that adolescent offender Randy, whose family was not involved in family therapy, fared better than Daryl at the end of treatment.

Randy experienced a positive shift in the area of self-concept. He also expressed fewer distorted beliefs at the end of treatment. From a clinical perspective, Randy demonstrated growth in a number of areas. His primary tasks for the future included reconnecting with his family of origin while continuing towards emancipation and maintaining his relapse prevention activities.

Client Satisfaction

Clients responding to the Consumer Satisfaction Questionnaire-8 (CSQ-8) (Larsen et al., 1979) indicated a high level of satisfaction with the project. Sixty-nine per cent of offenders were very satisfied and 31 per cent were mostly satisfied. Sixty-seven percent of parents were very satisfied and 33 per cent were mostly satisfied.

SUMMARY OF FINDINGS (Victims)

Psychometric Measures

The findings from the psychometric measures were analyzed separately for the adolescents whose families were engaged in the family therapy intervention and for the victims whose families were not engaged in therapy. While the family therapy group was initially composed of 12 adolescent victims, a variety of circumstances contributed to a high drop out rate from the family therapy treatment condition. At the end of the 18 month treatment phase, only two youths and their families remained in the family therapy group. Many of the victims who were originally assigned to the family therapy group transferred into the no family therapy group.

The internal transfers from the family therapy group to the no family therapy group had a significant impact on the evaluation component, reducing the evaluation team's ability to comment on the differential impact of the family therapy intervention. The only data derived from the psychometric measures which could be examined statistically were the pretest and post-test scores of the adolescents and their mothers who did not receive the family therapy intervention. The procedure that was utilized in this instance involved separate t-test analyses for dependent samples conducted on each of the psychometric measures for the no family therapy group. The established level of significance for the findings was p.10. The purpose of this statistical procedure was to determine the extent to which client scores changed from the beginning to the end of treatment in the no family therapy treatment condition.

The data derived from the two adolescents and their mothers who received the family therapy intervention was simply described on a case by case basis.

No Family Therapy Group

There were no changes observed in the mean level of depression experienced by the victims by the end of treatment. The mean pretest score for the 17 cases was 13.23 (sd=12.61) and the mean post-test score was 10.88 (sd=11.12). Both the pretest and post-test scores placed the adolescents in the mild-moderate range of depression.

There were no differences observed in the mean self-concept rating obtained before and after treatment. The pretest mean of 58.13 (sd=14.02) corresponds to a percentile score of 63. The post-test mean of 59.4 (sd=14.49) corresponds to a percentile score of 66. The percentile scores for the 15 victims who completed both pretest and post-test measures correspond to the average range of self-concept.

A statistically significant increase in distorted beliefs was observed for the 15 adolescents included in this analysis. The change between the pretest mean of 47.13 (sd=9.01) and the post-test mean of 51.13 (sd=10.85) was statistically significant(t=-1.99, df=14, p.10).

There was little change in the scores obtained from the loneliness scale from pretest to post-test. The pretest mean of 39.93 (sd=9.43, N=16) is within one standard deviation above the mean provided for this age group, as is the post-test mean of 41 (sd=12.67).

The results from the Social Desirability Scale suggest that the 10 adolescent victims who completed the measure were not influenced by a social desirability bias. The pretest mean of 4.2 (sd=2.09) and the post-test mean of 4.5 (sd=1.9) closely correspond to the mean score obtained for the normative sample.

The adolescents' mean pretest total score of 53.3 (sd=9.33, N=12) and mean post-test total score of 52.75 (sd=9.SS) on the FAM both fell within the average range of family functioning. Similarly, all of the subscale scores fell within the average range before and after treatment. There were generally no shifts observed in the adolescents' total score or subscale scores over time. This pattern was also observed with respect to the three mothers' scores that were available for analysis.

There was no significant change in the extent to which family issues were perceived as problems by the 10 adolescents who completed the Family Problem Checklist both before and after treatment.

