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DEVELOPMENT OF A SEXUAL ABUSE TRAINING CURRICULUM
FOR THE ADDICTION FIELD

by

MARY LOU JONES

A dissertation submitted to the Graduate Faculty in Social Welfare in partial fulfillment of the requirements for the degree of Doctor of Social Welfare, The City University of New York.

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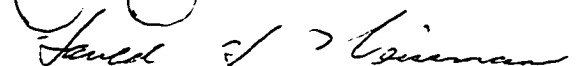
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This manuscript has been read and accepted for the Graduate Faculty in Social Welfare
in satisfaction of the dissertation requirement for the degree of Doctor of Social Welfare.

9/16/76
Date


Chair of Examining Committee

9/16/76
Date


Executive Officer


Irwin Epstein, D.S.W.

Virginia Strand, D.S.W.
Supervisory Committee

THE CITY UNIVERSITY OF NEW YORK

Abstract

DEVELOPMENT OF A SEXUAL ABUSE TRAINING CURRICULUM FOR THE ADDICTION FIELD

by

Mary Lou Jones

Adviser: Professor Gary Anderson

Social workers in a variety of capacities must identify, diagnose and treat survivors of sexual abuse. Today, many clinicians are becoming more aware that adults who seek treatment have a developmental history that includes both incest and addiction. The association between alcohol and drug abuse and child maltreatment is common in the literature. In addition, adults in treatment who were sexually abused as children frequently describe concurrent parental alcohol and drug abuse as well.

An additional problem for the helping professional, however, is that cases may not manifest themselves as sexual abuse, but rather, as other types of dysfunction, i.e., depression, suicide attempts, drug and alcohol abuse, etc. Yet the professional receives little or no training in sexual abuse; it is a specialty area and requires knowledge beyond that found in most professional schools and training programs.

In response to the lack of training in the addiction field, and to support the literature – which challenges professionals to implement training in the area of sexual abuse – this

investigator developed a model training program to respond to the special needs of social workers practicing within the alcohol and drug Service Delivery System of Nassau County.

The two-fold purpose of this study was to gather information about the Sexual Abuse Training Course from workers and their supervisors who participated in this training primarily through a qualitative research approach utilizing a standardized, open-ended interview guide. In addition, some quantitative data of pre-test/post-test results and a written evaluation were also used, so that a formal Sexual Abuse Training Curriculum was developed from the suggestions of the course members, for the addiction field. No information regarding such training existed previously in the literature.

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I would like to acknowledge, with great appreciation, the strong support I received from my brother, Bob Schiliro, who would have been so very proud of his little sister, the Doctor!

“You have to accept whatever comes and the only important thing is that you meet it with courage and with the best that you have to give.”

– Eleanor Roosevelt

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Chapter I: Introduction

Today, many clinicians are becoming more and more aware that adults who seek treatment have a developmental history that include both incest and addiction (Hurley, 1991). In many families, incest and/or addiction is multi-generational (Liles, 1986; Briere, 1992). Black (1981) presents research indicating that 26% of children in alcoholic homes have been incest victims. Deutsch (1982) states that at least 15 million American school age children are living with parental alcoholism. Thus, as many as three to four million children in this country may live in homes where both incest and chemical dependency exist. Herman (1981), observed that alcoholism is frequently observed in incestuous fathers. Groth (1979), stated that the father may drink in order to disclaim responsibility for the act. Whether viewed as cause or effect, alcohol and other drugs have a significant impact upon the incidence of incest. Alcohol and other sedatives do have a disinhibitory effect, thereby creating the risk of violent and/or sexually abusive behaviors. Liles (1984), asserts that in a sample of 170 father-figure perpetrators of father-daughter incest, 45% consumed alcohol prior to molestation, and 38% of this population were judged to be alcoholic.

Although the empirical data on the long-term effects of living in an alcohol/drug addictive environment is limited, the recent growth of Adult Children of Alcoholic groups, as well as a growing clinical interest in the problem of Adult Children of Alcoholics suggests that this is a significant form of child maltreatment in our society today. The association between alcohol/drug abuse and child maltreatment is most common in the literature. In addition, adults in treatment who were sexually abused as children frequently describe their maltreatment in the context of parental drunkenness or drug intoxication. (Briere, 1992). Parental substance abuse and concurrent sexual abuse may have both unique and overlapping negative impacts upon the child's current and future functioning. (Elliot, Edwards 1991).

Increasing evidence reveals a high correlation between a history of sexual abuse and the manifestation of addictive behavior. Studies have indicated that early sexual trauma may lead to alcohol problems in women (Nielsen, 1984; Kovach 1983; Young, 1990; Hurley, 1991; Briere, 1992). Covington (1986) points out that early sexual abuse appears to predispose women toward alcoholism. When asked about experiences with incest or rape, 12% to over 50% of alcoholic women stated that they experienced incest and other childhood sexual abuse, and up to 74% reported all types of sexual abuse combined (Russell 1983). More recently, Odyssey House, a well-established residential treatment program, has reported that 44% of its female addicts were sexually abused as children (Young, 1990; Winick, Levine & Stone, 1992).

While the bulk of research on the relationship between childhood incest experiences and the development of alcoholism has been primarily exploratory, there appears, however, to be significant evidence to suggest that childhood incest experience may be antecedent to the development of alcoholism in some women (Wilsnack, 1984; Young, 1990).

In addition, more recently, the NYS Division of Alcoholism and Alcohol Abuse analyzed available data and indicated that approximately 67% of the chemically dependent female treatment population, in a sample from the NYS Alcoholism service delivery system, experienced sexual abuse as children (Miller, Downs 1989). The association between addictive behaviors, such as alcoholism, other drug abuse and the incidence of childhood sexual abuse is increasingly being documented (Courtois 1988; Gil 1988; Finkelhor & Browne 1986). While more research is needed in order to clarify the complex relationship between alcohol abuse/drug abuse and incestuous behavior, the literature does suggest that we should explore both sets of behaviors when either abuse occurs. (Barnard, 1984; Jones, 1989; Barnard, 1990).

Purpose of the Study

While the literature does challenge professionals to develop programs and training strategies to work with this population, no new information, appropriate to the area of training treatment professionals to both incest and addiction dynamics and treatment interventions have emerged. (Barnard, 1984, 1990; Neilsen, 1984; Jones, 1989; Liles, 1987; Faller, 1988; Woodside, 1991; Graziano, 1992; Stevens, 1992). Therefore, in response to

the lack of training in the addiction field, and to support the literature which challenges professionals to implement training curricula, this investigator responded to the need for the development and implementation of a training model in the areas of incest and addiction. Thus, the purpose of this study was to gather information and data from those workers (and their supervisors) who experienced this training course through a qualitative, phenomenological approach; and to describe and analyze this data in order that the training course be modified and further developed, thereby contributing to a curriculum on Sexual Abuse Training for the Chemical Dependency field.

As an outcome of this evaluation, a curriculum for Sex Abuse Training in the chemical dependency field, suggested by the course participants' comments, emerged. A training curriculum was constructed for the chemical dependency field that reflected what was most effective, what works best for clinicians who work with incest victims within the addiction field. As a result of this study then, a contribution of a curriculum product for Sex Abuse Training will be made to the chemical dependency field.

Chapter 2: Literature Review and Related Knowledge

Purpose of the Review

The purpose of the literature review is to inform the study in ways which clarify major issues, ideas, make important connections between incest and addiction, and to further develop the rationale of the study. A review of the literature also focuses on knowledge that is relevant to the study's purpose and primary objectives, which was to evaluate an incest training course for Social Workers involved in the addictions field and who work within the Nassau County Department of Drug and Alcohol Service Delivery System.

Incest and Child Sexual Abuse

Actually, incest and child sexual abuse have emerged as one of the major forms of child abuse. As recently as a decade ago, it was regarded as a rather uncommon problem.

Incest is much more prevalent and appears to be a more common phenomenon than first believed. Exact figures are unavailable because this crime often goes unreported and legal definitions vary according to jurisdiction. However, according to Briere (1991), the prevalence of childhood sexual abuse in our society is very high. The sexual victimization rate is considered to be approximately 20% - 30% for females (Finkelhor, Hotelling, Lewis, Smith, 1989; Russell, 1986) and approximately 10% - 15% for males.

(Finkelhor, et al, 1989); although recent studies indicate that the male abuse rate may reach 20% in some non-clinical populations (Herschel, Briere, Magallenes, Smiljanick, 1990). These are alarming statistics!

Childhood sexual abuse may be defined as contacts or interactions between a child and an adult when the child is being used as an object of gratification for the adult's sexual needs (De Vine 1980). Sexual abuse of children by an adult is victimization that occurs within the power differential of a relationship between perpetrator and victim and thus an imbalance of power is fostered. When this contact happens within the family system (e.g., father, mother, brother, sister, cousin, stepfather), it is defined as incest. Childhood sexual abuse occurs on a continuum, from overt to covert. Overt sexual abuse involves actual sexual contact, while covert sexual abuse includes more subtle sexual behaviors, such as exhibitionism, sexualized language, and lack of appropriate privacy. It is a traumatic experience that interferes with the child's normal, healthy development. Childhood sexual abuse often happens outside the family system, i.e., close neighbor, teacher, babysitting and involves similar dynamics, such as denial, repetitiveness, betrayal and trauma. Therefore, for the purposes of this dissertation, the terms "incest" and "childhood sexual abuse" will be used interchangeably.

Incest is not a new phenomenon, although its true dimensions are emerging only through recent awareness and study as noted above. Children have been subject to molestation, exploitation and intimidation by supposed caretakers throughout history. What appears to

have changed the most in our present generation is the sensitivity to recognize, explore and identify blatant inequities in parenting and to discover that such inequities have a substantial impact on character development, personality integration and emotional well-being of the more deprived and mistreated children (Summit 1983).

Political Issues

Because incest is not a new issue, it needs to be addressed as to why our society has not paid attention to it until only recently. Sexual abuse as a social problem is unique in that the treatment of adult survivors is as much a focus for sexual abuse experts as the protection of young victims. Most often, child advocacy suffers in competition with adult interests, and, there has been, at best, an evolutionary rather than a revolutionary response within the clinical and judicial fields (Summit, 1983). In recent years, federal funding, which once ignored the problem, is now placing resources into the sexual abuse arena since awareness, education and advocacy efforts by grass root groups and professionals have rallied to its support (Briere, 1991).

In addition, in our society, incest is an act primarily committed by men (Finkelhor, 1982; Russell, 1986; Finkelhor & Browne, 1986; Sgroi, 1992). One thing that this does is to make incest a subject to which men and women have different reactions. Incest is an act that incriminates a particular sex -- a rather uncomfortable fact for men to deal with. It made it harder for them to work as enthusiastically on this problem and to avoid defensive responses to the (often female) victim. Since men, usually, occupy the most

powerful policy making positions, the gender of politics of sexual abuse can often hamper effective policies and public action around the problem. In addition, since more men tend to hold powerful policy making positions they tend to direct funds elsewhere than child sexual abuse (Finkelhor, 1982).

Also, the factor of secrecy surrounding incest and the emotional response generated by incest, has had a strong negative impact on research (Hurley, 1991). Consequently, researchers may be deterred from investigating a subject that evokes such strong emotional responses such as "repugnance, uneasy fascination, fear, guilt and anger." (Giaretto, 1976). Secrecy also compounds the consequences of incest on the survivor (Gelinas, 1983). As noted, secrecy surrounds sexual abuse which allows its reoccurrence and engenders shame in the child. Breaking this silence may be quite difficult since the child may have been threatened with extremely dire consequences for telling. Thus, the burden of living with stigma and shame fall heavy on the child.

When research efforts are made, many respondents are reluctant to acknowledge an incest history (Lowery, 1987; Meiselman, 1978) thus maintaining the secrecy; the incest survivor may seek professional therapy without mentioning the sexual abuse, particularly if no inquiry is made. Many therapists may be uncomfortable with incest disclosures and may unintentionally reinforce the "no talk" rule (Courtois, 1988).

Research Issues

Nonetheless, while the volume of literature on incest has grown considerably, the state of the art on incest research has been severely criticized (Briere, 1992; Briere and Runtz, 1987; Finkelhor, 1984). These criticisms fall primarily in two categories: inconsistencies relating to "operational" definitions of incest; and methodological limitations. While incest is identified as the most common type of sexual abuse (Finkelhor and Browne, 1986), it is also the most varying in definition. Incest definitions range from the very broad to the conservative (Briere 1992), with components of those definitions varying with regard to the type of sexual activity (physical vs. non-physical contact or psychological); the relationship of the perpetrator to the victim (father/step vs. other male relatives, older siblings, surrogate or adoptive relatives vs. blood relatives); and the degree of sexual contact (single vs. multiple incidents). The wide spectrum of incest definitions poses problems for the state of research on incest because findings from different studies are compared without accounting for the discrepancies in definitions. (Hurley 1991).

Similarly, with the interplay between incest and addiction, methodological limitations, which include failure to use large samples, to include adequate comparison groups, to employ objective measures and apply statistical data analysis, have precluded the development of effective conceptual models of child sexual abuse. Moreover, these limitations may retard future research efforts because they prevent study replications. (Hurley, 1991).

In addition, it is anticipated that this investigator's own study will include similar methodological limitations, as noted above, since qualitative studies are exploratory in nature (i.e. small samples, no comparison groups, etc.) and the findings tend not to be generalizable to the larger population.

Social Dynamics of Incest

Incest seems to flourish in certain kinds of circumstances. One of these is a high degree of family isolation. The isolation serves, in part, to keep neighbors and other social agencies from being aware of what is going on in the family. Sexual abuse also appears to reflect a social climate in families where privacy is never highly regarded, where the life of the family occurs far from the scrutiny of others (Finkelhor, 1982; Sgroi, 1992).

Incestuous families have also been noted for being highly patriarchal. It would be unfair to say that all incestuous fathers are of the dominant type, but a significant number are. Even the less dominant among the offenders do seem to share one of the assumptions of this patriarchal ideology -- that is, the father can do what he wants to his children and his own family without censure at the hands of society. While other indicators and factors need to be present to fully account for incest to occur, both social isolation and patriarchal family structures do seem to be sociological markers -- characteristics of a high risk for incest to occur; these markers do appear to play a major role in facilitating incest. (Finkelhor 1982; Finkelhor & Browne 1986).

While incest occurs in all social classes, racial and ethnic groups, the vast majority, probably over 90% never come to the attention of any social agency (Herman, 1981; Gonsiorvik, Bear, LeTourneau (1994). Rather, poor and disorganized families are over-represented among reported cases because they lack the resources to preserve secrecy (Gomez, 1992).

Incestuous families are not easily recognizable due to their conventional appearance. In most cases, the family structure represents a pathological exaggeration of generally accepted patriarchal norms. Fathers are often well respected in their communities and are described as "good providers." Often the wife is dependent upon him for economic survival. (Finkelhor, 1982; Sgroi, 1992).

Issues Related to Mothers in Incestuous Families

Working with the mother in the incestuous family can be both demanding and challenging for the clinician. Some attention has always focused on the mothers of incest victims by practitioners and researchers interested in the family dynamics of sexual abuse. However, the victim, as well as, the perpetrator have received much more attention. It appears that when the mother has been focused upon, it has been suggested that such dynamics were rooted in the mother's individual psychopathology in order to describe the interactional dynamics characteristic of the mother-child, mother-husband/partner or family relationships (Strand, 1991).

Kaufman, Peck and Tagiuri (1954) perceive the mother's behavior as non-protective and in some cases as contributing to the incestuous behavior. They also view the mother's own psychopathology as rooted in deprivation in her own family of origin. Meiselman (1978) also suggests the individual psychopathology of the mother. She describes the features of passivity, dependency and masochism as well as her inability to adequately sexually function as results of her psychopathology (Strand, 1991).

Sgroi (1984) described the interactional styles of mothers in her research. Common characteristics include the inability to trust, psychological absence, impaired self-image, denial, unrealistic expectations, impaired socialization and a lack of assertiveness.

Faller (1988) looked at the qualities of independence, nurturance and protectiveness as those that must be assessed at the time of disclosure so that a case plan be developed that would protect the child. According to Strand (1991), implicit in these criteria is that dependence, lack of an "appropriate and loving relationship," and failure to protect, are characteristics of the mother's attributes. Thus these characteristics must be evaluated before a child who has disclosed sexual abuse could be left with the mother.

However, those writing from the feminist perspective offer a different causal explanation. They perceive incest as rooted in a patriarchal arrangement of family life and of the relationships between men and women and the basic social inequality between the sexes which contribute to the implicit sanction of the father turning towards his daughter for

sexual gratification. Research reveals, however, that "no father is driven to incest for the lack of access to his spouse" (Herman, 1981, p. 43). The idea is that there are many families in which the mother may abdicate maternal responsibilities for a range of reasons including physical disability, mental illness, mental retardation or death, but that without the act of sexual abuse on the part of the offending parent, sexual abuse will not occur (Strand, 1990).

However, the mother has been traditionally seen as the one who must bear responsibility for the other parent's behavior since, unfortunately, "mother blaming" is a common characteristic of our society which affects mental health professionals as well (Strand, 1990).

Empirical research with the mother in the incest family has recently been able to offer information which challenges the idea of the collusive and non-protective mother (Strand, 1991). Sirles and Franke (1989), found that the majority of mothers from a treatment program believed their child's report of abuse. Pierce and Pierce (1991), indicated similar results in their sample which also was consistent with the Sirles and Franke study.

Both the feminist view and the emerging empirical research suggest an alternative perception of an understanding of the mother. Virginia Strand (1990, 1991), believes that the tendency to blame the mother has been measured against unrealistic standards. She states that, traditionally, the standard of mother as nurturer and protector reflects an

idealization of women. Subsequently, the inevitable devaluation of mothers when they do not live up to this idealized image accounts for the blame attributed to her. (Strand, 1991). Strand (1991) further discusses that the contribution of ego psychologists, object relations theorists and self-psychologists have failed to understand that women's psychological development is different from men, and has led to a failure to understand and articulate the psychological position of the mother in the incest family. Strand utilizes the Traumagenic Dynamic Model (a conceptual framework offered by Finkelhor and Browne (1985)) which provides a lens by which to view the mother's position more empathically.

Issues Related to Secrecy

The above statistics indicate that incest is a public mental health problem of major proportions and that only a small fraction of it has been detected by professionals. According to Hurley (1991), inherent in almost any discussion of incest in the literature is the common notion that incest is a "universal" taboo (Herman, 1981; Justice & Justice, 1979; Meiselman, 1978). Hurley (1991) further cites, however, that Armstrong (1978) posed an argument to the contrary. According to Armstrong, "incest is not truly a taboo; just a very, very long-lived, well-suppressed secret." Thus, the real taboo is not incest, but *talking* about incest. Hurley (1991) additionally cites Armstrong's contention that if it would be a true taboo, it would be a "true deterrent"; yet the degree to which the so-called taboo is violated in the U.S. alone is staggering.