Offending Behaviour

Information was obtained 18 months post-treatment from official and unofficial sources for seven Phase I victims. For the 14 victims who completed Phase II, information was collected only during their involvement in the project.

Of the 21 victims, two victims offended while they were engaged in treatment with the project: one during the group phase of treatment and the other very close to termination with his therapist. Neither adolescent had received family therapy as part of the treatment intervention. In addition to their victimization histories, both adolescents had engaged in offending behaviour after they had been victimized and prior to their admission to the Marymound project. Due to both adolescent victims' histories of offending behaviour, these cases do not add to the knowledge base regarding the alleged victim-turned-offender cycle.

Empirical Case Studies

Case studies were developed on two matched offender and two matched victim cases throughout the treatment project. Each matched pair of cases included one adolescent whose family was engaged in family therapy and one adolescent whose family did not receive the family therapy intervention.

From a clinical and research perspective, both adolescent victims remained very distressed and had many unresolved issues at the end of therapy. Both had experienced major traumas and losses. While neither case can be considered a "Success," the adolescent who did not receive family therapy, experienced an increase in positive self-concept, and a decrease in loneliness and depression by the end of treatment.

Client Satisfaction

The Consumer Satisfaction Questionnaire-8 was also mailed to the adolescent victims to solicit feedback on their overall satisfaction with the project as well as their satisfaction with specific aspects of service delivery. In total, 16 out of 25 victims completed questionnaires, representing a response rate of 64%.

On the whole, the 16 clients reported being satisfied with the Marymound project. Our study found that 93% of the clients reported that they were generally satisfied with the service provided. A difference in levels of satisfaction between Phase I and Phase II clients was found. The Phase II adolescent victims appeared to be generally less satisfied with treatment than the Phase I clients. Despite the variation between Phase I and Phase II respondents, client feedback on the services received indicated that, for the most part, services were found to be helpful and of good quality.

CONCLUSIONS[3]

For the male adolescent offenders, results from the psychometric tests, the tracking study of reoffending behaviour and the empirical case studies all suggest that the family therapy intervention was no more effective in treating this population than was individual and group therapy. In fact, the only statistically significant difference that could be found between matched groups of offenders was an increase in the cognitive distortions experienced by the adolescent offenders in the family therapy group. While both groups were rated by the therapists at the end of treatment as being at low risk of reoffending, the literature suggests that unless cognitive distortions are addressed the adolescent offenders who received family therapy may be at risk of reoffending in the future.

Despite this unsettling finding, both the family therapy and no family therapy groups of offenders experienced statistically significant reductions in depression and improvements in self-concept. With respect to self-concept, the no family therapy group experienced the greatest gains over the course of treatment. Family therapy did appear to have a favourable impact on the mothers' perception of family functioning, as assessed by the Family Assessment Measure III.

Overall, for the male adolescent victims, the psychometric tests, the empirical case studies, and the clinical observations indicate that the treatment project was not successful in meeting the diverse needs of these youths. There was little change observed in many of their psychosocial characteristics and a statistically significant increase in their distorted beliefs.

Reoffending data suggested that some of the victims should have gone directly into offender-

[3] For a detailed discussion and analysis of evaluation results, conclusions and recommendations see *The Marymound Model: A Sequential Approach to the Treatment of Male Adolescent Sexual Offenders and Sexual Abuse Victims - Final Report (1992).*

specific treatment. This points more generally to the overlapping nature of the victim and offender populations which is supported by Ryan (1989), and challenges reconceptualization of some aspects of victim treatment. However, the authors felt that it was clear from their study that victims with a history of sexual aggression must have their offending behaviour addressed prior to en aging in a victim-specific treatment process.

The Integrated Treatment Model For Sexually Abused Children and Their Mothers[1]

CONTACT

Vancouver Incest and Sexual Abuse Centre (VISAC)
#202 - 1193 Kingsway
Vancouver, British Columbia
V5V 3C9
Telephone: (604) 874-2938
Fax: (604) 874-9898

BACKGROUND

The Integrated Treatment Model (ITM) was sponsored initially by the Vancouver Incest and Sexual Abuse Centre Society (VISACS) and subsequently in January, 1987, by Family Services of Greater Vancouver (FSGV). The VISAC name was retained. The project was funded by Health and Welfare Canada and spanned a three-year period, from January 1, 1986 to December 31, 1988.

During this time period 147 families were referred to the ITM. Approximately half of the referrals were made by the Ministry of Social Services and Housing (MSSH); the remaining referrals came from a variety of community agencies. Families were also self-referred.

Since this report, written in 1989, VISAC has changed and expanded. The program remains integrated with increased services to victims, families, non-offending parents and survivors of child sexual abuse. VISAC is now funded primarily through B.C. Provincial Government contracts.

VISAC also now provides information, education, consultation and referral services to the general and professional community in the field of child sexual abuse.

PROGRAM DESCRIPTION

The focus of the ITM program was to provide intensive, short term therapy involving

[1] A project funded by National Welfare Grants, Health and Welfare Canada. Copies of the complete Final Report are available from VISAC through Family Services of Greater Vancouver, 1616 West 7th Avenue, Vancouver V6J 1S5 (604) 731-4951. **Information and excerpts taken directly from the final report.**

individualized treatment and family support to child incest victims and their mothers. In the families treated during the project, the father, or father figure, was the primary offender, and the "family" was taken to mean the non-offending mother and her child(ren).

Treatment involved individual, family and group therapy for the mothers; individual and family therapy for the children; and individual and group therapy for adolescents. Treatment extended for six to eight months and involved one to two weekly sessions of one to two hours each. The integrated treatment approach involved not only direct counselling services to the client, but also working closely with community resources to assist the family.

SERVICE PROVIDERS

The initial staff consisted of two counsellors and a coordinator. Additional sexual abuse treatment training was offered to the staff. A sexual abuse treatment practitioner remained as a consultant for the first two years.

All the staff provided treatment to child victims, their mothers and to other (non-abused) family members. In addition, staff liaised actively with others involved in each case, such as victim support worker, crown counsel (if charges were laid) and social workers.

Program publicity and networking with other agencies were carried out primarily by the coordinator. The project used volunteers only sporadically.

THEORETICAL FRAMEWORK

The program's treatment philosophy included a feminist perspective, a strong child advocacy perspective and a recognition that sexual abuse is not isolated from other forms of psychological maltreatment. The treatment method was ego-supportive and used a wide range of techniques involving relaxation, affirmation, ventilation, exploration and refraining.

Lack of parental empathy and role reversal were central issues in treatment. It was believed that the more non-offending parents were able to balance power and control within their relationships, the more they were able to provide safety and protection to the child.

VISAC believes that sexual abuse affects all members of a family system, but the accountability and responsibility rests with the offender, not the other or child victim. The viability of the single parent family system, as opposed to the reconstructed nuclear family, was an important treatment concept.

Mothers are encouraged to develop a sense of self competency, control and inner power over their lives in order to eliminate abusive relationships, and to explore their early childhood abuse in order to develop empathy with the child. The development of a non-abusive, non-exploitive parenting relationship helped to prevent further trauma to the child.

Group therapy was considered a valuable adjunct to individual treatment, both from VISAC's

observation and client feedback. The opportunity to be with others who shared the experience reduced the sense of shame and isolation.

Group therapy with mothers explored issues of personal growth, self-esteem, communication, childhood memories, rebonding the body and human sexuality. The parenting group focused on children's emotional needs as the source of behavioral problems.

Families were evaluated and screened in the initial two sessions with an eight week assessment period. The mother's level of denial of the abuse was the most difficult to assess.

In the treatment of child sexual abuse cases, there is a conflict between a child-centred approach and a family-centred approach to family reunification. In our experience with most mothers and some children, feelings of betrayal and a reluctance to trust the offender resulted in an unwillingness to reconcile with the offender. Mothers expressed a need for redefinition and "restructuring" of the family unit, involving mothers and child(ren). As the mother became aware of the oppressive situation, she was more able to explore options and felt empowered to make informed decisions in the selection of a new partner.