Finkelhor (1979) conservatively estimated that one million American women have experienced incest. In a later study by Russell (1984), she reported data that suggests that Finkelhor's prevalence figures may be underestimated by as much as three million. The current literature suggests that in most population studies, female victims outnumber male victims, but a specific ratio is difficult to determine (Briere, 1992). Thus, the real taboo, perhaps, is not incest, but talking about the incest. The validity that incest historically has been couched in secrecy was also noted by other authors and researchers (Herman, 1981; Gelinas, 1983; Lowery, 1987).

Impact of Clinical Theories on Sexual Abuse

Through a review of the historical literature on incest Herman (1981), traces the origin of what she refers to as "a vastly elaborated intellectual tradition which served the purpose of suppressing the truth about incest" to Sigmund Freud. Herman (1981) noted that as early as 1896, Freud speculated in "The Aetiology of Hysteria," that sexual abuse in childhood might be a causal factor in the subsequent development of emotional problems in women. Herman further stated that, in spite of the fact that female patients offered numerous accounts of childhood incestuous incidents, initiated by fathers or other trusted male adults, Freud concluded that such disclosures must be fantasy. (Herman 1981).

It is interesting to note that two different psychoanalytic theories about the etiology of neurosis seem quite opposed to the other: one points to trauma, the other to conflict. Initially, Freud believed in "The Seduction Theory", according to which sexual trauma

would explain neurotic symptoms. When he discovered that psychic reality or fantasy could prevail over external reality, Freud postulated "The Conflict Theory" and apparently, gave up his earlier Seduction Theory. (Gonzarain and Buchele, 1988). It appears that with Freud's discovery of intrapsychic reality, the life of fantasy as a determinant of mental symptoms so struck him and so skewed the emphasis of his writings, as perhaps to obscure from readers the fact of actually occurring incest. At this time, in the late 1890's, a repressive society, most likely, would welcome this "misinformation". (Gonzarain and Buchele, 1988).

Other clinical theories have also created an impact on sexual abuse data and research. As a backlash to conservative Freudian theory, it is important to note that Feminism and the women's movement have opened up greater possibilities of realizing one's full potential as a human being. Feminists have challenged the inevitability of a patriarchal system that accepts the exploitation of smaller and more physically vulnerable individuals. They have explored ways of interrelating through cooperation and mutual respect rather than seeing violence and competition as the only means of resolving differences. There is little doubt that Feminism has forced our society to recognize the existence of incest. Feminists have championed this cause. (Lew 1988).

According to David Finkelhor (1982), sexual abuse has entered the public limelight not primarily because the true prevalence has increased, but because it had been championed by a coalition of groups who are well-experienced in promoting social problems,

specifically the women's movement and the children's protection movement. The turnaround for adult victims came with the landmark paper in the clinical literature during a time of protest led by the women's movement. "Rape Trauma Syndrome," by Burgess and Holmstrom, appeared in 1974. It provided guidelines for the recognition and management of the traumatic psychological issues as well as the establishment of a logical sequence to the victim's shame, self-blame and secrecy which so typically camouflaged the attack. Its publication initiated what proved to be a trend toward more sympathetic reception of rape victims both in clinics and in the courts (Summit, 1983).

The passage of the Child Abuse Prevention and Treatment Act, the establishment of the National Center on Child Abuse and Neglect, and the Women's Movement facilitated the process to bring incest to the forefront with researchers, authors and the general population.

The Trauma of Childhood Sexual Abuse and Its Treatment

Due to the decrease of secrecy surrounding incest, not only did the amount of literature on incest increase, but what emerged was a significant agreement shared by many researchers that the childhood incest experience could produce devastating effects on the victim, i.e., depression, promiscuity, self destructive behaviors including alcoholism and drug abuse (Harter, et al, 1988; Herman, et al, 1986; Lowery, 1987; Siegel, Romig, 1988, Hurley, 1991).

Child sexual abuse is a unique type of trauma with a number of characteristics predicting severity and type of aftereffect. The most salient of these are:

1. such abuse is often chronic, occurring over an extended period of time on a regular and frequent basis;
2. it often begins when the child is very young and also may continue through latency and adolescence;
3. it may include a variety of sexual behaviors that escalate and become more physically intrusive over its duration;
4. coercion and misrepresentation are used to perpetrate the abuse and the child's powerlessness and immaturity are used to gain compliance;
5. it most often is perpetrated by a relative or a trusted acquaintance who takes advantage of his or her access to the child and betrays their relationship;
6. it is often embedded within other forms of child abuse and family dysfunction; and
7. the child who reports the abuse is most likely not believed. (Finkelhor and Browne, 1985, Russell, 1986, Courtois, 1988).

Herman (1986), van der Kolk (1987) and, most recently Briere, (1991) have suggested that abuse aftereffects and psychological defense strategies can be so pervasive and can affect one's personality development to such a degree that the child and later the adult can be said to suffer from "walking post-traumatic stress disorder" (Courtois, 1988).

Beverly James (1990), an expert in the treatment of child victims, has suggested helping traumatized children to achieve mastery over their experiences so that early interventions in the treatment process at a young age will have a significant impact upon the child's integration of such experiences in adulthood.

In the last several years, the theoretical foundations and goals of therapy for survivors of child sexual abuse have been described (Bass and Davis, 1988), (Briere and Runtz, 1987; Courtois, 1988; Gil, 1988; Sgroi, 1989). A strong consensus exists among these authors about the most useful theoretical models and goals of treatment for this population. Courtois (1988), reviewed four theoretical models pertaining to the after-effects of incest and sexual abuse from which the above noted authors cumulative ideas and strategies derive. These models and approaches include traumatic stress/victimization, self-development, feminist and loss models. A number of conceptualizations of the goals, phases, tasks or stages of the therapy process have been suggested by Courtois (1988), Gil (1988), Herman (1990), Sgroi (1989) with a fair degree of consistency between them. These are summarized here to provide an overview of the treatment process. The prevailing perspective among clinicians is that individual assessment and treatment planning are essential. The individuality of response within the broader range of response patterns of survivors is well documented Finkelhor and Browne (1985) Russell (1986), Courtois (1988), Briere, 1991, Sgroi, 1992).

In general, the process of resolution therapy for child sexual abuse is of a long term rather than a short-term nature. Little outcome data on treatment effectiveness is yet available and some recommendations are based largely on clinical reports (Courtois, 1988), (Briere, 1991). Long-term treatment is seen as needed for the generally pervasive effects of abuse, the compounding of effects over time due to the absence of previous treatment and the complexities of post-traumatic responses. Because of the intensity of the affect inherent in trauma, uncovering must proceed at a pace that is tolerable to the client and that does not precipitate decompensation. Optimally, this step follows a period of time devoted to the stabilization of the client's life and defenses. Bass and Davis (1988) and Sgroi (1989) have described recovery as a spiral rather than a linear process, whereby the client is likely to go through one or more phases of perspectives in dealing with the abuse. Briefly, the therapy process can be thought to encompass the following goals, stages and issues: the decision to heal and make a commitment to treatment; the emergency stage - post-traumatic symptoms may appear but these reactions are seen as "normative" to the recovery process; memory retrieval - both memory and affect of the abuse are retrieved i.e., nightmares, flashbacks, memory fragments, perceptual disturbances, etc.; believing it was real; acceptance stage; recounting the abuse - breaking the secrecy of many years; resolving issues of responsibility, self-blame, and complicity; the recognition, labeling and expression of feelings; grieving; cognitive restructuring of distorted beliefs; disclosure, confrontation and other issues involving the perpetrator and others; and self-appreciation, self-determination and behavior change (Courtois, 1988).

Recovery can take place only within the context of relationships; it cannot occur in isolation. Group therapy for sexual abuse issues is especially useful in treatment (Courtois, 1988). The core experiences of psychological trauma are disempowerment and disconnection from others. In renewed connections through the group process, the survivor re-creates the psychological faculties that were deformed and damaged by the traumatic experience. These faculties include the capacities for trust, autonomy and intimacy (Herman, 1992).

Conducted slowly and carefully according to prescribed guidelines, this treatment has great potential to ameliorate symptoms of long duration and severity. The trauma is treated directly because trauma and its untreated effects are held to be the root of later distress and dysfunction. Following trauma resolution, other symptoms and difficulties become of the focus of treatment (Courtois, 1988).

Male Victims

While many of the issues and attitudes are shared equally by male and female survivors, male survivors may be captive of a certain cultural bias that places a peculiar twist on their recovery. Our culture champions their image of the decisive - take charge man; the man in control of his destiny. The man is seen as powerful, not powerless. Such a man is not a victim. Having grown up internalizing the image of this cultural hero model, male survivors of sexual abuse are often at odds with their own history and themselves. As a

result, a male victim of sexual abuse may deny or struggle with the reality of his victimization, which defines himself as unmanly, inadequate (Nice and Forrest, 1990).

Many of the issues raised by men who are survivors resemble those cited in the literature as common responses of women to sexual abuse. Issues related to each of the four traumagenic dynamics proposed by Finkelhor and Browne (1985) - stigmatization, betrayal, traumatic sexualization and powerlessness are also reported by men. Also like women, the men felt they were bad, worthless, different from those around them (Mendel, 1993). However, due to differences in the male and female socialization process, several other issues appear to be especially characteristic of male survivors: dissonance between the male role-expectation and the experience of victimization, as briefly, described above; shame and gender shame; and identification with the perpetrator and fear of continuing the cycle of abuse.

While shame related to sexual abuse is common to both male and female survivors, shame for men who were sexually abused experience an additional stratum which Dimock, Hunter and Struve (1991) call gender shame. As the term implies, this refers to a sense of shame about oneself as a member of the class "men." This "class shame" elicits profound ambivalence and confusion in terms of male survivors' identities as men and their identification with men; males perceive one's gender as loathsome which does not facilitate the development of a positive sense of self-esteem. (Mendel, 1993).

Perhaps the single most salient issue for the male survivor is the fear of perpetrating (Brucker and Johnson, 1987). There is a sense among male survivors that they are virtually fated to perpetrate the cycle of abuse. For numerous reasons, it does appear that men are more likely to gravitate to the perpetrator role rather than the victim role. Sources of this tendency include:

- male socialization as active and aggressive;
- a trend toward identification with the same-sex parent, thus perpetuating existing sex differences in rates of perpetration;
- the need to master trauma through identification with the aggressor and, thus, reassure oneself that one is not weak or helpless;
- the societal equation of males with oppressors and females with victims; and
- the lack of resources and outlets available to the male victims (Mendel, 1993).

Female Offenders

A review of the literature on sexual offenses against children committed by female offenders point out that relatively little research has been conducted (Groth, 1979), (Finkelhor, 1984), (Matthews 1989). Given that the majority of reported child molestations are committed by men (studies demonstrate approximately 80% - 95%) the issues of female offenders has been virtually ignored (Elliott, 1994).

The majority of publications and research on this topic have appeared since 1987. Consequently, the existing knowledge and data is somewhat preliminary and conflicting.

With respect to the incidence of female child molesters, the literature is problematic in terms of what constitutes sexual abuse by a female, underreporting, inconsistency and unrepresentative population samples are examples cited for some of these problems.

Matthews (1989) maintains that viewing females as perpetrators of sexual abuse, perhaps, parallels viewing males as victims and challenges traditional cultural stereotypes.

Females are thought of as mothers, nurturers, those who provide care for others, not people who harm or abuse them. Historically, females have been viewed as non-initiators, limit-setters, and anatomically, the receivers of sexuality; it is difficult for some to imagine a female sexually abusing others.

Other problems arise with regards to reporting sexual abuse offenses by females. Male victims are less likely to report being victimized by a woman due to societal norms that endorse and even glorify older women/young boy relationships and fantasies (Hunter, 1990).

Male Offenders

Generally, in order to safeguard children against sexual victimization, they are admonished to watch out for "strangers." For the most part, the child molester is not a stranger. The large majority are known, and often related, to their victims. Accordingly, no social or demographic characteristics were found to differentiate the child molester from the general population; not his race, religion, intelligence, education, vocation, socio-economic class, or the like (Groth, 1982, Salter, 1995). It is noted that child

molestation cuts across the whole spectrum of diagnostic categories and for the most part, it is not the mentally ill, but the emotionally troubled who are the sexual offenders.

Defects in their functioning are not cognitive, perceptual or emotional, but rather interpersonal. In most cases, the offenders have been themselves victims of physical, psychological or sexual abuse, which had precluded the development of a relatedness to others. It can also be noted that the abuse of drugs and alcohol play a role in this issue (Groth 1982).

One of the most basic observations that can be made about child offenders is that they are not all alike (Groth, 1982; Herman, 1990; Salter 1995). Herman (1990) agreed that, "The most striking characteristic of offenders from a diagnostic standpoint is their apparent normalcy." Increasingly, research and clinical experience both suggest that sexual offending is a highly compulsive and repetitive behavior. Typically, the offense for which an offender is caught is by no means his first assault (Salter, 1995). However, research confirms the fact that many sex offenders have no pathology discernible by generic psychological tests or clinical interview. The most chilling aspect of this behavior is its invisibility. Abel (et al 1987) set detection at 3%, Russell (1984) found only 5% of crimes were ever reported to police and fewer, than 1% resulted in arrests, convictions and imprisonment (Salter 1995).

Given the devastation wreaked by sexual assault, it is sadly ironic that something so malignant could be so silent. In part, this is due to the fact that offenders can be and often

are, well educated, highly respected members of their communities. Unfortunately, such legal cases often pit such "pillars of the community" against their victims.

Typology: Fixated vs. Regressed Offenders

While a basic observation is that all offenders are not alike, sexual offenders can be divided into two basic types on their level of socio-sexual maturation (Groth 1982). The Fixated Offender whose primary sexual orientation is towards children and the Regressed Offender, whose involvements with a child appear to be a departure under stress, from a primary orientation to peers.

Cross-generational sexual behavior, then, constitutes fixation towards children as a result of arrested socio-sexual development, or it may constitute a regression, the result of a sudden or progressive deterioration of emotionally meaningful or gratifying adult relationships. In general, fixated child molesters are drawn to male children, primarily, in that they identify with the child. They feel themselves more to be a child than an adult and find themselves more comfortable, sexually, with children than adults.

Regressed child molesters appear to turn to a child, sexually, as a substitute for their adult relationships which have become conflictual or emotionally unfulfilling. Since most such offenders are emotionally, primarily, invested in women in their adult relationships, they tend to target girls as their victims (Groth, 1982).

The psychological basis then of child molesting is feelings of inadequacy, immaturity, vulnerability, helplessness and isolation. Psychologically, the Fixated offender experiences himself as a child, whereas the Regressed offender experiences the child as a "pseudo-adult." (Groth, 1982).

Statistics are still not conclusive of what percent of victims later victimize; however, reports of offenders clearly point to the cause and effect relationship between these two experiences. There is considerable confirmation that many victimized children later victimize. This is particularly true of male victims. While there is increasing evidence, as noted above, that females do indeed perpetrate, the majority of offenders do appear to be male. Male victims more readily than female victims choose to take on the power behavior of the adult offender, which societally, is in keeping with the concept that males tend to act out aggressively (Mendel, 1995).

In order to combat sexual molestation of children, one of the crucial factors is the identification and treatment of the offender. There are four basic treatment modalities for the offender:

1. **Chemotherapy** - used to moderate sexual aggressiveness and enhance self-regulation.
2. **Behavior Modification** - Through a series of conditioning exercises based on learning principles, sexual arousal to children becomes diminished and sexual responsiveness to adults is enhanced.

3. **Psychotherapy** - This modality encompasses a wide range of approaches based upon interpersonal interaction and views the offending sexual behavior as symptomatic of emotional conflicts.
4. **Psychosocial education** - This modality views sexual offenses to be the products of defects in human development and attempts to remedy such defects through a combination of re-education, re-socialization and counselling.

As yet, no single method of treatment or type of therapeutic intervention has proved totally effective. It is very significant to note that to effect such treatment requires a multi-disciplinary team approach. Child molestation is a behavior that crosses legal, clinical and social boundaries and there must be close collaboration among all who play a role in the management of the offender - the clinician, the court, the probation officer, etc. (Groth, 1982). Outcome of sex offender treatment is not measured in terms of self-esteem or decreased personal distress, but rather reduced recidivism. The development of specialized treatment services for offenders has yielded far better results than the generic, insight-oriented therapy common ten years ago. These approaches appear promising but research and further evaluation is required (Salter, 1995).

Vicarious Traumatization

Mental health professionals who spend a significant proportion of their professional time doing therapy with, or studying people who have been victimized, are not immune to painful images, thoughts and feelings associated with exposure to their clients traumatic

memories. These reactions can occur as a short-term reaction to working with certain clients, as described in the literature on countertransference in work with victims (Danieli, 1981, Lindy 1988), or as a long-term alteration in the therapists's own cognitive ideas, beliefs, or expectations about self and others.

In the past two decades, mental health professionals have indicated a great interest in the psychological aftermath of victimization, (i.e., Figley, 1985, 1988, Van der Kolk 1987).

While much has been written on the psychological consequences of traumatic experiences for victims, less attention has been focused on the enduring psychological consequences for therapists working with those victims. Persons who work with victims may experience profound psychological effects that can be painful and disruptive for the therapist and can persist for months or years after work with traumatized persons. (McCann, Pearlman 1990). The process, of "vicarious traumatization," (McCann & Pearlman, 1990) is a significant concept for the therapist to understand for self-care.

Burnout

Working with victims has much in common with working with any difficult population, i.e., seriously ill, severe psychiatric problems, etc. Burnout refers to psychological strain of working with such populations. Working with victims may produce symptoms of burnout in professionals, i.e. depression, boredom, discouragement, etc.; but while the burnout literature is relevant to working with trauma victims, (Danieli, 1981), the potential effects of working with trauma survivors are distinct from those working with other

difficult populations, since the therapist is exposed to the emotionally shocking images of horror and suffering that are characteristic of serious traumas i.e., physical and sexual abuse (McCann & Pearlman, 1990).

Countertransference

The countertransference literature also provides additional background for understanding the concept of "vicarious traumatization." Countertransference literature usually refers to the activation of the therapist's own unresolved or unconscious conflicts or concerns.

Within the victimization literature, countertransference has more broadly incorporated painful feelings and thoughts that can accompany work with trauma victims.

The different literature parallels the two lines of thinking in the field of traumatic stress. which places different emphasis on whether characteristics of the stressor or the individual's personal characteristics determine their responses to trauma. That is, "burnout" literature parallels the focus on the stressor in that it suggests that the therapist is distressed due to the nature of the external event; and the countertransference literature parallels the focus on personal characteristics, whereby it explains the individual responses as a function of one's unresolved psychological issues.

McCann and Pearlman's (1990) view is that the therapists's unique responses to client material is shaped by both characteristics of the situation and the therapist's unique psychological needs. Vicarious traumatization is broader than countertransference as it

implies that the therapist's cognitive world will be altered by dealing with traumatic material. All therapists working with trauma will experience lasting effects on their cognition, having a significant impact on the therapists's feelings, relationships and life. As a result, therapists may experience PTSD symptoms themselves, including intrusive thoughts, images and painful reactions. The therapist must acknowledge, express and work through these painful experiences in a supportive environment, such as a support group, etc., learning appropriate self care.