In VISAC's view, the needs of most incest families cannot be served within a short-term treatment model without screening and assessment of the parent-child relationships and the quality of the non-offending parent's history of deprivation/abuse. Mothers who can go beyond the intellectualization of feelings, and who are capable of insight and empathy are more likely to benefit from a short-term model. While a short-term model does serve to normalize the present experiences of child sexual abuse, it does not normalize what growing up means to the mother who experienced abuse in her childhood. This is a longer-term process.

VISAC found the short-term model helpful for crisis intervention purposes, in providing immediate help to the families in gaining an intellectual understanding of the incident, bringing their feelings into the open, exploring coping mechanisms and planning to reduce further abusive experiences to the child.

The short-term model may also be sufficient in cases involving victims who were abused outside the family, who have the support of significant others and who have not experienced a history of severe physical or emotional abuse.

VISAC believes most ITM clients completed a significant level of growth within a minimum of five months of treatment. This was viewed as the initial stage for future growth and change and most families were referred on for further treatment.

TREATMENT PHASES AND TIME FRAME

Most families stayed in treatment an average 8.5 months. ITM staff defined four stages of assessment and treatment:

1. Assessment and Program Information Stage (1-8 weeks)

2. Initial Treatment Phase (8-10 weeks)
   Basic sexual abuse information, support stage.

3. Mid-Phase (2nd-6th months)
   Information on abusive dynamics.
   Exploration and recovery of mother's childhood and identification and articulation of needs and potential.
   Exploration of anger, depression, sexuality.

4. End Phase
   Synthesis of new information and insights.
   Review and practise of parenting skills, changes in role reversal patterns.
   Exploration of children's needs.
   Review of treatment accomplishments.
   Referral to treatment or ongoing support resources.
   Mothers received an average of 66 hours of treatment time, compared to 28.5 hours for child victims. In most cases, this range and variability in treatment time was appropriate, considering the needs and receptiveness of clients. Children particularly do not seem amenable to long periods of time in treatment.

EVALUATION

Purpose and Methods

The evaluation of ITM was designed with two specific purposes in mind.

1. External research purpose: to answer questions related to program impact and effectiveness.

2. Internal monitoring purpose: to assist the staff in identifying and tracking relevant treatment issues.

A number of evaluation strategies and methods were used to provide the widest possible view of the operation of ITM and the impact and effectiveness of treatment. The methods and formats used and their purposes are described below:

1. Basic program documentation consisted of initial intake and screening data. It provided information on factors which affect the outcome of treatment such as the mother's level of denial, substance abuse and past emotional disorders.

2. Mother's pre- and post-treatment data forms collected a range of information about the mother, including demographic and childhood abuse data, marital relationships and health indicators.

3. Child's (victim) pre-and post-treatment form collected a range of information about the child including physical, emotional and sexual abuse history and health status. A check list of 64 behavioral symptoms commonly associated with sexual abuse was included.

4. Family function check list (intake and outgoing). A comprehensive check list which identified the presence and degree of certain attitudes and behaviours associated with the sexually abusive family such as family authoritarian patterns, respect for privacy, attitudes towards sexuality, parental self-esteem levels and role referral patterns. An outgoing check list reviewed the changes and improvements in these areas.

5. Mother's behavioral check list. Compilation of major issues related to the functioning of the mother such as role reversal and self-esteem.

6. Authoritarian Family Ideology test (AFI). A standardized test which measured the degree of parental authoritarianism, intrusiveness and lack of parental empathy and respect for children.

7. Family update looked at general family functioning and presence of re-abuse up to six months post-treatment.

8. Program document review. Other program documents related to program functioning such as telephone answering sheets and client referral forms. These provided an overview of community response to the program.