This process is essential if therapists are to ameliorate the damaging effects of their work with victims. If these issues are not resolved, there is a risk that the therapist may numb one's feelings or become emotionally distant, thus being unable to maintain an empathic and responsive relationship with clients.

Curriculum Development

As previously noted, as a response to the lack of incest training in the addiction field and to support the literature which challenges professionals to implement training (Barnard, 1984; Nielsen, 1984; Jones, 1989; Liles 1986, Faller, 1988; Woodside, 1991; Briere, 1991; and Graziano 1992), a model training curriculum was developed, after the data of this study was analyzed, to respond to the special needs of social workers practicing in the addiction field.

In terms of curriculum building, the content must include the knowledge base, i.e., theory, research and practice wisdom. It must also include the practice skills, i.e., exploration and data gathering, differential assessment and differential planning, intervention and evaluation (CSWE, 1982). As with all well-functioning systems, a program is a transacting system in which each component is purposely related to all others. As in curriculum development then, the overall goal is to ensure that all components are adequately related to each other. The goals of curriculum development imply the content of the course to be addressed (Ewalt, 1983).

While it is essential that all professional social workers have in common knowledge, values and skills that are generally transferrable from one setting, population group, geographic area or problem to another, it is also essential that advanced professional social work practitioners have the special knowledge and skills appropriate to a specific role, field practice, population or problem area (CSWE, 1982).

Among the values and principles that guide social workers in their practice, and should manifest throughout every curriculum, are the professional principles and values within the quality of their practice. In addition, maintaining continuous growth in the knowledge and skills of their profession through continuing education is also essential (CSWE, 1982).

Administrators and program directors continue to be challenged by the question of whether or not training is effective. Formative evaluations can be very useful in both the planning and implementation stages of short-term educational programs (Fellin, 1994). Evaluations of the educational offerings were used to relate program content to the expressed needs of the course members through the various tools utilized for program evaluation – written evaluations and interviews. These types of evaluations are viewed as especially useful for ongoing program and development and curriculum building. In particular, formative evaluations contribute to the refinement of continuing education programs by assessing the teaching efforts during the implementation of the education programs.

The overall goal of the training curriculum is to increase the worker's knowledge and skills related to incest and sexual abuse with the chemically dependent client and to stimulate and facilitate the application and integration of knowledge and skills into professional practice (Fellin, 1994).

The Correlation Between a History of Childhood Sexual Abuse and Addiction

Recently, research efforts have been conducted to better understand the incidence of childhood sexual abuse in the history of addiction (Wilsnack, 1984). The following section reviews the fragmentary knowledge that exists on the addicted survivor. There are occasional references in the clinical anecdotal literature on incest to the relationship between the childhood sexual abuse experience and alcohol/drug abuse. (Armstrong,

1978; Forward & Buck, 1978; Herman, 1981). Wilsnack (1984), suggests that childhood sexual abuse may be a rather prevalent experience among the addictions and that the gap in the literature is most likely due to a failure on the part of the researchers and professionals to ask questions that were previously considered too sensitive. Since it has been only recently that researchers and professionals have begun to ask the "sensitive questions," the information which does exist on addiction and sexual abuse continue to be sparse (Hurley, 1991).

While the concept of traumatic stress plays a significant role in the diagnosis of incest survivors, the developmental framework within which the victimization has occurred may be overlooked. (Graziano, 1992). According to Graziano (1992), as well as another study by Donaldson and Gardner (1985), the survivors of childhood sexual abuse may also bring with them more than the symptoms of PTSD which tends to be the primary diagnosis that is utilized for these clients. In many cases, they also carry a legacy of early physical and emotional abuse, neglect, and family violence which also affected their early development. Consequently the incest survivor may appear not necessarily for outpatient therapy related to the abuse, but in a variety of inpatient and outpatient settings which also include substance abuse programs. As a result, workers in most settings are now often faced with the task of recognizing and dealing with the symptoms of sexual abuse even though the survivor does not overtly identify or recognize them. However, if workers are sensitized to the sexual abuse issues their clients are struggling with, either referrals can be made to appropriate sources after focused short-term treatment, or new

resources, such as support groups can be made available within a variety of agency settings. Therefore, additional training for workers in this area is required to treat these issues. (Graziano, 1992).

One of the earliest pieces of research in the area of incest, identified chronic alcoholism or at least "drunken comportment" as a primary variable in the incestuous family member (Marcuse, 1923, cited in Barnard, 1984). Since this fundamental work, others have established the connections between alcoholism and incest (Black, 1981, Deutsch, 1982; Herman 1981; Liles, 1986; Lustig, 1966, cited in Liles, 1986; Meiselman, 1978).

More recently, many studies also report a concurrence between childhood sexual abuse and alcohol abuse in women. (Miller, et. al., 1989; Roksenow, et al, 1988; Sullivan, 1988; Evans and Schaefer, 1987; Kovach, 1986; Ludwig, 1989). In addition, studies also indicate unresolved trauma issues, such as sexual abuse, to be a factor in male chemical abuse as well (Schaefer and Evans, 1989).

While it would be unlikely to assert that all families with an adult alcoholic will be found to be incestuous or that all incestuous families will have an adult alcoholic, clinical experiences does suggest that these two problems frequently co-exist.

Actually, increasing evidence reveals a high correlation between a history of childhood sexual abuse and addiction. For example, Kovack (1983) and Nielsen (1984) studied

alcohol and drug problems in women and indicated that early sexual trauma may lead to alcohol and drug problems later on in life. In a review of the sexuality of female alcoholics, Covington (1986) related that early sexual abuse experiences appears to pre-dispose women toward alcoholism. When asked about incest or rape experiences, 12% to over 50% of alcoholic females stated that they experienced childhood sexual abuse; and up to 74% reported all types of sexual abuse combined (Russell, 1983). The strength of this potential association are the findings of Breiere and Runtz (1987) that sexually abused female crisis center clients had ten times the likelihood of an addiction history than a comparison group of female crisis clients who had not been sexually abused as children. More recent studies also cite sexual abuse as being linked to later substance abuse in a variety of studies (Roksenow, Corbett and DeVine, 1988); (Briere and Woo, 1991).

Practically every major study available on incest characterizes incest as a symptom of dysfunctional systems (Herman, 1981; Meiselman, 1978); Browning and Boatman, 1977). Dysfunctional features within the incestuous family system fall into three general categories: alcoholism and addiction; in one or both parents (usually the father or stepfather); physical, mental or emotional disability in the mother, and the unnatural role of wife-mother of the victim within the family unit. Moreover, the mother's emotional and/or physical absence as well as the father's alcoholism dramatically contribute to the unnatural role of surrogate wife-mother either forced upon or assumed by the incest victim (Herman, 1981).

Furthermore, a strong relationship between self-destructive behaviors, e.g., alcohol/drug abuse and childhood sexual abuse among adults had been described (Gil, 1988; Miller, 1987). Bass and Davis (1988), experts in the field of incest recovery, stated that addictions are a common way of coping with the pain of sexual abuse. Often alcohol and drugs are used to numb feelings and suppress memories. Thus the emergence of these childhood memories may become a high risk precipitating factor for relapse.

The Correlation Between Childhood Sexual Abuse and Relapse

As previously stated, addressing the issue of childhood sexual abuse is essential for effective treatment of the addicted survivor. (Covington, 1986; Schaefer and Evans, 1989; Young, 1990). The literature establishes the positive correlation between addiction and childhood sexual abuse. Traditionally, relapse issues have been addressed in the addiction treatment field. However, with childhood sexual abuse as a possible predisposing factor to relapse, the literature has only just recently begun to explore and identify this area in the field. (Schaefer and Evans, 1989; Root, 1989; Young, 1990; Hurley, 1991). Classic theories of dependence and current theories of relapse prevention have not addressed the high potential for relapse associated with internally generated phenomena such as the effects of early childhood sexual abuse (Young, 1990). Therefore, with the advent of these ideas - that childhood sexual abuse issues are a possible relapse trigger - the Addictions field only has recently accepted sexual abuse within the realm of their treatment responsibility. Prior to this time, sexual abuse treatment was under the purview of the mental health field. However, the literature search has yielded few articles

which actually offer treatment strategies when working with sexual abuse victims who are also drug and alcohol addicted (Skorina and Kovack, 1986; Schaefer and Evans, 1989; Young, 1990).

Actually, while the literature challenges professionals to develop programs and training strategies to treat this population, no new information in the literature, appropriate to the area of training treatment professionals to both the addiction and incest issue have emerged.

It is important to note that the specific area of expertise which the professional develops during the course of training often dictates the manner in which he or she diagnoses and treats the problem. Alcohol and drug-trained professionals will diagnose and treat chemical dependency while clinicians familiar with incest tend to more quickly diagnose and treat that problem. Once the similarities and relationship between these two areas are brought into our conscious and diagnostic awareness, both phenomena can be appropriately diagnosed and treatment efforts implemented.

The scope of the problem is significant in that it affects a large part of the population. As noted above, a conservative estimate is that 25% of females and 10% of males will be sexually abused in their lifetime (Russell, 1984). According to Briere (1991) the prevalence of childhood sexual abuse in our society is very high. The sexual victimization rate is considered to be approximately 20% to 30% for females (Finkelhor, Hoteling, Lewis and

Smith, 1989); and approximately 10% - 15% for males (Finkelhor et al, 1989); although recent studies indicate that the male sexual abuse rate may reach 20% in some non-clinical populations. (Herschel, Briere, Magellones, Smiljanik, 1990). The estimates increase dramatically to 40% - 70% for the women in chemically dependent treatment populations. (Nielson, 1984; Young, 1991).

Despite the fact that addiction treatment programs frequently encounter incest and that mental health programs frequently deal with chemical dependency, service providers often have little understanding of each other's fields, as noted above. Due to stigma, denial and the fact that the workers have not been trained to ask about incest/chemical dependency issues, either the drug/alcohol or incest issues are often left undetected or untreated. Due to the high rates of recidivism among the drug and alcohol addicted population, it has become generally accepted in the field that, perhaps, incest issues may be a major source of relapse in this population. Actually, as noted above, the association between drug and alcohol addiction and the incidence of childhood sexual abuse is increasingly being documented in the literature (Courtois, 1988; Gil, 1988, Young, 1990; Hurley, 1991; Briere, 1991; Graziano, 1992).

Young (1990) states: " One of the greatest unacknowledged contributors to recidivism in alcoholism and other addictions may be the failure to identify and treat underlying childhood sexual abuse issues." Other addiction specialists have also suggested that

untreated trauma issues, i.e., sexual abuse, may be an unrecognized but primary issue in recidivism. (Root, 1989).

The need for this study was determined by a literature review, exploration of current knowledge and the investigator's experience in the field. In addition to a search of the literature in relation to incest, childhood sexual abuse, addiction and sexual abuse, relapse issues in addiction, the investigator personally contacted the National Clearinghouse for Alcohol and Drug Information, located in Rockville, Maryland, as well as the National Resource Center on Child Sexual Abuse of the National Center on Child Abuse and Neglect, located in Huntsville Alabama, to determine whether actual training materials, manuals, etc. were published for training social workers in this critical area. Actually, the National Resource Center on Child Sexual Abuse provides accurate and timely information critical to the practice, policy and program decisions which must be made by mental health professionals in their work. It is to be noted that the National Resource Center has created a nationally, highly acclaimed training program which provides experienced professionals the most up-to-date empirical knowledge, skills, tools, techniques and strategies to intervene effectively with the sexually abused family system. This program has been in operation for about two years, but, according to its Director, Ethel Amacher, CSW, no articles or critical evaluations have as yet been written or published on these training programs. (It is also to be noted that when questioned as to the inclusion of information regarding addiction in their training curriculum, the response was that addiction issues were not included despite the positive correlation between the

two issues. As a result of this investigator's discussion with The Center's training coordinator, Ms. Shari Long, it was agreed that the issue of addressing both sexual abuse and addiction was, indeed, important and that this issue will be placed on the agenda for the Training Board to discuss. Perhaps, if agreed upon, addiction issues and related information can be added to their training program). Likewise, no published articles or training information exists in relation to incest training or childhood sexual abuse in the addiction field as offered by the National Clearinghouse for Alcohol and Drug Information as this is such a new area of inquiry.

Related Information on Continuing Education

A review of the literature in this area focused on knowledge which was also relevant to the study's purpose and primary objectives. For the study's objective of evaluating an incest training model which was designed by the investigator to respond to the special needs of social workers practicing in the drug and alcohol service delivery field, knowledge related to training in drug and alcohol, and the current information on continuing education for the professional social worker, was also explored since it appeared to be closely related to this study.

Continuing education includes any planned, educationally sound experience that encompasses, but is not limited to, post university courses, staff development service training, self-study and peer consultation and supervision (Roat, 1989). While there is no consensus on the definition of continuing education, the above-generic, holistic definition

essentially agrees with definitions expressed by various researchers (Faherty, 1979, Gibelman and Humphyreys, 1979).

Thus, the areas of the literature search reviewed as pertinent to the study's purpose are related to the special needs and interests of the social worker and the current status of social worker training in the field of practice. Results indicated a perceived need for continuing education among social workers to enhance professional performance (Roat, 1988). For nearly two decades, Social Work has "championed" continuing education for its professionals. It has promoted education opportunities through its professional associations, social agencies, etc. Continuing education has become synonymous with maintenance of professional competence and an update of critical new knowledge.

However, continuing education also promotes the personal evolution of the learner - our "evolving self," (Karpiak, 1992) - and most significantly, broadens our personal vision of social responsibility (Karpiak 1992). Perceived in this way, continuing education becomes a lifelong activity, evolving and changing in its process as it "interweaves" with the changing and evolving self (Karpiak 1992).

The idea of the "teachable moment" was first introduced by Havighurst (1972). Teachable moments come about during periods of personal or professional tension and crises. These moments are viewed by Havinghurst as an opportunity to develop new levels of professional knowing progressing to greater integration and wholeness.

A "teachable moment" often arises when the worker becomes aware there is more to know - another way of viewing an issue or doing something different (Karpiak, 1992).

"...with professional work, this 'teachable moment', this level of knowing, is predominantly rational, conceptual and conscious. It represents a desire to become more aware of what one is doing or not doing. Formal continuing education courses, generally taught by knowledgeable practitioners, provide theoretical material that workers expect to apply later to their practice situations" (Karpiak, 1992).

However, unless students recognize their own barriers to the learning experience, they will be unable to be receptive to alternatives as posed to them in the educational process (Lewis, 1991). By constructing innovative, experiential material for the adult learner, it is believed the learning process is enhanced since the effects and design is effective in creating approaches to facilitate the session's learning objectives (Rothman, 1973).

Questions and answers are encouraged so that dialog between the teaching and learning process can occur. In addition, however, certain facts, situations, theories and events must also be part of the student's "equipment" by which to enter into fruitful discussions (Perlman, 1951).

Characteristics of the Adult Professional Learner

What Works Best: Strategies/Methods and Consequences

In relation to learner needs and capacities, it is critical to understand the adult learner as postulated by Malcolm Knowles (1986), under the concept of *andragogy*, the practice of

helping adults to learn. The experienced practitioner, is less apt to reveal difficulties he/she encounters due to his/her perception of his/herself as an advanced professional. The experienced professional is averse to exposing self to learning if it involves, as its main objectives, critical analysis of his/her own work. Rather, the experienced learner prefers to enter the educational arena in the belief that he/she will be exposed to the new knowledge or new skills not usually acquired through normal channels of professional preparation (Rothman, 1973). The advanced professional tends to be more comfortable in approaching the learning if the object of learning is to change circumstances external to themselves, i.e., changing the service delivery system, or practice procedures in those systems (Rothman, 1973).

Therefore, a significant and helpful strategy utilized in the incest training for the Social Workers is to inform them that since incest is such a "new" area in addiction treatment, the Social Workers are considered to be "pioneers" in an expanding field. In addition, due to this training, they will possess advanced educational skills and knowledge to implement innovative practice procedures, thus increasing their repertoire of treatment strategies to create new treatment modalities for their addicted clients who are incest survivors. Thus, they can have a positive impact and effect changes to facilitate client recovery and, ultimately, effect a change in the alcohol and drug service delivery system in Nassau County.

This strategy satisfies a sense of personal achievement since one of the many roles of being a Social Worker in our profession is that of a "change agent," and thus can have an impact on treatment outcome, as well as influence a positive change in the System. This sense of achievement then fosters a feeling of personal reward and enhanced professional development (McKeachie, 1986).

A primary issue at most levels of education is whether objectives are to be based on the needs and interests of students or the content to be mastered. In the area of continuing educational objectives with the adult learner, the objectives are primarily viewed as being student-centered. Mutual engagement in determining educational objectives sets apart continuing education from other forms of Social Work education. While one purpose of continuing education is to emphasize the learning aspect as it relates to updating knowledge, the improvement of skills as well as creativity in practice, continuing education is also seen as a primary means of contributing directly to changing institutions and organizations (Rothman, 1973). Thus, educational objectives also now pertain to the learner as target or instrument of change.

In terms of teaching methods with experienced practitioners, a variety of modes are used which include the classic academic lecture, as well as more experiential style exercises since advanced practitioners form a heterogeneous group of learning preferences (Rushton, Martyn, 1990). By constructing innovative, experiential methods for the adult learner, i.e., use of films, media, desensitization exercises, i.e., rank order value

clarifications related to sexuality and sexual abuse, the learning process becomes enhanced. Thus, creative approaches facilitate the professional adult learner's interest and enthusiasm. (Rothman, 1973). The purpose of these methods is to allow the student to experience their own attitudes, prejudices and beliefs so that they are not acted upon inappropriately in their counselling sessions with sexually abused clients. In working with such emotionally-charged issues as sexual abuse, a pre-requisite for the professional dealing with this problem is to deal with one's own emotional reaction to such cases and material. Many people are not comfortable with their own sexuality, nor the sexuality of others. Professionals are also not immune to these difficulties. As long as professionals cannot name the problem, read about it, listen to victims and talk to them about what has happened, how can we expect to help them? (Faller, 1988).

The advanced professional desires to perceive the teacher as "the expert" and does not like to critically analyze his/her own work; and, as noted, enjoys the challenge of being able to change circumstances external to themselves, i.e., procedures, systems, clinical structure. (Rothman, 1973). In addition, the concept of mutual assistance, well known to Social Workers, is readily transferable to the learning situation. The concept of mutual assistance implies that group members must perceive their likenesses and differences and that reciprocity becomes a valued group norm.

Another method for the incest training course this investigator incorporated was a 45-minute to one hour group process piece into each three-hour session. This method

served the purpose of mutual aid, in order to facilitate questions, thoughts, feelings, ideas and problems related to the sexual abuse issue that the workers may be experiencing.

Karpiak (1992) discusses the concept of the "evolving self" and personal as well as professional knowing. Personal knowing is "whole person knowing," it is integrative and self-conscious. In Social Work practice, personal knowing finds expression in artistry and craftsmanship. Workers who move to this level of knowing are more capable than ever before of making significant contributions through teaching, supervision, socio-political action and community work (Karpiak, 1992).