9. Program consultation. Although the evaluator did not observe direct interaction between therapists and client, all cases were discussed on a bimonthly basis with staff.

Thirty-one families consisting of 31 mothers, 45 sexual abuse victims and two father offenders were initially accepted for assessment and treatment by ITM. Four of these families dropped out of treatment after 1-3 months. Three of these cases involved mothers who were not appropriate candidates for treatment. However, ITM staff also offered some level of treatment to offenders (two), siblings, other family members and adult survivors. The total number of people to whom the program offered some level of treatment was 87.

Evaluation Results

To assess the impact and effectiveness of ITM treatment, behavioral changes or other indicators in mothers and children were examined, comparing their status at the beginning and end of treatment. A brief sixth month follow-up post-treatment assessment was also made to assess the family's status and the child's freedom from abuse.

In almost all areas, our data indicate that by the end of 5-12 months of treatment, family and personal functioning had improved for most clients.

Mothers

Areas of significant improvement: denial of own abuse; role reversal with children; role reversal with own parents; assertiveness; self-esteem; lack of trust; inability to handle/express anger; unresolved sexuality; and emotional abusiveness. Only one indicator (denial of abuse impact on children) did not show either statistical significance or a general trend towards improvement.

Mothers also showed a lessening of health-related symptoms by the end of treatment (from an average of 6.8 symptoms per client to 5.5); 72% of the mothers showed some degree of improvement or a decrease in frequency of symptoms. Particular symptoms such as anxiety disorders were reduced in the majority of cases.

Children

Forty-eight of the 66 behavioral symptoms manifested by children at intake were significantly improved by the end of treatment. Some symptoms such as overeating" and "excessive masturbation" showed no overall improvement on a statistical level.

There were no clear trends in the types of symptoms that appeared to be amenable to ITM treatment. However, sexual identity and areas related to sexuality still appeared to be a problem for most children.

The impact of treatment on children on a client-by-client basis was also addressed. A majority of the children (22/33 or 67%) showed significant improvement in their overall level of functioning when all the behavioral indicators were examined. Ten children (30%) showed no significant improvement (although they showed no deterioration). One child showed a deterioration in symptoms. (This was a child who was homeless for 11 weeks because an appropriate home placement could not be found by the Ministry of Social Services). There was also a reduction in the number of health-related problems by the end of treatment (from an average of 1.5 symptoms per child to .75). The number of children without health problems also increased from 30% to 50%.

Role Reversal Patterns

The Authoritarian Family Ideology (AFI) test examined some aspects of role reversal. According to this test, there was a statistically significant improvement on mothers' attitudes and behaviour. The staff check list also found that the majority of mothers assumed more adult roles by the end of treatment.

Indicators Associated with Client Change in Treatment

An attempt was made to define indicators which were most closely associated with progress in treatment. In the case of children, we looked at the following indicators:

1. Overall severity of sexual abuse trauma

2. Overall abuse rating (emotional/physical/sexual)

3. Amount of time mother spent in treatment

4. Previous sexual abuse history

5. Mother's previous sexual abuse history

6. Amount of time child spent in therapy

7. Age of child at time of abuse (under 6 years, over 6 years)

8. Relationship of abuser (whether biological father or other father figure).

Most of these indicators (1,4,5,6,8) had no association with treatment success or lack of success. However, three indicators - the length of time the mother spent in treatment, the overall abuse rating for each child (severity of emotional, physical, sexual abuse and neglect), and the child's age at the time of abuse were all associated with change in treatment. The following trends appear to exist:

∇ The older the child when abused, the less effective the treatment.

∇ The more time a mother spends in therapy, the more effective the treatment for the child.

∇ The more severe the overall abuse, the less effective the treatment.

Sixth Month Assessment of Family Status and Child Safety

Of the 27 children who were assessed, two were abused after treatment ended.Charges were laid against the offender.