It is hoped that through lecture, discussion, film, experiential exercises, as well as, mutual aid (process group), these tools will become resources for the advanced professional workers to share their experiences, feelings and insights with their colleagues and that "knowing" will become integrative.

In addition, learning, perhaps, will be also enhanced through the vehicle of the student-teacher relationship. Through the practice of andragogy, the adult learner and experienced worker is respected for what they offer the profession. Like the Social Worker, the educator must assume multiple roles. In addition to "expert," "authority figure," "socializing agent", "facilitator," and "ego ideal" (all appropriate teaching roles), the teacher as "person," and the appropriate "use" of self cannot be neglected (Rothman, 1973).

As a result, a "collegial" rather than a "subordinate" relationship is experienced by the professional which will encourage the learning through a mutually validating relationship (Skolnick, 1991).

Summary

Social Workers in a variety of capacities must identify, diagnose and treat situations of sexual abuse. Mental health professionals are seeing adults who have been victims of sexual abuse as children. An additional challenge, however, to the helping professional is that cases may not manifest themselves as sexual abuse, but rather, as other kinds of dysfunction. Among the various presenting problems – drug and alcohol abuse, depression, suicide attempts, etc. – these may all be sequelae of sexual abuse (Faller, 1988). Yet, the helping professional receives little training in sexual abuse; it is not ordinarily taught in schools of social work or psychology graduate programs. Sexual abuse is a specialty area and requires knowledge beyond that found in most professional training programs (Faller, 1988).

In response, therefore, to the lack of incest training in the addiction field, and to support the literature which challenges professionals to implement training (Barnard, 1984, 1986; Neilsen, 1984; Jones, 1986; Liles, 1987, Faller, 1988; Woodside, 1991; Briere, 1991, Graziano, 1992) as well as the encouragement of the administration of the Nassau County Department of Drug and Alcohol Addiction, this investigator developed a model training program to respond to the special needs of social workers participating in practice in their

respective addiction treatment agencies throughout the Nassau County Department of Drug and Alcohol Service Delivery System.

In the absence of a single theoretical base for training programs, this model integrated the current status of incest knowledge and current addiction knowledge, as well as my own expertise, to form the basis of the course structure.

Thus, the twofold purpose of this study was to gather information about the course from those workers, and their supervisors, who experienced this training through, primarily, a qualitative approach of using a standardized, open-ended interview guide, but also utilizing some quantitative data of the written evaluations and pre- and post-test results of the course members, to create and develop a Sexual Abuse Training curriculum for the addiction field. No information about such training existed previously in the literature.

Chapter 3: Research Methodology

Course Description

The purpose of the course, in general, is to train social workers with at least two to three years of experience in the addiction field, in recognizing symptoms, and learning family and personal dynamics; also to facilitate the development of treatment skills through exposure to incest treatment theories in order to treat the effects of incest on their addicted client population.

The "original" curriculum, prior to the course evaluation, included the following objectives:

- a. to "desensitize" the emotionally charged issue of child sexual abuse through the exploration of emotional reactions to film and experiential exercises; to increase understanding of the scope of the sexual abuse issue through demographics and statistics, as well as to enhance the understanding of incest dynamics through a course overview;
- b. to understand the impact of incest as an intergenerational family problem, as well as within a family-centered perspective of the chemically dependent family system; to identify the similarities in family dynamics of the incestuous and

- alcohol/drug abusing families; to increase the psychological and psychosocial profiles of family members, including the offender, within the chemically dependent incestuous family;
- c. to identify the behavioral and emotional manifestations of sexual abuse; to introduce and understand a conceptual framework for understanding the psychological impact of incest victimization utilizing Suzanne Sgroi's Sexual Abuse Syndrome Model – Engagement phase, Sexual Interaction phase, Secrecy phase, Disclosure phase, Suppression phase – which provides further understanding of the process of victimization;
 - d. to introduce and understand the Traumagenic Model as developed by David Finkelhor, Ph.D., for understanding the implications for treatment of the chemically dependent sexual abuse survivor (i.e., traumatic sexualization, betrayal, stigma and powerlessness); to demonstrate that the model can be used in the assessment and treatment of the chemically dependent sexual abuse survivor;
 - e. to consider the unique experiences of both male and female incest victims and how their experience culturally impacts upon each gender;
 - f. to introduce different treatment strategies, i.e., the techniques and modalities for treatment interventions with the chemically dependent survivor, as formulated, for example, by Eliana Gil, Ph.D.;
 - g. to introduce different treatment strategies, i.e., the techniques and modalities for treatment interventions with the chemically dependent survivor, as formulated, for example, by Suzanane Sgroi, M.D.

Briefly, the changes which were made as suggested by the course members in their evaluations (and these will be discussed in more depth in Chapter 4) included the modifications of:

- creating an entire session devoted to offenders, including treatment strategies;
- a case scenario of a role-play with a sexually abused chemically dependent client;
- a case presentation and various case examples infused throughout the curriculum.

Thus, the above listing of objectives was modified to reflect these changes – specifically, objectives e., f, and g. – as will be noted in Chapter 4. It is to be noted that approximately ten classical articles, as well as current "state of the art" articles, are distributed to the Social Workers for their study and reference.

The architectural function in designing a program for continuing education of advanced professionals, consisted of selecting a combination of learning formats that would most effectively accomplish the program's objectives. Most organized learning takes place in groups since efficiency of operation in dealing with people in collectives as well as the utilization of their rich resources and motivations for learning is provided in a group format (Knowles, 1986). The scheduling of the 21 hour course, every other week, over a 2 1/2 month period was specifically planned to take into account the emotionally charged nature of the course content (which can be overwhelming to even a seasoned clinician) and the educationally sound idea that better learning takes place over time (Knowles, 1986).

As noted, each session was conducted for a three hour period. After approximately 1½ to 1¾ hours, a 15-minute coffee break was taken; the group re-convened for approximately 45 minutes to one hour in a "circle format" to "debrief." Discussion dealing with thoughts, feelings, problems with practice, etc. related to the material presented was encouraged so that the learning process could be better integrated. The course content reflected an intermediate level of knowledge offered, including an overview of incest dynamics involved in the chemically addicted family system, as well as strategies to identify , intervene and treat the incest survivor in the chemically addicted population.

Appropriate consideration was given to the time and work constraints of the Social Workers who participated in the course, as well as the issues related to the financial resources available to the funding source.

As a result of accomplishing these learning goals, the student will be able to demonstrate:

- a. an ability to formulate an assessment that explicitly takes into account the physical, psychological, social, cultural and legal aspects of the dynamics involved in the chemically dependent incestuous family system so that effective treatment can take place.
- b. develop appropriate treatment plans for the incest victim and implement various specialized skills and techniques to effectively treat the individual to deal with both incest and addiction issues so as to minimize relapse episodes.

Project Goals and Objectives

The purpose of this study is exploratory: it attempts to gain information on how a sexual abuse training course developed by this investigator has impacted on workers in the field of addiction, especially since the literature search indicates that no information exists on sexual abuse training in the addiction field.

The objectives and goals of this project, respectively, are to examine and explore the opinions, experiences and feelings of both former course members and agency supervisors about the nature and value of the incest training course this investigator conducted in the Fall of 1993 and again, in the Fall of 1994. To better understand the experiences and perspectives gained by the Social Worker practitioners who participated in the incest training course, as well as their supervisors, this study seeks to assess and improve the development of future incest training programs within the Nassau County Alcohol and Drug Service Delivery System, as well as to contribute a training model to the field of addiction for those who are working with incest survivors.

It is quite significant to indicate that the main contribution of this work was curriculum construction of a Sexual Abuse Training Program for the addiction field. The crafting and development of this curriculum product thus became the study's focus and primary purpose.

Type of Study

A qualitative research project was conducted. As noted above, the purpose of this research project was to better understand the experiences and perspectives of the Social Work practitioners who attended the incest training program, as well as their supervisors, for the purpose of a program evaluation. Program evaluations assist us in answering critical questions about human service programs. These programs are planned to achieve certain outcomes. When one wants to assess the program's usefulness in achieving certain results, it is important to know: What is the impact of the program? Is the program efficient in achieving certain goals? Are the program results clearly related to the program's impact (Smith, 1990)? Based upon this program evaluation, improvements in the training program were implemented, so that what is most effective would be further developed and contributed to the field of addiction for training, so that those workers who are dealing with clients who are also incest survivors will be better prepared to work with this population.

Since qualitative and quantitative methods involve different strengths and weaknesses, they represent alternatives and are not mutually exclusive strategies for research.

However, qualitative designs permit the researcher to study selected issues in depth and detail. The formative approach of this design focuses on a specific context and serves the purpose of improving a specific program, policy or product. Formative approaches often rely primarily on qualitative methods. (Patton, 1990).

In terms of a research study, I have selected a phenomenological approach.

Phenomenological inquiry focuses on the question, "What is the structure and essence of experience of the phenomena for these people." The phenomena being experienced may be emotions, a relationship, an organization, a culture, or a program. (Patton, 1990).

The phenomenological perspective focuses on what people experience and how they interpret the world; it describes what people experience and how it is that they experience what they experience. This, then, was the primary purpose of the study: to gather information and data and to describe and analyze it so that the training program was improved based upon the workers' and supervisors' needs and responses.

Sampling Procedures

Unlike quantitative methods which typically depend on larger samples selected randomly for generalization, qualitative inquiry usually focuses on relatively small samples selected purposefully with regards to information rich cases for study in depth. According to Patton (1990), "The validity, meaningfulness and insights generated from qualitative inquiry have more to do with the information-richness of the cases selected ... than with sample size" (p. 185). Sample size and characteristics of the sample population should be consistent with the purpose of the study and the central study question (Bernstein, 1989). Glasser and Strauss (1967) stress selection of groups for discovering theory in accordance with their "theoretical relevance for furthering the development of emerging categories" (p. 49). Therefore, with regards to this study, the sample included the 18 Social Workers

who participated in the incest training programs conducted in Fall 1993 and Fall 1994, as well as the five Supervisors to whom they report, so that their views may also be gained to determine if they perceive benefits to their supervisees' practice with clients who were sexually abused as children. The sample consists of 12 females and 6 males who completed this incest training program. These practitioners are Social Workers who have had at least 2 - 3 years of prior experience in the field of addiction working within the Nassau County Department of Drug and Alcohol Addiction's Service Delivery System. They include workers assigned to both the outpatient and inpatient facilities as well as the Detoxification Unit, which is a hospital-based unit located at Nassau County Medical Center.

It is assumed that a sample of 18 Social Workers who participated in the incest training and five of their supervisors, would provide information-rich responses to achieve the study's purpose. The sample was large enough to "provide simultaneous maximization or minimization of both the differences and the similarities of data that bear on the categories being studied" (Glasser & Strauss, 1967, p. 55), but "small enough to make the data management feasible" (Bernstein, 1989, p. 57).

Data Collection & Measurement

A basic approach to collecting the data involved a standardized open-ended interview guide (Appendix A). This questionnaire consists of questions thoughtfully worded and arranged with the intention of asking each respondent the same questions in order to gain

their thoughts, feelings, ideas, and perspectives on the course and the effects of the course on the current practice. A time period of 1- 1½ hours was allotted to each respondent for the research interview. By controlling and standardizing the open-ended interview, the evaluator obtains data that are systematic and thorough for each respondent (Patton, 1990). In addition, a brief, standardized, interview guide (Appendix B) was also administered to the five supervisors of the Social Workers who participated in the incest training program, utilizing the above format of personal interviews of approximately one hour duration. The research interview is a powerful and versatile technique for generating information. Interviewing involves a face to face exchange between the person seeking information and the person giving it. The interviewer's goal is to gather relevant data by encouraging and facilitating the respondent to provide unbiased answers to questions (Epstein & Tripodi, 1977).

This qualitative piece will gain the views and perspectives of the supervisors experiences with their supervisees in the area of integrating the incest training into the Social Workers' current practice with their clients on their respective units.

In addition, a pre-test and a post-test consisting of 20 T/F questions (Appendix C) was administered to the Social Workers. It had been compiled, tested and refined in two previous trainings, as well as by 15 DSW doctoral students in the the Hunter program who suggested some changes, which were implemented.

Also, a comprehensive, written evaluation (Appendix D) was given to the Social Workers upon completion of the program which included a Likert Scale ranking various program components, as well as an opportunity to offer additional written comments about the training program. Therefore, while this study employs both qualitative and quantitative methods in a manner which is supportive and complementary of each other, the study is primarily a qualitative one. Even though qualitative methods dominate this study, quantitative methods bring an important addition through a set of standardized quantitative data gathering measurement tools; i.e., the pre-test/post-test and evaluation forms and will enhance the data. In terms of the symbolic quantitative data gathered as noted above, a percentage of correct answers on the pre-test and post-test of the participant Social Workers will be computed to determine a measure of "knowledge gained" from the course. In addition, the Likert-type scale Evaluation Form, taken at the end of the last course session, will be used to measure "attitudes" and the benefits the participants received from their involvement in the course.

Conducting the Interview

This doctoral project was presented to the Protection of Human Subjects Committee in an effort to assure that the study does not violate the rights of the social workers or their supervisors participating in the project.

Participants were contacted by phone to discuss the purpose of the study and requested their participation for an hour and a half interview. At that time, permission to tape the

interview and take notes was requested to facilitate the interview process. I stressed the confidentiality of the interview, which increased the likelihood of participation.

Anonymity for themselves as well as their agency in the written dissertation was assured.

Interviewees were given a choice about the location of the interview to maximize their level of comfort in participating. As noted above, a qualitative interviewing strategy has been chosen "... to provide a framework within which respondents can express their own understanding in their own terms" (Patton, 1990, p. 290). The qualitative interviews were completed in three months. Tape recorded interviews were used as a back up to hand-written notes recorded by the interviewer and reviewed for on-going analysis. Analysis of findings together with the written dissertation was completed in approximately six months.

Data Analysis

Because qualitative data analysis ultimately depends on the analytical intellect and style of the analyst, the human factor is the "great strength" and the fundamental weakness of qualitative inquiry and analysis.

While there is a part of qualitative analysis that is highly creative, depending on the insights and conceptual capabilities of the analyst, there is also a technical side to analysis that is analytically rigorous, mentally replicable and explicitly systematic. It need not be antithetical to the creative aspects of qualitative analysis to: address issues of validity and reliability in qualitative inquiry. The qualitative researcher has the obligation to be

methodical in reporting the sufficient details of data collection and the processes of analysis to permit others to judge the quality of the resulting product. (Patton, 1990).

While there are no straightforward tests for reliability and validity in qualitative analysis, this does not mean that there are no guidelines to assist in analyzing the data.

Content Analysis

Content Analysis is the process of identifying, coding and categorizing the primary patterns in the data, i.e., by analyzing the content of the interview. The purpose of classifying qualitative data for Content Analysis is to facilitate the search for patterns and themes within a particular setting or across cases. Case analysis of a single program involves organizing the data of participants in the program. The purpose is to gather comprehensive, systematic and in-depth information about each case of interest; making sure that the information for each case is as complete as possible. In this case, analysis began with the individual case studies of the participants within the program, then the cross-case pattern analysis of the individual cases was a major part of the data for the program case study.(Patton, 1990).

Inductive Analysis

An Inductive Analysis was also be conducted to learn about the patterns, themes and categories that emerge from the data rather than being imposed prior to data collection and analysis. Theoretical sampling was done to identify, develop and relate repeated

categories into concepts (Strauss & Corbin, 1990). Interview notes were reviewed to provide further clarification and context to the analysis. Analysis continued until "theoretical saturation" was reached, that is, until no additional data were found, whereby the researcher can develop new properties of a category (Glaser & Strauss, 1967, p. 61). In addition, a demographic profile of the sample was created using the demographic data sheet. The profile highlighted similarities and differences among the sample in relation to factors such as age and years in the field.

Data Interpretation and Findings

Once the tasks of organization and description of the data were complete, it was then appropriate to move on to consideration of causes, consequences and relationships that emerged from the data.

Interpretation involves going beyond the descriptive data. Interpretation attaches significance to what was found, offering explanations, drawing conclusions, making inferences, building linkages, etc. of an interpretation. According to Patton (1990), all of this is expected and appropriate, as long as the researcher owns the interpretation and makes clear the difference between description and interpretation.

The purpose of qualitative evaluation is to generate findings useful for decision making and action. Therefore, this study generated understanding, information and suggestions to further improve the Incest Training Program for Social Workers in the Addiction field

within the Nassau County Department of Drug and Alcohol Addiction, as well as to suggest a training model for the field of Addiction to better equip future participants to meet the challenge of working with the addicted incest survivor.

Problems & Limitations

Because of the small sample involved in this study, it is limited in generalizability, however, it does appear that continuing education can effectively enhance professionals and organizational performance. In addition to this problem, the following problems were cited prior to the research.

1. it was anticipated that time constraints may limit the amount of material which participants can present in interviews. While this may have been true, in actuality, the one to one and half hours interview time was found to be appropriately adequate.

2. It was also anticipated that the amount of time elapsed between the course, which was completed in December 1993 and the scheduled interview dates which are anticipated to begin during the Spring of 1994 may have an impact on the accuracy of memory. It was significant to note, however, a study, "Two Post-Qualifying Courses in Social Work: The Views of the Course Members and Their Employers," by Rushton and Martyn (1990), which appeared in the British Journal of Social Work, and evaluated two courses which aimed to enhance practice with children and families, including child abuse. The sample included all members who participated in this training between 1979 and 1986; a period which encompassed seven years.

The completed questionnaires and interviews were administered in 1987. Due to the extensive amount of time which elapsed between the actual course and the evaluation interviews, it was noted that since views may change over time, the respondents were asked whether they thought differently about the course from their present vantage point years later. The majority held to the same opinion, while 21 percent thought more highly of it in retrospect, and only seven percent less highly. It is, however, noted that since a time lapse period existed for this study, before the actual evaluation interview took place that the accuracy of memory may have been affected. While this was anticipated and even addressed in the opening statement by this investigator, accuracy of memory did not appear to be inhibited once the interviews were underway.

3. There is always the possibility that the participants will provide socially desirable answers or will be inhibited in their answers as they are interviewed face to face. While this also had been anticipated, the course members appeared critically appropriate concerning the course, with this investigator.
4. Even with assurance of confidentiality, as well as anonymity in the presentation of the findings, questions about organizational constraints may have resulted in compromised responses due to fear of being exposed to the organization; or participants may also have provided overly critical answers. Thus, validity and reliability of the data may have been adversely affected. However, it is to be noted that the former course members appeared quite open with this investigator and one of

the two of the course members who was dropped from the study was extremely critical of the course. One of the members had received extensive training several years ago and expected "much more advanced material" than presented in the course which was given to Social Workers who had little or no previous training.

5. The data was collected and the way in which it was analyzed may have been affected by the researcher utilizing qualitative methodology (Patton, 1990). This researcher was continually cognizant of the way in which she was involved in social action efforts within the sexual abuse and addictions fields, so that caution was exercised not to manipulate the data to fit into preconceived notions about the topic. To guard against researcher bias, emerging perceptions and hypotheses can be tested in the interviewing process and through repeated re-coding and reviewing of the data.