Impact of Court Proceedings on Clients and Treatment

Although a criterion for entry to ITM was that the offence be reported to Social Services, in 27% of the cases (9/33), offenders were not charged. In 24 cases where charges were laid there were convictions in only 13 (54%) cases (in three cases proceedings were still under way), in eight cases there were acquittals. When one considers all the 33 victims, only 39% (13/33) saw their offender both charged and convicted.

Victims and their families were negatively affected when the offender was not charged or convicted. The impacts were personal but also sometimes affected the treatment process.Where offenders were convicted, children felt vindicated in their handling of the sexual abuse. The conviction seemed to release them from the weight of responsibility and self-blame. The mothers also felt supported by a guilty verdict.

Impact of Sexual Abuse Treatment Staff

As well as stress related to actual cases, ITM staff reported two other important impacts of this type of work. "It touches life very deeply," noted one therapist. One's own (sometimes painful) childhood, present life and parenting philosophy and methods are all likely to become scrutinized. On a more political level, staff reported a new level of consciousness about the status of children in society generally. "Children have no rights; they have fewer rights than animals." Staff became hypersensitive to child safety issues.

The peer supervision structure, the large number of supportive and informative workshops, and consultation with the program advisor all helped to relieve their isolation. The physical environment of ITM reflected peacefulness and support. Additionally, some staff, at various times, found their own source of (therapeutic) support to help them work through issues arising from work.

RECOMMENDATIONS

It is recommended that Family Services develop strategies about the future use of volunteers in the sexual abuse counselling program to define appropriate selection, training and placement criteria. It is recommended that Family Services explore ways of initiating and supporting the following types of groups for sexually abuse clients: pre-teen discussion support groups; male victim support groups; mother/child play support groups and post-treatment support groups.

It is recommended that Family Services develop a capacity to provide treatment for offenders or a formal relationship with another program providing such treatment.

It is recommended that the previous sexual abuse history of mothers be studies in relation to its potential as a risk factor for the daughter's sexual abuse.

It is recommended that any group providing child sexual abuse counselling develop concrete ways of handling inevitable staff stress levels. Some strategies might be biweekly "processing" sessions, staff attendance at supportive workshops, or program support for staff who wish to arrange their own therapeutic support.

The Family Sexual Abuse Treatment Program (FSATP)[1]

CONTACT

Social Work Department
Calgary District Hospital Group
7007-14th Street S.W.
Calgary, Alberta
T2V 1P9
Telephone (403) 541-3468
Fax (403) 541-3434

BACKGROUND

The FSATP was developed in 1986 in response to Child Welfare needs to provide additional treatment services to victims of child sexual abuse and their families. The FSATP responds to the Alberta Family and Social Service focus on strengthening the family in order to prevent or reduce the extensive use of government intervention in the care of children. The program is flexible in accepting families for treatment where the child is initially in residential care or where the offender has been removed from the home. It is not a requirement that both parents be involved in treatment, although this is often an advantage.

The FSATP works closely with Child Welfare workers to ensure that treatment and case planning are coordinated.

CLIENTELE

The FSATP provides treatment to cases of intrafamilial sexual abuse including any form of sexual activity between a child and a parent, parent surrogate, sibling or extended family member.

Adolescent offenders who have committed intra- or extrafamilial abuse are seen in the context of their families. Cases of extrafamilial abuse where the offender was a teacher or baby-sitter, or otherwise external to the family being served, are considered on an individual basis and accepted only if space permits.

Victims under the age of eight, are usually referred to Alberta Children's Hospital while adult survivors are referred to the Sexual Assault Centre.

The programme is contracted to provide treatment at any given time for thirty (30) cases actively in treatment. For the fiscal year April 1990 to the end of March 1991 there were a total of 54

[1] Family Sexual Abuse Treatment Program 1991-1992. Children and Family Services Social Work Department Rockyview General Hospital, Calgary District Hospital Group Calgary, Alberta. **Information and excerpts taken directly from the Family Sexual Abuse Treatment Program report, Schedule A.**

families given service.

SERVICE PROVIDERS

The program employs a program director, two full time social workers, a psychologist, secretary and consultants.

THEORETICAL FRAMEWORK

The distinguishing feature of the FSATP is the inclusion of all family members in treatment whenever possible. Individual, marital and group therapy are used to support the family therapy process.

The primary objective of the program is ensuring the well-being of the child through preventing the recurrence of sexual abuse. To meet this objective, the program contends that incest is most effectively treated within the context of the family. Prior individual or group therapy is not seen as a mandatory prerequisite before family therapy can begin. Thus, victims and offenders, together with other family members, may be treated together from the onset of therapy. However, it should be emphasized that each family member is evaluated on an individual basis and this evaluation includes assessing the appropriate treatment modality(ies).

Treatment focuses on the vulnerability of the family to sexual abuse and seeks to strengthen the family by addressing these vulnerabilities (e.g. problems related to hierarchy, boundaries, patterns of communication, gender issues, family rules and family myths).

The FSATP grew out of the work of Larson and Maddock (1986) who suggested that sexually abusive behaviour could be broadly categorized as follows:

- Category I - affection exchange;
- Category II - erotic exchange;
- Category III - aggression exchange; and
- Category IV - expression of rage.

These categories, while sufficiently well defined to allow for the categorization of families, are not mutually exclusive and are seen as lying on a continuum.

Following an extensive assessment which includes the therapist's assessment and psychological testing, the families are conceptualized into one of the four categories depending upon the function which the sexual abuse appears to fill. The purpose for such categorization is that the strategic/systemic family therapy offered by the programme is viewed as more suitable with Categories I and II, somewhat less suitable with Category III, and not suitable with Category IV.

Therefore families assessed as belonging to Category IV are referred to other programmes. Such categorization also serves as a guide for treatment once a family has been accepted for treatment.

Philosophical Principals of the FSATP

1. Sexual abuse affects the entire nuclear family system and frequently the extended family network.

2. Sexual abuse is often associated with family disorganization or dysfunction.

3. The focus of treatment is to improve and strengthen appropriate family structure and functioning, with the hope of reducing the family's vulnerability to further sexual abuse.

4. The focus of treatment is on interactions between family members (i.e. context) rather than content.

5. When appropriate, victims of sexual abuse are helped to resolve the abuse in the context of the family.

6. Treatment is change and action oriented - thus emphasizing behaviour change.

7. In addition to family therapy, group and/or individual therapy are used to help all family members resolve the sexual abuse.

PROGRAMME OBJECTIVES (1991-92)

In addition to the underlying goals of offering effective treatment to the 30 families as discussed above, the specific objectives are:

1. To plan, offer, and evaluate additional group services for victims and non-offending spouses.

2. Programme evaluation. To re-write the programme evaluation component using the Programme Structure and Logic Model.

3. To increase the existing focus on maintaining and strengthening collaboration with Child Welfare staff.

4. Public information.

Ongoing Service Objectives

A. Child Protection. To ensure the safety and protection of the child by ensuring that sexual abuse does not occur again. Strengthening the family contributes in various ways toward ensuring that abuse will not happen again. However, in addition the individual needs of the victim are addressed and an atmosphere of safety is created so that the victim can discuss any worries about their safety with the therapist.

B. To help the offender take responsibility for the sexual abuse. The offender may not always be involved in therapy or may be in therapy with the child. However, when the offender is part of treatment the techniques of family therapy, peer group counselling, individual counselling, and education are used to help the offender realistically look at his actions.

C. Strengthening the family unit. The following nine specific objectives have been developed with specific activities connected to them to meet objective 440).

1. To establish an appropriate family structure.

2. To increase marital satisfaction.

3. To increase the self-esteem of family members.

4. To increase the family's coping mechanisms.

5. To establish effective communication.

6. To clarify family value systems with regard to sexual behaviour.

7. To clarify family myths with regard to gender issues.

8. To clarify family myths with regard to sexual development.

9. To assist the family throughout the court process.

PROGRAM DESCRIPTION

Once a treatment approach has been selected, the therapist coordinates all therapy for the family. On-going family meetings are provided throughout the course of treatment, even if family therapy is not the current treatment of choice.