In addition to the above, other ways of collecting data so that validity and reliability are enhanced in this qualitative study, was through a "spot check" of sample records of the worker's notes which pertain to the indication of appropriate treatment for the sexually abused client in the drug and alcohol abuse agency. A "spot check" of a sample of four records of workers indicated that clients were receiving appropriate treatment based upon their history of sexual abuse as a child by referral to appropriate workers skilled in dealing with both addiction and sexual abuse issues for further treatment. Also as noted above, various supervisors of the course members were also interviewed in order to determine the effectiveness of the sexual abuse training course on their workers' practice.

Chapter 4: Evaluation of the Sexual Abuse Training Model: The Process of Curriculum Building for Curriculum Development

The dual objectives of this study were:

1. to examine the opinions and feelings of former course members and agency supervisors to evaluate the nature and value of a Sexual Abuse Training Course given to Social Workers in the Nassau County Department of Drug and Alcohol Addiction Service Delivery System in the Fall of 1993 and 1994. This course aimed to respond to the needs of practice agencies while ensuring the availability of new theoretical and research based knowledge. It is important to note that the course had been conceived as a dynamic response to the changing needs of the chemical dependency field since data had begun to emerge that positively correlated the variables of sexual abuse and addiction;
2. as a result of the data collection and analysis, modifications have been made based upon the results of this study, so that a formal Sexual Abuse Training curriculum

was created and developed for future use by the addiction field. At the time of this study, no model had existed in the literature.

In the Spring of 1995, 18 former course members, as well as five supervisors within the Nassau County Alcohol and Drug Service Delivery System were interviewed face-to-face and considered to be part of the study. The supervisors also received this training previously and were supportive of this training for their workers. As noted above, the workers all agreed that they needed to know more in order to effectively treat the chemically dependent person who was sexually abused. Thus, members came to the training somewhat aware, very interested and receptive to the training.

As noted above, 18 workers, 12 females and 6 males were interviewed. The mean age was 42 years; the youngest member was 29 years old and the oldest member was 59 years. Mean years in practice was 10 years, the range being from 1 to 20 years. Group members were predominantly white (67%), with two students (11%) Afro-American and three students (17%) Hispanic; one student (5%) was from India. All members held a Masters degree - two members had a Masters degree in Nursing while all other members held a Masters degree in Social Work. Primarily, the workers' practice included working with both male and female chemically dependent clients, some family members, i.e., spouses, adult children of alcoholics. Caseloads consisted mainly of mandated and some voluntary clients. Groups are considered to be the choice treatment modality in working within the addiction field as demonstrated by the workers leading an average of two to three groups

per week, primarily with chemically dependent clients. Individual sessions averaged 12 - 18 per week. While all workers counseled some clients for a two to three year period, most worked with clients for approximately six months to a year in treatment. Five workers practiced within either a residential or day-treatment setting and experienced working only with chemically dependent clients.

Course Evaluation: Interviews with Former Course Members

The face-to face interviews were conducted four months after the Fall 1994 course took place and 16 months after the Fall 1993 course was completed.

The Interview Schedule included 16 questions; some of which were quite similar to other questions - thus, some overlap existed. A "sweep and flow to the questioning process" emerged and in interviewing the course members, and to guide that process to report the analyzed data more effectively, questions were integrated into "categories" so that five areas developed separately from the current practice data reflected by the first question. Information requested by the fourteenth question concerning offenders of sexual abuse and information requested by Questions 11 and 12 regarding the course members' preferences, the course structure and ideas for the development of a similar training, will be discussed in the overall comments part at the end of this section and make up Areas IV and V. Representative responses of the individual Social Workers follow.

Area I: Feelings - Lack of Identification - How Identified Now

Questions 2, 3 & 6 : "What feelings did you experience prior to the training if you encountered a client who was sexually abused?; In your experience what factors contributed to a lack of identification of sexual abuse with clients?; As a result of the training, how do you now identify these issues with your clients?

While it generally appeared, from the interviews, that a lack of knowledge of symptomatology and family history patterns played a role in not identifying sexual abuse, the workers feelings, and sensitization to such emotionally charged issues appeared to block much of the awareness to appropriately diagnose sexual abuse with their clients.

"I had so many mixed feelings - confusion - not understanding how this could happen to a child! My own lack of education and my uncomfortable feelings probably prevented me from identifying it."

"I felt inadequate and incompetent. I was afraid to hear it (the sexual abuse) since I had no education on it and felt unable to help the client. Now, I know that substance abuse is a major symptom of sexual abuse and I ask more questions directly."

As previously noted, unless course members recognize their own barriers to the learning experience, they will be unable to be receptive to alternatives as posed to them during the educational process. In working with such emotionally charged issues as sexual abuse, a crucial step is to deal with one's own emotional reactions. Professionals are not immune to these issues.

"I'd feel panic - terror to hear of the abuse. I didn't even think I could ever deal with this issue before the training."

"I'd feel angry and frustrated - I was also defensive and protective of myself. Sometimes, I would explore it further or change the topic if it got too uncomfortable for me."

If one cannot identify the problem, listen to victims talk about what happened to them as abused children, then a worker will not be effective in the treatment process. The majority of course members expressed feeling overwhelmed, anxious, afraid, although empathic, towards their clients; but also felt too inadequate to proceed with sexual abuse as a treatment issue with their clients prior to the training.

"I would feel a sense of hesitation - of not knowing where to go; I felt ineffectual and anxious; There was no training in Social Work school or in the Addiction field (before your training). When sexual abuse came up, while I didn't change the topic, I didn't encourage the clients to discuss it as I do now. The anxiety isn't there for me anymore. I ask questions now - sexually acting out, poor boundaries, relapses - these are the 'red flags' for me now. Even if the clients deny it upon intake, several months later, they say to me 'something weird did happen to me as a kid. They feel more comfortable since I brought it up."

"I would feel very uncomfortable not knowing whether to pursue the issue of sexual abuse or not. Mostly, I would not explore it. I lacked the education and didn't recognize the symptoms. Now, I look at "red flags" of sexually acting out, relapse, eating disorders, etc."

Summary

The first category, Area I, incorporates the issues related to the workers own sensitization issues to sexual abuse. The connection within this area relates to the workers own feelings of ambivalence in recognizing and identifying sexual abuse with their clients. Most course members reported intensely strong feelings concerning childhood sexual abuse. While most, if not all, course members received little or no information and/or

training prior to this course, what most frequently appeared throughout the interviews were their feelings of inadequacy and incompetence toward identifying and dealing with the topic of sexual abuse with their clients due to their own extreme discomfort with such an emotionally charged issue.

Specifically, in response to the section in Question #6 concerning identification of the sexual abuse issues after experiencing the course, the members consistently expressed that their uncomfortable feelings of fear, panic, inadequacy and feelings of being overwhelmed by the topic, prevented them from "seeing the symptoms," i.e., sexual acting out, poor interpersonal boundaries, etc., and that since the training, they can now identify these "red flags" as symptoms, and thus can further explore the issue more effectively so as to identify sexual abuse issues with their clients.

Thus, because of the training then, the members reported that they were able to identify their own feelings, issues, etc. in order for them to feel more comfortable and competent to deal with their clients' sexual abuse issues.

Area II - Experience of Training - Effectiveness of Training - Benefits of Training

Questions 4, 5 & 10: "What was it like for you to be involved in training;?" "How has the training been effective for you in working with sexually abused victims now?" and "What do you see as the benefits of the training program for you?"

These questions elicited generally very positive responses among the course members.

There was a strong sense that a more extensive knowledge base in sexual abuse was required to practice with their clients, as was offered to them in this training course.

"It was a good experience for me. It greatly diminished my fear of working with sexual abuse. I feel more capable and competent - more prepared to identify sexual abuse, assess it and intervene; and knowing now that survivors can recover so that a true self develops!"

"It's interesting, most of the reporting of sexual abuse of children has been 'post-seminar.' I do pick up these 'red flags' now and my clients do open up to me since I've had this training."

Course members stressed growth in personal confidence, and educational development within the topic of sexual abuse, as a major course benefit, as well as a search for self-validation from their peers within the group process. While didactic material was considered very important to the course members, much growth emphasis was placed upon the group process and thus the concept of mutual assistance. This concept implies that group members perceive their likenesses and differences and that reciprocity becomes a valued group norm - even for professionals! The commonality in learning is based upon how the learner comprehends and observes his or her own contributions being incorporated by another. Such mutual aid is crucial in a group or teaching situation, but especially so with advanced practitioners as can be seen by their responses.

"I was thankful to be there (at the training). I was like a sponge soaking up the information. I especially liked the group process. It was important for me that the other professionals shared their feelings and experiences of

feeling inadequate at times. The training has been very effective for me. I can recognize symptoms and other family dynamic issues to identify sex abuse. I can now 'hear' them (the clients) as well as listen to them."

"I really liked the training. It was good peer support in the group process; I feel more grounded. I've started working with male survivors and now run a male (survivors) group. It's been very effective. The biggest benefit was to take the knowledge and apply it to practice. As a result of this training, our unit has integrated and incorporated changes in the program."

"The knowledge and benefits I received ... that I was with other professionals to see and hear what they were doing and to embrace their ideas and to expand mine. Also, being with my peers - at times we all feel hopeless and inadequate - this was beneficial for me. As a result of the training, I now lead an ongoing female survivors group - we've changed our program to include this issue. This is a great benefit from the training."

"The training was a great asset for me - very valuable to my practice. I benefitted by having my colleagues attend and benefitted from the idea of practitioners sharing their feelings."

Vicarious traumatization issues appeared to further sensitize the worker to personal struggles. Vicarious traumatization occurs when the worker incorporates feelings, attitudes, concepts of the client into the self (projective identification), so that distortions occur for the professional. A brief overview and framework in the training offers recognition of this dynamic and discusses ways of dealing with it in terms of taking care of "self" in terms of "therapist self-care" by attending an ongoing sexual abuse peer supervision group (which becomes a "cuddle" group for the worker), on a regular basis, etc. This idea becomes crucial for the worker so that the professional can better be able to integrate knowledge, feelings and thinking so as not to overwhelm him/herself in the treatment process.

"It was a positive experience for me. Actually, it is exhausting work and the issue related to 'vicarious traumatization' (of the worker) was very positive for me. I'm expanding my own coping mechanisms to deal more effectively with myself and, therefore, my clients."

"The 'vicarious traumatization' piece desensitized me as to how universal it is for all practitioners, at time, to feel inept. This was very valuable for me."

Summary

The rationale for creating this category, Area II, based itself upon the course members responses in "liking the training" since it benefitted them by gaining not only cognitive material, but also crucial peer support gained through the group process. Thus, having a more positive effect on the level of competency, as well as feeling "normal" among their peers since all course members shared their feelings of inadequacy, fears and incompetencies - even as advanced practitioners with one another. This process appeared to hold the most benefits for the course members. The "experience" with the training, the "effectiveness" of the training, lead to the "benefits" of the training for the course members. These benefits then, appeared to be most worthwhile to the coursemembers.

Area III - Milestones - Important Moments in Training - Changes in Attitudes, Practice

Questions: 7, 8 & 9: "In terms of the training, can you identify certain "milestones" that helped you change your practice?"; "If you were to single out a "most important moment" for you in the training, what would it be?"; "As a result of this moment, how has your practice changed?"

The answers to these questions were expressed in a more phenomenological approach by the members. Basically, this refers to an approach which shows how people describe and experience things through their senses - a philosophical assumption which says we can only know what we experience by looking at perceptions and their meanings in awareness. The phenomenological perspective focuses on what people experience and how it is they experience what they experience.

"A 'moment' for me was about the process of therapy - that clients come in as victims - become survivors and after working through these issues, they then leave as 'people'! I've learned to honor the process. Survivors don't have to be damaged for life!"

"The 'moment' came for me with the attitude of hope for the survivors; that they do recover! The hope of this has made my practice more positive."

As noted above, a "teachable moment" often arises when the worker becomes aware that there is more to know. Teachable moments come about during periods of personal or professional tension and crises. These moments offer the opportunity to develop new levels of professional "knowing" which progresses towards greater integration and wholeness. Their experiences, interests, attitudes and enthusiasm about the knowledge gained in the course became apparent when they answered this question.

"A most important 'moment' for me was emotionally . I was impacted by the training - certain cases I had over the years popped out at me - I remember them because I missed them - no education or training. We all miss cases as the training taught me, but my 'moment' was a change in attitude. My perspective changed- I've now become more confident."

"It was the whole 'gestalt' - that we had this training - the importance of it and that the whole agency was behind the training; that was a milestone for me - a significant 'moment' that they thought it important for us to have this training."

A major milestone for two Social Workers occurred when they each shared their personal experiences with their own abuse as children and from this awareness gained from the course, sought appropriate support for themselves.

"The moment and the milestone was reading and dealing with the 'vicarious traumatization' of the therapist. It started me dealing with my own issues of abuse ... as a result of that moment, I sought help for myself!"

"A milestone for me was the presentation on 'vicarious traumatization' of the therapist. It is so important to have this training. I wouldn't have recognized it as my own issue. I learned that I needed to take care of me in order to take care of my clients."

Also, the majority of the Social Workers expressed their 'moments' or 'milestones' as related to learning about male survivors and especially, the perpetrators.

"I never thought I could work with the abuser - but now my attitude is different - more compassionate due to knowing that there is a high percentage of male survivors among the perpetrator population..."

"Also, when we spoke of the perpetrators - that information created such a change in attitude for me - I saw these "horrible perps" as troubled people - this was a true moment for me!"

"The male survivors and offender session was very helpful. I could see how important this training is - without it - workers shouldn't be treating it (sexual abuse)."

"Male Survivors and Offenders" was a milestone that changed my attitude. I had a lot of anger and felt "why bother with them" - but understanding that they most likely were victims themselves helped me immensely."

Summary

This third category, Area III illustrates the course members significant experiences in the content/process of the course which facilitated the motivation for an actual change in their practice with their clients to occur. Many described an attitude change, an "aha!" experience that created this "teachable moment" for them. This category also elicited responses by two of the workers to respond to their own sexual abuse issues as children. Both identified the issue and sought out treatment for themselves and indicated this to be both a personal, as well as professional, benefit (and challenge) for each of them.

The section in Question #9 regarding how practice has changed for the workers as a result of the training, was a difficult answer to measure and define; the workers seemed to have trouble "putting their finger on it" - the actual changes in their practice. While quantitative research expresses facts - it cannot adequately portray feelings. However, even qualitative measures cannot adequately reflect such a myriad of complex feelings when related to such strong emotional phenomena. This appears to have occurred with the responses to this question. Members responded similarly how their practice has become "more positive", "more hopeful" of the process of treatment; they have a feeling of "confidence" in their practice which was not there prior to the training. While most coursemembers never worked with an "identified" abuser, several members shared that their practice would be more "compassionate" toward the abuser - that their feelings and attitudes were changed due to the information gained during the training process. It appeared that the responses to Questions 7, 8, and especially 9, revealed more subtle-yet

important—changes in the workers' practice. However, while these responses by the workers indicate an effect in "attitude" rather than actual "knowledge" gained, it does appear that practice is further enhanced due to these changes in attitude.

The majority of workers have not worked with offenders as an identified client population. These "moments or "milestones" for the majority reflected important issues for the Social Workers especially as it was strongly expressed by the workers in Question 14.

Area IV - Question 14: "In terms of Offenders, have you had any experience with working with them?" " What are your feelings regarding this population?"

While the area of sexual abuse is emotionally charged, an area which appeared to elicit even stronger emotionally charged feelings is the area of offenders. By keeping ones's own reactions and feelings out of awareness, the treatment process becomes impaired. In contrast, the examination of the professional's feelings and reactions can provide information, perspective and understanding which becomes valuable and crucial to the treatment process with offenders.

"My feelings at first was to 'beat the daylight' out of the perpetrators; but through this seminar, I know they need help and treatment not to re-offend. I grew from the training. I'm much more aware of 'perps' as people!"

"My affect is one of anger that surfaces towards the perps. I want to protect the victim ... Sometimes I feel so enraged at them ... but now, due to the training, I bring up these feelings in supervision and now know that

they (the offenders) were probably, most likely, victims themselves - as children - this has helped me immensely."

In order for more effective treatment to take place, former course members were given an opportunity to express their emotional reactions to this issue so that they may further explore such emotionally charged material; that if these issues arise for them, their reactions do not intrude upon the treatment process.

"Probably, the greatest thing I got from this training was a sensitivity for the offender. I can now see them as victims of their own childhoods."

"I've learned not to reject them as persons. I can deal with offender issues more easily. I grew from the training. I'm more comfortable with this issue and more desensitized."

"Prior to the training, I felt revulsion and fear. Now I'm more understanding and empathetic. While I don't want to work with them, I can have more empathy for them."

In work with offenders, therapists confront not only sadistic acts and fantasies of the offender, but may also need to confront their own impulses, which is difficult to do, so as not to intrude into the treatment process.

"I guess if I had more education and training on offenders, I could work with them, but my feelings are anger, frustration and wanting to move away from them."

"While I want to have more empathy for them, I want also to be very harsh on them ... but while I don't want to work with them I can have more empathy."

"I've never worked with this population before, but I do see them now as vulnerable due to the training - since many of them were sexually abused as children themselves. I've never worked with them (as an

identified population), but due to the course, I'd be more comfortable working with them if I had to."

"I never thought I could work with this population, but given more training, I think I would be able to do this due to this training!"

Summary

Question 14, as a separate category, was extremely important for the workers to answer, since they expressed their feelings about this population. This question emerged as the one which illicited the strongest emotions on the part of the course members to answering any other single question asked of them. As a result of this question, the training was modified so that an entire session was devoted to the issues of offenders and their treatment rather than to be split between male survivors and offenders, as was the case prior to the interviews—which, in turn, offered the motivation to change the curriculum.

Area V - Questions 11 and 12 - Suggestions for a Modified Curriculum

"If you were developing a similar training, what features would you like to see added or deleted." "Did you prefer films, discussions, experiential exercises or lectures?"

This category, Area V, Questions 11 & 12 was placed at the end of the reported results since these questions included the actual suggestions to modify the curriculum. Thus, the overall comments and responses to these questions were utilized to determine how the new curriculum could be made more effective.

"It was a good mix ... Films, discussion and process was good... Add more information related to offenders."

"I would add some role playing. I learn better experientially. I liked the combination of techniques used. Experiential, films, lectures, discussion group was also good."

"The structure was good. Didactic and group interaction process was very important for me. I prefer experiential exercises and discussion. I'd like to see more case presentations.

"I would add some role playing. I learn better experientially. I liked the combination of techniques used. Films, lectures, discussion group was also good."

"The structure was good. Especially the group process piece - it was good to here other advanced professionals also feeling inadequate at times - that was empowering!"

"I liked the format. Content was good; speaker and information resources were excellent. I especially liked the group process piece. I prefer practical stuff like a case presentation and vignettes."

"I enjoyed the discussion and the speaker, especially the mutual aid. The mix of male and female workers was good. Would have liked more on offender issues and treatment."

"I liked the group discussion piece best and emphasis on male victims - especially liked the issues related to vicarious traumatization - it's so important to care for ourselves! Lectures, and films as learning tools were great."

"I would like to see a continuity or an update - and more information on offenders."

Data from Written Evaluations

As can be seen by the comments related to Questions 11 & 12, ("If you were developing a similar training, what features would you like to see added or deleted;" "Did you prefer films, discussions, experiential exercises or lectures?") the overall responses about the members' suggestions and ideas in the face-to face interviews also corresponded with

their noted comments on the written evaluation forms. It is important to note that these comments were written four to 15 months prior to the actual face-to-face interviews; it appears that these responses remain to be a reliable part of the study. A Likert scale, together with open-ended questions made up the written evaluation given at the completion of the course. Overall, satisfaction with the course was extremely high with 100% of members being either very to extremely satisfied on a scale of 1 to 5 (1=low - high=5) (See Table I). (It is important to note that since views may change over time, members were asked whether they thought differently about the course in retrospect at the time of the face-to-face interview. The majority of the members held to the same opinion and some members thought more highly of it as they continued their practice with clients).

The following comments reflect the major preferences of the members, and were taken directly from their written evaluations:

"The structure was good... articles were helpful... a good mix between theory - didactic - films and process. The 'debriefing' was very important (the group process piece)! The every-other-week structure was good...need time to absorb intensely emotional material." "Very good to hear advanced professionals also feeling inadequate - that was empowering!" "I would like to see a role play of an early treatment session; I learn better experientially." "More information on offenders and treatment." "The group process piece was extremely helpful...a case vignette - case examples would be helpful too." "I liked the 'vicarious traumatization' piece it's very important to care for ourselves." "Basically, leave course as it is a - good mix!"

Pre-Test/Post-Test Data

While the purpose of including pre-test/post-test data was to enhance the qualitative data, there appeared to be a small increase between the pre-test and the post-test scores. The data indicated that on 10 of the 20 questions, course members scored a post-test increase; on two questions, course members scored a post-test decrease; and on eight questions no change occurred. The data indicates noteworthy changes in the following questions:

For questions #5, #12 and #18 respectively: “Incest is considered to be a misuse of power;” “Approximately 5% of incest perpetrators are female;” and “Betrayal, Stigmatization and Powerlessness are concepts utilized in the Traumagenic Model of David Finkelhor,” all three indicate an increase in the post-test scores. This is due likely to the technical course content taught and knowledge gained by the course members. (See Table 2.)

For Question #2, “Rigid roles and rules are often found in an incestuous family,” a decrease was shown from pre- to post-test scores. This may indicate that for this question course members may have confused “rigid roles and rules” with “blurred boundaries,” which also occurs in incestuous families and was a concept discussed in the training.

In terms of these small differences, it may be explained that some of the questions may have been too general - that while it is important that the mass media has “popularized” sexual abuse in terms of encouraging celebrity personalities to “come out” and admit that

sexual abuse had occurred to them as children, some of this information has become more prevalent in the general population, as well as in the professional population. This may have accounted for some of the impact upon the knowledge of the course members prior to taking the course and the pre-test. Therefore, it does appear that in the future a more sensitive measure could be developed in this area to gain more accurate results.

It certainly does appear, however, that the qualitative methods utilized the interview in the study to corroborate the data collected from the written evaluations which indicated an overall satisfaction by course members who were “very” to “extremely” satisfied with the course. (See Table 1.)

Table 1: Written Evaluations

N = 18 (in percentages)					
Question #:	1	2	3	4	5
1. Increased knowledge			11	11	78
2. Organization of delivery			11	28	61
3. Usefulness of training				17	83
4. Comprehensiveness				28	72
6. Overall goal achievement			6	33	61
7. Rating of training				22	78
10. Overall rating				28	72
	<u>Too Slow</u>		<u>Just Right</u>		<u>Too Fast</u>
5. Pacing of training	11		83		6

(Questions 8 and 9 are open-ended responses reported in text.)

Scale: (low level) 1 2 3 4 5 (high level)

Table 2: Percentage Correct on Pre-test and Post-test Scores**N = 18**

<u>Item # ⁽¹⁾</u>	<u>Pre-test</u>	<u>Post-test</u>	<u>Increase (+)</u> <u>Decrease (-)</u>
1	100	100	
2	94	78	-16
3	89	94	+6
4	94	94	
5	83	100	+17
6	89	89	
7	94	100	+6
8	94	83	-11
9	100	100	
10	89	89	
11	17	22	+5
12	67	100	+33
13	78	89	+11
14	89	89	
15	83	94	+11
16	28	33	+5
17	89	100	+11
18	50	78	+28
19	94	94	
20	100	100	

Differences between pre-test and post-test scores:

<u>Pre-test</u>	<u>Post-test</u>		
<u>Mean</u>	<u>Mean</u>	<u>t-value</u>	<u>p-level ⁽²⁾</u>
81.9	86.9	2.05	p= .05

The mean test score increased from an average of 81.9 in the pre-test to 86.9 in the post-test, a difference of five points on the test. The increase recorded was exactly at the level of statistical significance ($t = 2.05$, $p = .05$) meaning the amount of change and the direction showed an increase in knowledge by the completion of the training.

⁽¹⁾ See Appendix C for pre- and post-test questions

⁽²⁾ for one-tailed test

The Staff Member, The Course and the Agency: Supervisors' Views

The brief questionnaires administered to the Supervisors who had an average of 11 years experience in the addiction field, were also seasoned practitioners themselves. They were asked to comment on seven questions in face-to-face interviews. It is to be noted that all Supervisors interviewed had participated in a similar training created for them by this investigator prior to their staff members taking the course.

As an overview, the first question dealt with their own experience on their unit with the issues of clients who were chemically dependent and sexually abused. All Supervisors expressed the idea of recognizing a high prevalence of such clients. Informal estimates given by the Supervisors indicated approximately 50 % of their female clients and approximately 20 percent of their male clients reported sexual abuse in childhood.

In terms of the second question, the most common reply the Supervisors considered to be the aims of further training for their workers to have, was that the training program up-date the knowledge of the workers while increasing their professional expertise.

In response to the third question, all of the Supervisors spoke very positively of the availability of the course as well as the course itself. They thought it had achieved its stated aims. Examples were given (Questions 4 & 5) of newly acquired skills at a more advanced level. They also referred to professional development and cited clearer thinking and greater confidence shown by their workers:

"Workers don't come to me as often and say they're stuck since the training."

"Yes, there has been a lot of changes. My workers are much more sophisticated. They are more sensitive and ask the 'right' questions to pick up on sexual abuse symptoms since the training. They are much more comfortable in their practice and are better able to deal with sexual abuse and alcoholism now."

As a result of the training the Supervisors discussed how changes were implemented on their units through expanded services. (Question 6).

"A couple of things have occurred; we now raise the issue upon intake... we do address sexual abuse as a topic in our Education Series, aside from workers being much more sensitive to the sexual abuse issue now."

"We had many changes occur. We started an educational component on sexual abuse in our Education Series. We've remodeled our intake forms. We have also created our first short-term male survivors group which was shown to be a success."

"As a result of the training, we have developed a 'Trauma Track' for female survivors - a major innovation for this unit!"

In response to the seventh question concerning ways to improve the training, the Supervisors also agreed with their workers, as follows:

"Some more information on offenders and treatment be included."

"I'd like to see more case material interspersed throughout the training... a role play too."

One supervisor requested information be included on Sexual Addiction and its relation to sexual abuse and drug and alcohol addiction. The field has become more aware that sexual addiction appears also to be another issue connected with many of the addicts

involved in treatment, and that this may mask the sexual abuse issues. While this appears to be relevant and deserves further investigation, at present, it goes beyond the scope of this study.

Summary of Verbal and Written Evaluations of Workers and Supervisors

The course evaluations, both verbal and written, together with the interviews with the supervisors all, indicate a very high level of satisfaction with the Sexual Abuse Training Course. The knowledge and resource material presented were most positively received by the course members. The course structure utilizing lecture, a speaker, films, experiential exercises, as well as the every-other week format was highly valued by the members. The most effective parts of the training for most members appeared to be not only the information and knowledge gained on the issue of sexual abuse, but the validation of mutual aid and peer support among the professionals offered in the group process piece at the end of each session. The members valued the opportunity to express their feelings and ideas and experiences with other workers in a non-judgmental environment and thus gained the education and support they needed to continue in such a critical area of their clinical practice.

Summary of Changes Which Modified the Sexual Abuse Training Curriculum Based Upon the Evaluations

Based upon the majority of responses, as noted above, the curriculum was changed and further developed to include the members ideas and suggestions. In general, three areas emerged from the data that developed the modified curriculum:

1. The members indicated that they enjoyed experiential learning tools; the majority requested a role -play situation in regards to early treatment process. This idea was reflected in the creation of a case scenario role play between the facilitator and a volunteer course member, who would play the role of a new client coming into outpatient treatment who was chemically dependent and had been sexually abused as a child; the client was experiencing problems remaining straight and sober after a few attempts at sobriety.
2. An entire session was re-created to include more information related to specifics on treatment strategies concerning the offender, rather than to split the session with information on male survivors, which is now dealt with in Session #6, "Male Survivors/Special Issues." In addition, more case examples from the offender speaker's practice were included. As noted above, at the present time there is relatively little research available on female offenders. As a result, the information presented by the speaker is based primarily upon theory and practice with the male offender.

3. Also, additional case material were infused throughout the curriculum by the facilitator to enhance the didactic material presented in the lecture and group process piece. Specifically, this occurs when the treatment strategy models are presented, as well as during the presentation of the differences between male and female survivors.

It is also to be noted that various handouts and articles regarding pertinent sexual abuse information are also included as part of the training curriculum to enhance the information presented during the various sessions.

Discussion of Curriculum Development and Its Building Process

The goal of curriculum building and development is to integrate values, knowledge and skills of the profession into competent practice (Ewalt 1983). While it is essential that all professionals have in common knowledge, values and skills that are generally transferable from one setting, population group, geographic area or problem to another, it is also essential that advanced workers have the special knowledge and skills appropriate to a specific role, field of practice, population or problem area.

Among the values and principles that guide Social Workers in their practice and that should be manifest throughout every curriculum, are the professional principles and values within the quality of their practice. In addition, maintaining continuous growth in

the knowledge and skills of their procession through continuing education is also essential (CSWE 1982).

It is significant to note that the Center for Training and Research in Child Abuse and Family Violence of the Fordham University School of Social Service was instrumental in the development process of the Sexual Abuse Training Curriculum for Chemical Dependency Workers. The generic guidelines utilized for this curriculum were built upon the sexual abuse curriculum from the Center for Training and Research in Child Abuse and Family Violence.

Additionally, the following handouts were developed and distributed through Fordham's Center for Training and Research in Child Abuse and Family Violence for their Sexual Abuse Training Curriculum. These handouts also became integrated into the new curriculum for chemical Dependency Workers:

- Handout #6 Incest Family Dynamics by Noel Larson and James Maddock
- Handout #8 Characteristics of the Healthy Child by Alayne Yates
- Handout #9 Characteristics of the Eroticized Child by Alayne Yates
- Handout #10 Child Sexual Abuse Dynamics of Victimization — developed by Fordham University School of Social Service Center for Training and Research in Child Abuse and Family Violence
- Handout #11 Four Traumagenic Dynamics of Sexual Abuse by Davide Finkelhor and Angela Browne
- Handout #12 Traumagenic Dynamics in the Impact of Child Sexual Abuse by David Finkelhor and Angela Browne

Handout #13 Four Preconditions: A Model (for Sexual Abuse) by David Finkelhor

The single most important step in curriculum development is the specification of objectives. Once these objectives are specified, all elements of curriculum are expected to support the stated objectives. Objectives ordinarily include statements regarding the mission of teaching. They are statements about what the training intends to provide the students (Ewalt, 1983).

As noted above, the major learning objectives of the course are:

- a. to "desensitize" the emotionally charged issue of child sexual abuse through the exploration of emotional reactions to film and experiential exercises; to increase understanding of the scope of the sexual abuse issue through demographics and statistics, as well as to enhance the understanding of incest dynamics through a course overview;
- b. to understand the impact of incest as an intergenerational family problem, as well as within a family-centered perspective of the chemically dependent family system; to identify the similarities in family dynamics of the incestuous and alcohol/drug abusing families; to increase the psychological and psychosocial profiles of family members, including the offender, within the chemically dependent incestuous family;
- c. to identify the behavioral and emotional manifestations of sexual abuse; to introduce and understand a conceptual framework for understanding the psychological impact

of incest victimization utilizing Suzanne Sgroi's Sexual Abuse Syndrome Model – Engagement phase, Sexual Interaction phase, Secrecy phase, Disclosure phase, Suppression phase – which provides further understanding of the process of victimization;

- d. to introduce and understand the Traumagenic Model as developed by D. Finkelhor, Ph.D., for understanding the implications for treatment of the chemically dependent sexual abuse survivor (i.e., traumatic sexualization, betrayal, stigma and powerlessness); to demonstrate that the model can be used in the assessment and treatment of the chemically dependent sexual abuse survivor; includes a case presentation from a course member's practice for assessment by the trainees;
- e. to introduce the conceptual framework of the Four-State Pre-Condition Model, as developed by David Finkelhor, Ph.D., for understanding the motivation of the incest offender; to provide an understanding of the goals and treatment strategies involved in the treatment of the sexual abuse offender, including case examples from the speaker's practice with offenders;
- f. to provide information regarding the salient differences between male and female incest survivors; review the Traumagenic Dynamics Model as a framework for treatment of the chemically dependent sexual abuse survivor; as well as to provide information regarding the process of treatment and goals of therapy according to Eliana Gil, Ph.D., in relation to the chemically dependent individual and relapse issues; includes a role-play situation with a newly-sober client in order to develop

more effective skills in interviewing the sexually-abused chemically dependent client;

- g. to review and provide further information and treatment strategies and goals for the chemically dependent sexual abuse survivor; to introduce the conceptual framework and treatment model of Suzanne Sgroi, M.D.; to provide an overview and framework on "vicarious traumatization" of the therapist utilizing the concepts for therapist self-care.

As a result of accomplishing these learning objectives, the student will be able to demonstrate the ability to:

- a. formulate an assessment that explicitly takes into account the physical, psychological, social, cultural and legal aspects of the dynamics involved in the chemically dependent incestuous family system so that effective treatment can take place.
- b. develop appropriate treatment plans for the incest victim and implement various specialized skills and techniques to effectively treat the individual to deal with both incest and addiction issues so as to minimize relapse episodes.

Curriculum Building Process

A central question in professional education and curriculum development, as noted above, is how the adult learning process is affected between the preferences of the individual learner, the context of the learning and the teaching methods used. As

previously noted, in the area of continuing educational objectives with the adult learner, the objectives are primarily viewed as being student-centered. Mutual engagement in determining educational objectives sets apart continuing education from other forms of Social Work education. While one purpose of continuing education is to emphasize the learning aspect as it relates to updating knowledge, the improvement of skills as well as creativity in practice, continuing education is also seen as a primary means of contributing directly to changing institutions and organizations (Rothman, 1973). Thus, educational objectives also now pertain to the learner as target or instrument of change.

In terms of teaching methods with experienced practitioners, a variety of modes were used which included the classic academic lecture, as well as more experiential style exercises since advanced practitioners form a heterogeneous group of learning preferences (Rushton, Martyn, 1990). By constructing innovative, experiential methods for the adult learner, i.e., use of films, media, desensitization exercises, i.e., rank order value clarifications related to sexuality and sexual abuse, the learning process becomes enhanced. Thus, creative approaches facilitate the professional adult learner's interest and enthusiasm, (Rothman, 1973).

In addition, the purpose of these methods is to allow the student to experience their own attitudes and feelings so that they are not acted upon inappropriately in their counselling sessions with sexually abused clients. Karpiak (1992) discusses, as noted above, the concept of the "evolving self" and the personal as well as professional knowing. Personal

knowing is "whole person knowing." It is integrative and self-conscious. Workers who move to this level of knowing are more capable of making significant contributions with their clients and with their work.

While learning preferences do not fall into a simple pattern, the majority of workers preferred the lecture/discussion format. However, the expert presentation on offenders was well regarded and highly valued, as well as the experiential exercises and film format. The group process piece, also highly valued was used to integrate the many aspects of the learning to facilitate the management of anxiety, as well as to enlist the support of mutual aid for the workers.

Especially germane to curriculum development for training is the ongoing controversy about the relative importance of content and process. Usually, continuing education within the agency setting tends to stress content since the sessions are short-term, job oriented, focused on specific issues, etc.; (Watson 1989). However, the Sexual Abuse training curriculum was developed to encompass both content and process which, as can be seen by the evaluations, both verbal and written, was a highly successful combination.

Major Content of Course, Sequencing and Teaching Methods

A range of areas to be covered include characteristics and dynamics of the family and its members, including the offender; needs and stages of the development of the incest

experience, the impact of culture, age, sex on the individual. The client-worker relationship, therapist self care, treatment techniques and stages and process of treatment.

The curriculum is based upon a 21 hour, seven one half day format conducted on an every other week basis; it takes approximately three and one half months to complete the course. Educationally, more productive learning takes place over time. In addition, especially when working with such emotionally charged material, feedback from previous training sessions confirmed this aspect of the course format. In addition, another consideration for the time format deals with organizational constraints. Such constraints tend to discourage staff from leaving the agency and client responsibilities for extended time periods; therefore, the three hour day, every-other-week period also takes this into consideration. While an "intensive three-day seminar (seven hours each day) would be too intense for workers to absorb the emotionally-sensitive material as relates to child sexual abuse issues, the single half-day format every other week for seven sessions appears to be most appropriate for more productive learning as well as more productive use of time to meet agency needs. It appears that course members needed some time in between each session to process the material. Each session is three hours and includes a 15 minute break, as well as a 45 minute group process discussion period prior to the end of each session in order to discuss and process the emotionally-charged material presented, as well as to consider case material from the worker's practice with the client. The group breaks up into a circle for the group process so that discussion is better facilitated.

The curriculum was developed, as noted, so that the course material builds upon each session from a "desensitization" experiential session – which encourages the course members to explore their own emotional reactions to the issue of child sexual abuse as well as a course overview of sexual abuse – to treatment strategies and goals of treatment for the chemically dependent sexual abuse survivor, which completes the last session.

The principles which were used to construct and guide the development of the curriculum was considered, especially with the advanced professional in mind. Specifically, while continuing education has become synonymous with the principle of professional competence and the updating of new knowledge; the principle of promoting the evolution of the learner is utilized to broaden the personal vision of the worker's value on social responsibility. Thus, the principle of continuing education becomes a lifelong activity evolving change as process.