Treatment is carried out on an outpatient basis, using the facilities at the Rockyview General Hospital. Inpatient facilities are available to the FSATP at both the Holy Cross Hospital and Rockyview General Hospital, should clients require short-term psychiatric treatment or medical

treatment.

The range of services offered include assessment, individual counselling, marital and family counselling, group treatment, and education.

Additional services may be developed by the programme to meet specific family needs. Clients may be referred outside the programme to groups offered through other community based programmes while they continue in treatment at FSATP.

Within the Hospital, it is the role of the prime therapist to coordinate treatment services for the client and/or family system. This is done to ensure that treatment goals and plans are being met and that clients are not referred to too many services at one time. The prime therapists also has a responsibility to liaise and communicate with Alberta Family and Social Services. The relationship between Child Welfare and FSATP staff is crucial. Programme staff must know they will have A.F.S.S. support regarding assessment and treatment. The family must clearly know that Child Welfare is the authority and is recommending treatment for the family.

FSATP staff provide practicums to students. Training in the FSATP's theoretical framework is provided to professional groups on a request basis.

The specific activities or techniques which back up the above objectives are presently being re-written by the programme under the organization of the Programme Structure and Logic Model.

EVALUATION

The purpose and methods used to evaluate the FSATP program are outlined below. The results and analysis have yet to compiled. For more information, the full program report is available from the above mentioned contact.

When appropriate, clients referred to the FSATP are initially assessed within the family context. Following the initial family session, the therapist arranges for psychological testing for all family members over the age of six. Once the psychological testing is completed, the therapist continues to assess the family, often by interviewing individual family members or dyads in order to complete as thorough an assessment as possible.

The therapist uses the results of their assessment with the results of the psychological testing to write the initial clinical assessment. When possible, the assessment attempts to address the following factors:

- ∇ description of disclosure duration and frequency
- ∇ nature of the sexual abuse

- ∇ family vulnerability to sexual abuse: preconditions, precipitator
- ∇ sexual abuse in family of origin
- ∇ personality factors for individual family members
- ∇ family systems factors: degree of coercion - adaptability, family structure, family style, family communication
- ∇ socio-environmental factors: attitudes towards male/female roles, tolerance towards sexuality/incest, behaviour in the community, stress, social isolation, opportunity factor, major life changes.
- ∇ reconditions for offender: motivation to abuse, overcoming internal inhibitions, overcoming external inhibitions, overcoming child's resistance.
- ∇ victim responses to event: behavioral responses, psychological responses, cognitive responses.

The purpose of the Pre- Treatment Assessment is two-fold. The first and primary purpose is clinical (e.g. assessing suitability of family for treatment at the FSATP; treatment planning). The second purpose is related to assessing treatment outcome. The FSATP carries out both pre- and post-treatment assessment.

Following the completion of all initial assessment sessions and the evaluation, the case is conferenced with all relevant program and community professionals and treatment decisions are made at this stage.

Termination is discussed with the family and other involved professionals before any formal termination process is set in motion. If agreement is reached, the family is asked to participate in post-treatment evaluation. The therapist writes a discharge report at the end of treatment.

An Evaluation of Service questionnaire is mailed to the family after termination in order to assess the client's perception of the usefulness of the program.

No follow-up procedures are in place at the present time although procedures envisaged for the future include an interview or a telephone call by the therapist after six months. Follow-up procedures are actively being developed at this point in time.

Program outcome is assessed in three ways:

1. Therapist evaluation as presented in the progress and discharge reports.
2. Client satisfaction as indicated by the client satisfaction form completed after termination.

3. Results of the psychological test battery which comprise the pre- and post-treatment evaluation.

In addition, the degree to which objectives of the program are achieved are measured separately, and will be described in a separate document, the Program Structure and Logic Model.