As noted above in the literature review section, relative to learner needs and capacities it is important to understand the adult learner as postulated by Malcolm Knowles under the concept of *andragogy*, the practice of helping adults to learn. The experienced practitioner especially is less apt to reveal difficulties he/she encounters due to his/her perception of his/herself as an advanced professional. Beulah Rothman (1973), notes that the experienced professional is averse to exposing self to learning if it involves as its main objectives critical analysis of his/her own work. Rather, the experienced learner prefers to enter the educational arena in the belief that he/she will be exposed to the new

knowledge or new skills not usually acquired through normal channels of professional preparation. The coursemembers where enthusiastic to participate in the Sexual Abuse Training Course since the training was an innovative experience in the field and had not been offered before within the alcohol and drug service delivery system.

The process of the curriculum progresses so that each session provides the essential elements of understanding the dynamics of sexual abuse, assessing issues related to the victim, family members and offender as well as family issues, looking at special populations, i.e., male survivors, development of treatment plans so that effective treatment strategies can take place, including self-help approaches. As noted, a challenge in working with the advanced professional is that he/she learns best through a varied learning format. The use of lecture, discussion, film, experiential exercises and role play, as well as the utilization of an expert offender speaker were all included to specifically affect the design of the curriculum so that the learning environment was maximized for the advanced worker. Through the process of mutual aid, another significant Social Work principle, the course members were also encouraged to share their ideas, feelings, practice of new techniques and to participate in the trainings during the sessions, as well as in the group process.

Additionally, the advanced professional tends to be more comfortable in approaching the learning if the object of learning is to change circumstances external to themselves, i.e., changing the service delivery system or practice or procedures in those systems

(Rothman, 1973). The workers are encouraged to become a "change agent" with the system, which is also another highly valued Social Work principle in the profession. It is noted at the beginning of this seminar that they are being trained as "pioneers" in the field of drug and alcohol addiction since so few services exist for the incest victim in this delivery system. They are prepared to begin "new" practice procedures as well as beginning new treatment groups which will have an impact and thus change the overall alcohol and drug service delivery system in Nassau County. This is a powerful and helpful strategy for the seasoned professional to realize!

To restate and clarify the experienced professional's learning needs and capacities, the following principles proved helpful in developing the sexual abuse curriculum:

Principles Used for Curriculum Development with the Advanced Professional

Experienced practitioners:

- are less apt to reveal difficulties about themselves in their practice;
- are enthusiastic about acquiring new knowledge and skills not usually acquired through normal channels of professional preparation, i.e., innovative programs, etc.;
- learn best through a varied learning format: lectures, films, discussions, group process, etc.;
- utilize the mutual aid process to enhance learning;
- approach learning best if the object of learning is to change external circumstances, thus becoming a "change agent" within the system.

Summary

In terms of curriculum development for the professional, reinforcing this learning is a major problem in training, particularly if the training is complex or threatening. Use of training aids, such as films, speakers, exercises introduces a variety learning tools into the training format. The "mix" of various didactic, experiential exercises, films, etc. elicited a strong consensus among the course members which also guided the curriculum product through its evolutionary process. Also, since each person learns best in a particular way, one cannot assess the learning style of each course member depending on the ability to observe, conceptualize, reflect or experiment. Therefore, by varying the format, using lecture, discussion, role play, films, speakers, all preferences will be addressed.(Watson, 1989). As indicated by the course members evaluations, both verbal and written, the consensus enjoyed the "mix" of various teaching methods and techniques.

As noted above, the advanced professional desires to perceive the teacher as "the expert" and does not like to critically analyze his/her own work; and, as noted, enjoys the challenge of being able to change circumstances external to themselves, i.e., procedures, systems, clinical structure, etc. (Rothman 1973).

In addition, the concept of mutual assistance, well known to Social Workers, is readily transferable to the learning situation. The concept of mutual assistance implies that group members must perceive their likenesses and differences and that reciprocity becomes a valued group norm.

Therefore, another method included in the training course is a 45 minute group process piece. As noted, this method served the purpose of mutual aid, in order to facilitate thoughts, feelings, ideas, questions and problems related to the sexual abuse issue that workers may be experiencing. This group process proved to be a successful guiding piece in curriculum building since the extent to which the course members consistently appreciated the opportunity to engage their peers in discussion to gain validation, support and clarification was enthusiastically expressed through the verbal and written evaluations.

Once again, the basic changes which were crafted into the modified curriculum based upon the evaluations are as follows:

1. use of additional case examples infused throughout the curriculum;
2. an experiential role play offering treatment intervention in an initial or second session with a relapsing, chemically dependent female client who experienced sexual abuse in her childhood;
3. a session dealing with information on offenders, as well as strategies for their treatment.

Chapter V: Sexual Abuse Training Curriculum for Chemical Dependency Workers

The Curriculum is based upon a 21 hour, seven and one half day format conducted on an every other week basis. Each session is three hours and includes a 15 minute break, as well as a 45 minute group process discussion period prior to the end of each session, in order to discuss and process the material presented. The group breaks up into a circle for the group process so that the discussion is better facilitated.

Day One

Introduction: Pre-Test/Post-Test/Awareness Exercises/Film/Overview

9:00-9:15 Arrival/Registration

 Handout training folders

 Administer pre-test

Objective

1. To administer pre-test.

Content Themes

The pre-test presents some of the content themes and emphasizes the knowledge base that the trainees will be introduced to over the course of the 21 hour training.

Activities

Trainees will have 15 minutes to complete the multiple choice pre-test.

A folder containing articles, bibliography values and clarification exercise materials will be distributed.

Materials

Pre-Test/Bibliography/Values Clarification Materials,Articles, etc.

9:15-9:30

Objectives

1. To collect pre-test.
2. To review the agenda for the 21 hour program.
3. To introduce self and objectives of the training.
4. To explain evaluation format.
5. To review eligibility for certificates.
6. To review with trainees the sensitive nature of the material.

Content Themes

This section is basically introductory, orienting the members to the course. Introductions by the facilitator and course members are done after the pre-test is administered. An

overview of the agenda and course objectives is given. The primary goal of this section of the training program is to orient trainees to the course. Time will also be spent helping to prepare trainees for the sensitive nature of the material. This initial session is a crucial one since it sets the tone for the course and sensitizes the members to their feelings, prejudices, biases, etc., in response to the incest experience. Unless the course members recognize their own barriers to learning, effective treatment is unable to take place.

Activities

The trainer will introduce herself commenting on her specific background in the area of sexual abuse and chemical dependency.

The format for the 21 hour training will then be outlined, allowing for any questions or comments. The evaluation instruments will be described. These include a knowledge based pre-test and post-test and a short questionnaire, administered at the end of the training, which asks the trainee's reaction to the content, trainer, and training format. A folder containing articles, bibliography values clarification exercises will be distributed.

9:30-11:00

Objectives

1. To interpret the scope of the problem of sexual abuse in an historical and social context.

2. To enhance the trainees understanding of the dynamics of incest and impact on victims both as children and adults.
3. To encourage trainees to explore their own emotional reactions to the reality of sexual abuse.
4. To facilitate trainees to identify and clarify their emotional reactions to working with sexual abuse clients who are either chemically addicted or from chemically addictive families.

Content Themes

Drawing briefly on historical and societal analysis of sexual abuse, information will be presented to emphasize the historical roots of societal attitudes and behavior towards abused children. Workers generally do not have much knowledge about the prevalence studies (Kinsey, 1953, Finkelhor, 1978, Russell, 1983) within the normal population as well as newer studies in the chemical dependency field which have recently emerged (Young, 1990, Hurley, 1991, Wadsworth, 1995) .

Common emotional and behavioral indicators will be stressed as "red flags" especially with drug and alcohol clients for both identification and issues that may need to be addressed in treatment. Issues related to how to recognize the emotional and behavioral implications of these indicators as well as their impact, will be introduced.

It is important that workers have the opportunity to explore and identify the range of emotions that they bring to their work regarding sexual abuse issues. One of the most difficult areas for workers is identifying their emotional reactions and attitudes towards working with sexually abused clients and/or offenders. To help trainees in this area, several exercises have been developed: (a) a values clarification exercise in human sexual behaviors; (b) rank order exercise of case scenarios of different child sexual abuse situations; (c) a large group exercise whereby trainees identify any feeling they experience regarding sexual abuse and call them out to the trainer who lists them all on a chalk board. To the extent that trainees are aware of their feelings and difficulties they are better able to intervene and, therefore, effectively treat their clients.

Activities

Information from the following content areas will be presented in didactic form:

1. Social-cultural content within which to consider this problem.
2. Prevalence of child sexual abuse - both familial and extra familial.
3. Emotional and behavioral indicators of sexual abuse will be reviewed.
4. Introduction and viewing of the film "Better Safe Than Sorry II."
5. Each trainee will be given two values clarification exercises to complete for themselves. One exercise deals with rank ordering human sexual behaviors with their reactions indicating "No Restrictions," "Age Restrictions"; "Refer for Counseling"; "Imprisonment". The other exercise notes five situations in which children are sexually abused and the trainee is asked to rank order them, with #1

given to the situation they find most disturbing, through #5 for the situation they would find least disturbing.

6. Group Verbal Activity in which the trainees are asked to express any feeling they experience when they think of Child Sexual Abuse. The responses are then listed on a chalkboard by the trainer.

Materials

Film, "Better Safe Than Sorry II"

Values Clarification Exercises (Handouts 4 and 5)

11:00-11:15 Break

11:15-12:00 Group Format

Objectives

1. To facilitate the trainees experiences of the information presented earlier.
2. To further facilitate the feelings that the trainees experienced while completing the values clarification exercises on sexual behaviors and sexual abuse.
3. To encourage trainees to explore their emotional reactions to the area of sexual abuse.

Content Themes

For some workers, the work with the survivor is most difficult; for others it is working with the offender. To the extent that workers are aware of their problems they are better able to intervene in a professional and objective fashion. The integration between thinking, knowing, feeling and doing is often difficult to achieve. To facilitate this process, the group format will emphasize the application of the information presented while also utilizing the group as a "de-briefing" process for the trainees. They may, therefore, identify barriers to effective treatment with their clients for themselves, while also being exposed to a "normalizing" experience thus profiting from the process of a "collegial" support system.

Activities

Each trainee in the group will be asked for the feelings they experienced during the session. Trainees will be asked to share with the group some of their responses to the rank order exercises they completed as well as their feelings about their responses and to express the thoughts associated with the feelings. Feelings are also elicited from the trainees on the film "Better Safe Than Sorry II." As is done above, thoughts associated with these feelings are also elicited from the trainees. In general, this reveals distortions in thinking and/or misinformation. Processing this within the group results in better integrating feelings and thoughts so that more effective interaction can take place with clients.

Materials: Handouts 1, 2, 3, 4 and 5.

12:00 End of Day One.

HANDOUT #1

Re: 20 Question Pre-Test/Post-Test ~

Age: Sex: last four digits of SS/:

1. Many Children believe that sexual abuse was their fault. T F
2. Rigid roles and rules are often found in an incestuous family. T F
3. Many sexual abusers learn these behaviors in adulthood. T F
4. The child is never to blame for the sexual abuse. T F
5. Incest is considered to be a misuse of power. T F
6. Alcoholism and drug abuse are consistently found in incestuous families. T F
7. An offender is not usually considered to be a well-respected member of the family or society. T F
8. The taboo of incest in our society helps to prevent it. T F
9. Most likely, a boy who is molested by another male will become homosexual. T F
10. Children may feel pleasure when the incest occurs. T F
11. In our society, about 1 in 3 females and 1 in 7 males is sexually abused as children. T F
12. Approximately 5% of incest perpetrators are female. T F
13. The modal age of incest of female children occurs at age 7. T F
14. Boys and girls are abused about equally under the age of 8. T F
15. Fondling is the behavior most often cited in incest cases. T F
16. Group therapy is essential to the effective treatment of incest and alcoholism and needs to occur concurrently with individual therapy. T F
17. Sibling incest is more common than father-daughter incest. T F
18. Betrayal, stigmatization and powerlessness are concepts utilized in the Traumatic Model of David Finkelhor. T F
19. Suzanne Sgroi's incest model of five stages does not include a Disclosure phase. T F
20. The interactional patterns in the family teach the victim/perpetrator role to each family member whether or not that member had been sexually abused. T F

HANDOUT #2

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HANDOUT #3

Course Articles - Handouts -

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HANDOUT #4

VALUES CLARIFICATION

EXERCISE

Please rate from one (1) to five (5) the following case scenarios, based on which would be the easiest (1) for you to work with to (5) that which would be the most difficult:

- _____ A five year old boy who had been molested by a 40 year old man in the neighborhood; the molestation included anal penetration and oral sex.
- _____ A three year old girl molested by her father; involved fondling, digital penetration.
- _____ A 10 year old boy who had been abused by his mother; involved in oral-genital contact and fondling.
- _____ A 14 year old girl sexually abused by her step-father; included fondling, oral-genital contact, and intercourse.
- _____ A 7 year old girl, living with her mother who is gay and living with another woman; molested by her father while on visits to his house; fondling is the only sexual contact known to have occurred.

3/92

HANDOUT #5

SEXUAL SPECTRUM
REACTION FORM

REACTIONS:

- A No restrictions
 B Age restrictions
 C Refer for counseling
~~D Refer for psychiatric treatment~~
 E Imprisonment

BEHAVIORS	A	B	C	D	E
1. Menage a trois					
2. Adultery					
3. Female prostitution					
4. Male prostitution					
5. Obscene caller					
6. Male homosexuality					
7. Incest					
8. Voyeurism					
9. Fellation					
10. Intercourse - female dominant					
11. Necrophilia					
12. Cunnilingus					
13. Anal intercourse (homosexual)					
14. Anal intercourse (heterosexual)					
15. Flagellism-sadomasochism					
16. Transvestism					
17. Exhibitionism					
18. Pederasty					
19. Bestiality					
20. Bondage-sadomasochism					
21. Female homosexuality					
22. Fetishism					

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Day Two

Family System Dynamics/Similarities Between Incest and Addiction/

Profiles of Family Members Including the Offender

9:00-9:15 Arrival/Check in Dependant

9:15-11:00

Objectives

1. To provide information about family systems theory and family dynamics.
2. To identify the similarities in family dynamics of incest and alcohol/drug abuse.
3. To increase understanding of the dynamics common to the incestuous chemically dependant family.
4. To introduce information concerning the individual psychological and psychosocial profiles of family members within the chemically dependant incestuous family.

Content Themes

This section facilitates the course members' understanding of the impact of an incestuous relationship on a family. A conceptual framework for understanding family dynamics, as well as the individual's psychosocial dynamics within the chemically dependent family system, which includes the offender, will be presented. In order to understand the impact

of an incestuous relationship on a family, common patterns of family relationships, both healthy and dysfunctional, will be discussed using family systems concepts.

Following this, the dynamics commonly found in an incestuous family, as well as a chemically dependent family, will be discussed and emphasized. These dynamics include secrecy, denial, boundary distortions, disturbed marital system, dysfunctional parent-child relationships and sibling relationships typically characterized by conflict and isolation.

The manner in which the family dynamics of a chemically dependant incestuous family system make interventions very difficult will be explored. It will be pointed out that the tendency for all family members to deny both addiction and sexual abuse coupled with other dysfunctional patterns, especially in relationship to boundary confusion creates the need for specialized intervention.

Information will be offered to the trainees involving the psychological and psychosocial profiles of the individual members in the chemically dependant incestuous family, that is, the male offender, the mother and the incested child, in order to better understand the impact of the incestuous experience upon the individual within the family system.

Activities

A conceptual framework for understanding family dynamics as well as the individual members psychosocial dynamics within the chemically dependant incestuous system will be presented. The Family Dynamics Model " as developed by Noel Larson (CSW) will be emphasized. Information as described by A.Nicholas Groth, Ph.D., concerning the "Fixated" vs "Regressed" offender will presented as well as the psychological profiles of the mother and incested child in the family system.

Materials

Incest Family Dynamics (handout 6)

Fixated vs Regressed Offender Profile (handout 7)

11:00-11:15 Break

11:15-12:00 Group Format

Objectives

1. To facilitate the trainees feelings, reactions, ideas of the information presented earlier.

2. To encourage the trainees to explore their emotional reactions and thoughts to the area of the similarities between the family dynamics of the the chemically dependant and incestuous family systems.
3. To facilitate the expression of feelings and ideas regarding each member in the family system with emphasis on the issues related to the "fixated vs. regressed offender."

Content Themes

Due to the emotionally charged material presented in regards to the individual psychosocial profiles of the child, mother and male offender, (fixated vs regressed) as well as the dysfunctional patterns which take place in the chemically dependant incestuous family system, these similar patterns commonly include the family dynamics of secrecy, denial, boundary distortions, a disturbed marital system, dysfunctional parent-child relationships and sibling problems typically characterized by isolation and conflict for family members. The psychological profiles of the individual members in the family include denial of feelings, poor self-esteem, and a lack of support for individual differences. The opportunity in a "meeting for learning" approach is offered to the trainees to participate in the group discussion. A better understanding of the individuals within the family system as well as a family centered perspective of the chemically dependant incestuous family will be provided and clarified through the trainees' thoughts, questions and shared experiences.

Activities

Each trainee in the group will be asked for the reactions, thoughts and feelings they experienced during the session regarding the Family Dynamics Model as developed by Noel Larsen, and the similarities with the dynamics of the Chemically Dependent Family System, as well as their feelings and reactions to the information described by A. Nicholas Groth concerning the profiles of the "fixated vs. regressed" offender. In addition, the trainees will also be encouraged to share their feelings regarding the profiles of the child and non-offending mother in the incestuous family system.

Materials: Handouts 6 and 7.

12:00 noon End of Day Two

HANDOUT #6

INCEST FAMILY DYNAMICS

Noel R. Larson, Ph.D.
James W. Maddock, Ph.D.

1. Incest is a "family affair," symbolizing dysfunction within the family unit.
2. As a family illness, no one in the family escapes the "influence" of the symptom, which is inappropriate sexual contact.
3. Incest families are characterized by problems in boundaries in all four areas of boundary maintenance in families:
 - a. Overly rigid boundary around the family system, keeping in secret and pain.
 - b. Overly diffuse boundary between generations: Intergenerational boundary
 - c. Overly diffuse boundary between individuals: Interpersonal boundary
 - d. Overly diffuse boundary between reality and fantasy: Intrapsychic boundary
4. Incest follows along generational lines, throughout the extended family system.
5. The patterns of interaction in the family teach the perpetrator/victim pattern to all its members.
6. Sexualized dependency is central to the operation of the family.
7. Loss and abandonment underlie the basic family structure.
8. Incest as a symptom means different things in different families.
9. Treating the symptom without treating the illness is rarely useful and/or permanent.

HANDOUT #7

A. Nicholas Groth, Ph.D.
 R.R. #1 Box 484
 Lakeside Beach
 Webster, MA 01570
 (617) 943-2381

MOLESTATION

1. Approach is one of seduction or persuasion; offender gains access to victim through deception, enticement, and/or manipulation.
2. Passivity and dependency are major psychological dynamics.
3. Offender displays a positive emotional investment in child; child is seen as "soul" and "caring".
4. Offender typically seeks an ongoing (sexual) relationship with child; involved with child over extended period of time.
5. Victim is a prop in offender's fantasy onto whom offender's needs are projected.
6. Offender's sexual behavior sometimes confined to non-genital acts and/or gradually progresses to increasingly overt and intimate sexual acts.
7. Offender typically wants victim to enjoy the sexual activity; experiences sexual activity as acceptance or expression of affection.
8. Sexual misuse of the child

FIXATED

1. Primary sexual orientation is to children; sexual attraction to children recognized by offender as a permanent state; interest experienced as due to internal, psychological influences.
2. Pedophilic interests begin at adolescence.
3. No precipitating stress/no subjective distress.
4. Persistent interest and compulsive behavior.
5. Premeditated, pre-planned offenses.
6. Identification: offender identifies closely with the victim and equalizes his behavior to the level of the child and/or may adopt a pseudo-parental role to the victim.
7. Male (same sex) victims are primary targets.
8. Little or no sexual contact initiated with age-mates; offender is usually single or in a marriage of convenience.
9. Emphasis in sexual interaction usually focused on sexually stimulating the child and eliciting a positive erotic response from him/her.
10. Usually no history of alcohol or drug abuse and offense is not usually alcohol related.
11. Characterological immaturity; poor sociosexual/peer relationships.
12. Offense = maladaptive resolution of life development (maturation) issues.

REGRESSED

1. Primary sexual orientation is to age-mates; sexual attraction to children regarded by offender as a temporary lapse of control/judgement due to external, situational influences.
2. Pedophilic interests more likely to emerge in adulthood.
3. Precipitating stress usually evident.
4. Involvements may be more episodic and may wax and wane with stress.
5. Initial offense may be impulsive and not premeditated.
6. Substitution: offender replaces conflictual adult relationship with involvement with a child; victim is advanced to a pseudo-adult role and, in incest situations, the offender abandons his parental role.
7. Female (opposite sex) victims are primary targets.
8. Sexual contact with a child coexists with sexual contact with age-mates; offender is usually married or in common-law relationship.
9. Emphasis in sexual interaction usually focused on offender's arousal, stimulation, and sexual release; child is cast into adult sexual role.
10. Offense is often alcohol related.
11. More traditional lifestyle but under-developed peer relationships.
12. Offense = maladaptive attempt to cope with specific life stresses.

Day Three

Behavioral and Emotional Manifestations of Sexual Abuse/

Sexual Abuse Syndrome by Suzanne Sgroi

9:00-9:15 Arrival/Check in

9:15-11:00

Objectives

1. To discuss the behavior and emotional manifestations of sexual abuse.
2. To introduce a conceptual framework for understanding the psychological impact of incest victimization. (Sexual Abuse Syndrome)

Content Themes

Common emotional and behavioral indicators and symptoms will be stressed as "red flags" for both identification and issues that may need to be addressed in treatment. Issues related to recognition of these indicators and symptoms will be emphasized and implications for intervention will be discussed in the chemically dependant individual.

The child sexual abuse syndrome framework (Sgrori) consisting of the five phases of engagement, secrecy, sexual interaction, disclosure, and suppression will be introduced to provide a conceptual model for understanding the process of victimization.

- a. In relation to the **Engagement Phase**, which is a non-sexual phase, the use of the relationship with the child as well inducements and normalization of sexual intent will be explored.
- b. The **Sexual Interaction Phase** is looked at with the issues of frequency, progression, an ongoing attempt to normalize sexual behaviors as well as circumstances related to the use of photos, drugs, videotaping and impact upon the child.
- c. The **Secrecy Phase** is discussed in terms of a continuum of coercive techniques, appeal to affection for the offender, to physical threats and use of force on the child, as well as the exploitation of the child's vulnerabilities.
- d. The **Disclosure Phase**, if it occurs, is looked at as a process and not an event; it could be either accidental or purposeful.
- e. In reference to the **Suppression Phase**, the issues of internal pressure that the child experiences result in the defenses aimed at avoiding painful memories as well as external pressure placed upon the child by the response of the offender, family members and significant others is explored.

Activities

1. Information the Emotional and Behavioral indicators of sexual abuse will be reviewed in didactic form.

2. Normal Sexual Development will be reviewed.
3. The five phases of the child sexual abuse syndrome will be described and implications for assessing the emotional and behavioral manifestations of sexual abuse in childhood will be discussed, as well as how these manifestations are acted upon in adulthood in the chemically dependant and other family members within the system.

Materials

Characteristics of the Healthy/Eroticized Child (handouts 8 & 9)

Child Sexual Abuse Dynamics of Victimization (handout 10)

11:15-12:00 Group Format

Objectives

1. To encourage group discussion concerning the issues related to sexual development symptomatology of sexual abuse and the conceptual framework of the impact of the Sexual Abuse Syndrome Model.
2. To facilitate the thoughts, feelings, ideas of the trainees with regards to the process of the sexual abuse experiences and its impact upon the child as well as the adult survivor.

Content Themes

The common emotional and behavioral symptoms and indicators of sexual abuse are stressed to encourage identification of sexual abuse. Issues related to normal sexual development will also be reviewed, the five phases of the Child Sexual Abuse Syndrome as developed by Suzanne Sgroi, M.D., will be described (i.e., Engagement, Secrecy, Sexual Interaction, Disclosure and Suppression). This information, as well as the emotional and behavioral implications of sexual abuse – which may be acted upon as an adult by one who is chemically dependent – will also be explored.

Activities

Information from the following content areas will be explored in group format so that feelings, thoughts, and the ideas of the trainees can be facilitated:

1. Issues related to sexual development and symptomatology of sexual abuse of the chemically dependent client;
2. The conceptual framework of the impact of the Sexual Abuse Syndrome Model developed by Suzanne Sgroi, M.D., on the chemically dependent client.

Materials: Handouts 8, 9 and 10.

12:00 noon End of Day Three

HANDOUT #8

CHARACTERISTICS OF THE HEALTHY CHILD

Sexual Self: The child generally has a poor understanding of specific sexual body parts (e.g., urethra vs. vagina), commonly attaches a negative value to the entire genital area, but is curious about sexual functions and body parts.

Touching/Nurturing: The child can distinguish sexual from nonsexual touch. She can be distracted from

Basic Identity: sexual activities to engage in other play behaviors. She may fantasize or masturbate at times of boredom or she has worth inactivity.

Friendship: The child has multiple opportunities for friendship with accompanying development of skills and problem solving activities. She does not form intense attachments early. If sexually abused, she can rely on these resources to help restore sense of worth and age appropriate relationships.

Stress: The child has developed effective coping mechanisms to deal with day-to-day frustrations and stress.

Adapted from "Psychological Damage Associated with Extreme Eroticism in Young Children" by Alysne Yates, 1987, *Psychiatric Annals*, 17, pp. 257-261. Copyright by SLACK, Inc.

HANDOUT #9

CHARACTERISTICS OF THE EROTICIZED CHILD

Sexual Self: The child's private body parts are highly valued. Because this is the only area in which she feels she is valued by adults or people who can care for her, being sexually satisfying to others becomes extremely important and reinforcing. It becomes central to how she organizes her relationships to all other people.

Basic Identity:

Inferiority/Shame:

Child develops belief that she is "damaged goods."

Touching/Nurturing: The child will be aroused through casual interaction with playmates, adults or even large stuffed animals. She is unable to differentiate sexual from non-sexual touching. When the only close relationship has been a sexual relationship, the child has learned to expect that all touch leads to sexual behavior.

The child has little to build from but the abusive, sexualized relationship. Therefore, in stress the child reacts with a "simplistic, sexual approach to complex situations".

Friendship: The child is not allowed opportunities to develop friendships. She is emotionally neglected inside the family and emotionally isolated from the community. When there is the opportunity to have social contacts, the child forms personalized friendships. If these relationships do not become overly sexual, they are profoundly frustrating to the child because this is the only way she can understand and believe a relationship can continue. The child may react with anger or distancing.

Stress: Sexual activity (masturbation, etc.) may be her most familiar way of reducing tension since being sexual is the way she was taught to deal with her feelings. Therefore, well intentioned efforts to inhibit her sexual behavior may increase her distress and increase the likelihood of further sexual activity.

Adapted from "Psychological Damage Associated with Extreme Eroticism in Young Children" by Alayne Yates, 1987, *Psychiatric Annals*, 17, pp. 257-261. Copyright by SLACK, Inc.

HANDOUT #10

(Developed by Fordham University Graduate School of Social Service,
Center for Training and Research in Child Abuse and Family Violence)

CHILD SEXUAL ABUSE
DYNAMICS OF VICTIMIZATION

1. Engagement

- Non-sexual phase
- Use of relationship with child
- Inducements and normalization of sexual intent

2. Sexual Interaction

- Frequency
- Progression
- On-going attempt to normalize sexual behaviors
- Special circumstances: multiple perpetrators, use of photos, videotaping, drugs, ritual abuse

3. Secrecy

- Continuum of coercive techniques: appeal to affection for perpetrator to physical threats and use of force
- Manipulations match perpetrators' child relationships, and take advantage of child's vulnerabilities

4. Disclosure

- Process, not an event
- Accidental
- Purposeful

5. Suppression

- Internal pressure: child's defenses aimed at avoiding painful memories
- External pressure: response of perpetrator, family members and significant others.

Day Four

The Traumagenic Model: A Conceptual Framework for Treatment

9:00-9:15 Arrival/Check in

9:15-11:00

Objectives

1. To introduce the traumagenic dynamics model as a framework for understanding treatment priorities for the chemically dependent sexual abuse survivor.
2. To demonstrate that the model can be used in the assessment and treatment of the chemically dependent sexual abuse survivor.

Content Themes

Sexual abuse in childhood can be understood as a trauma. The traumagenic dynamics model as outlined by Finkelhor and Brown (1985) discusses the manner in which sexual victimization is different from other forms of victimization. The difference between sexual abuse and other kinds of trauma is that it is a secret, and therefore, cannot be processed and resolved by the child. The strong feelings of anger, rage, fear, shame, etc. are tied to the memories of the experiences. Since unprocessed memories cannot be moved to “past memory,” they are held in “current memory” and are defended against. Unlike a crisis such as a death, which after about a year can be recalled without very

strong affect, childhood memories of sexual abuse retain their original depth of feeling since there has not been a vehicle for their expression and resolution. Treatment is crucial for this to occur. Finkelhor and Browne suggest that the impact can be measured by assessing four areas. These are: the extent of the traumatic sexualization, the feelings of betrayal, the feelings of stigmatization, and the degree to which feelings of powerlessness have become internalized.

The first of the four elements, traumatic sexualization, refers to the impact that is specific to the sexual nature of the trauma. What acts the child has been forced to engage in and how the child experienced them are important to consider. The inappropriate early involvement of children and adolescents in adult sexuality needs to be understood in the context of development. Of particular importance to assess and treat is the extent to which the individual has divorced affection from sexuality and used splitting as a defense against the trauma.

The second component relates to betrayal, specifically by the offender, but the derivative of this is expressed in the inability of the individual to trust themselves and others. If disclosure had occurred, the sense of betrayal may have been amplified by the mother if she did not believe the victim. The implications of this for treatment are that the individual may be expected to have negative relationships within the social and sexual spheres, as well as in relationships with authority figures especially the therapist. The therapeutic goal becomes building trust and self-esteem.

Stigmatization is the third factor to be addressed. The individual's feelings of "why me" must be addressed. The child often feels stigmatized especially if everyone treated the child as if he/she were the problem. The therapeutic goals are to reduce the feelings of isolation and difference. Group treatment is suggested as the most effective modality for achieving this with the individual.

The fourth factor is that of powerlessness. It is important to understand that for an individual to have been sexually abused, control had been taken away. The child had experienced a lack of control over decision making, as well as a lack of control over his or her own body. The individual may present as overly compliant, or by contrast, manifest overtly aggressive or sexually acting out behaviors.

The therapist's role is to help the individual resolve the strong feelings associated with sexual victimization. It is particularly important for the trainees to understand that as traumatic memories surface, acting out may occur and to be prepared for it.

Activities

This material will be presented in didactic format.

Materials

Traumagenic Dynamics Model (handout 11)

11:00-11:15 Break

11:15-12:00 Group Format

Objectives

1. To facilitate a discussion to address what the therapist will be doing in treatment to address each of the dynamics.
2. To review one worker's case, assessing and establishing treatment goals while also identifying strategies.

Content Themes

Same as large group discussion.

Activities

A trainee will be asked to present one of their cases. Using the handout as a guideline the specific dynamics in this case will be evaluated. The group will then be asked to participate in establishing priorities and identify strategies that the worker could utilize.

Materials: Handouts 11 (For Traumagenic Dynamics) and 12 (Traumagenic Dynamics in the Impact of child Sexual Abuse).

12:00 noon End of Day Four

HANDOUT #11

FOUR TRAUMAGENIC DYNAMICS OF SEXUAL ABUSE

David Finkelhor and Angela Browne

I. **Traumatic Sexualization**- refers to the way in which a child's feelings and attitudes about their sexuality are shaped by the damaging interactions between themselves and their offender(s). Sexually abused children are often repeatedly rewarded for sexual behavior that they cannot understand, but which they learn to connect with affection, attention, feeling special and gifts. Children who are traumatized sexually are very confused about the role of sex in intimate relationships and often develop negative attitudes about their own bodies which can manifest emotionally and behaviorally as prostitution, anger, sex role confusion, fear of being touched and re-enacting the traumatic event through perpetration of younger children.

II. **Stigmatization**- refers to the way children feel when they blame themselves for the "problems" that have occurred because of their disclosure (see handout). This situation is worsened when family members blame the child and the child is further isolated by being made to tell their story over and over without support. Stigmatization makes children feel alone, ashamed, guilty and different.

III. **Betrayal**- refers to the feeling children have when they discover that someone on whom they are dependent has seemingly willfully harmed them. The nature and depth of the relationship with the offender will affect the degree of betrayal, as well as the extent to which the child was tricked. Betrayal affects the child's ability to trust and feel safe with others.

IV. **Powerlessness**- refers to helplessness children feel when they are unable to stop their abuse. Abuse by parents, especially authoritarian parents, will intensify the powerlessness and threats will not be necessary to force the child to submit. Children who are sexually abused will feel trapped and often lack the coping skills to make positive changes in their life.

TRAUMATIC DYNAMICS IN THE IMPACT OF CHILD SEXUAL ABUSE

David Finkelhor and Angela Browne

I. TRAUMATIC SEXUALIZATION

Dynamics

- Child rewarded for sexual behavior inappropriate to developmental level
- Offender exchanges attention and affection for sex
- Sexual parts of child fetishized
- Offender transmits misconceptions about sexual behavior and sexual morality
- Conditioning of sexual activity with negative emotions and associations

Psychological Impact

- Increased salience of sexual issues
- Confusion about sexual identity
- Confusion about sexual norms
- Confusion of sex with love and care-giving/care-giving
- Negative associations to sexual activities and arousal sensations
- Aversion to sex-intimacy

Behavioral Manifestations

- Sexual preoccupations and compulsive sexual behaviors
- Precoocious sexual activity
- Aggressive sexual behaviors
- Prostitution
- Sexual dysfunctions: flashbacks, difficult in arousal, orgasm
- Avoidance of or phobic reactions to sexual intimacy
- Inappropriate sexualization of parenting

II. STIGMATIZATION

Dynamics

- Offender blames, denigrates victim
- Child infers attitudes of shame about activities
- Others have shocked reaction to disclosure
- Others blame child for events
- Victim is stereotyped as damaged goods

Psychological Impact

- Guilt, shame
- Lowered self-esteem
- Sense of difference from others

Behavioral Manifestations

- Isolation
- Drug or alcohol abuse
- Criminal involvement
- Self-mutilation
- Suicide

III. REVENAL

Dynamics

- Trust and vulnerability manipulated
- Violation of expectation that others will provide care or protection
- Child's self-being disregarded
- Lack of support and protection from parent(s)

Psychological Impact

- Grief, depression
- Extreme dependency
- Impaired ability to judge trustworthiness of others
- Mistrust, particularly of men
- Anger, hostility

Behavioral Manifestations

- Clinging
- Vulnerability to subsequent abuse and exploitation
- Allowing own children to be victimized
- Isolation
- Discomfort in intimate relationships
- Marital problems
- Aggressive behavior
- Self-harm

IV. POWERLESSNESS

Dynamics

- Body territory invaded against the child's wishes
- Vulnerability to invasion continues over time
- Offender uses force or trickery to involve child
- Child feels unable to protect self and halt abuse
- Repeated experience of fear
- Child is unable to make others believe

Psychological Impact

- Anxiety, fear
- Lowered sense of efficacy
- Perception of self as victim
- Need to control
- Identification with the aggressor

Behavioral Manifestations

- Nightmares
- Phobias
- Somatic complaints; eating and sleeping disorders
- Depression
- Running away
- School problems, truancy
- Employment problems
- Vulnerability to subsequent victimization
- Aggressive behavior, bullying
- Delinquency
- Becoming an abuser

Day Five

Special Issues and Treatment Strategies with Offenders

9:00-9:15 Arrival/Check In

9:15-11:00 Guest Speaker (a professional who works with offenders)

Objectives

1. To introduce a conceptual framework for understanding the motivation of the incest offender.
2. To provide the trainees with an understanding of the goals and strategies employed in the treatment of the sexual offender.

Content Themes

The information presented in this session is based primarily upon the male offender since the expertise and practice of the speaker works with the male offender population. In addition, little research exists in dealing with the female offender at this time.

Finkelhor's Four Stage Precondition Model, which synthesizes many of the theories offered to account for the motivation to sexually abuse children will be presented. This model incorporates material from the theoretical approaches:

1. Motivation to abuse arising from the arousal to deviant sexual objects.
2. Motivation to abuse arousing from the inability to negotiate relationships with age-mates.
3. Motivation to abuse arising from the dysfunctional family system.

A review of the "Fixated vs Regressed" Offender Profile according to N.Groth will be provided. The need for specialized offender treatment with the chemically dependent to address these factors is discussed. An overview of different types of treatment and who is treatable is explored. Assessing and measuring the effectiveness of treatment will be shared with trainees. Questions and information to ask offenders will be reviewed. Issues related to what access the offender should have with the child as it relates to "Risk Assessment" (Abuse Maltreatment influences) will be highlighted. The importance of also dealing with alcohol/drug problems—which emphasize abstinence as a condition to treatment—will also be discussed. This will help worker improve assessment skills. Treatment implications for the offender, visitation and reunification will be presented.

Activities

This material will be presented by the guest speaker in didactic format. Case examples and vignettes will be presented to illustrate the major elements of the Pre-Condition model.

Materials

Four Precondition Model (handout 13)

11:00-11:15 Break

11:15-12:00 Group Format

Objectives

1. To provide an opportunity for the trainees to ask questions of the speaker, relate comments as well as to discuss various issues related to offenders and offender treatment.
2. To encourage the trainees to express their emotional reactions to the issue of offenders so that this emotionally charged area can be further explored and more effective treatment can take place for clients.

Content Themes

Ample time will be provided to the trainees for questioning, to comment and relate to the speaker's presentation on offenders and offender treatment. Due to the emotionally charged material presented, trainees will also have the opportunity to process their feelings and reactions to offender issues that arise for them so that these issues do not intrude in the treatment process.

Activities

The circle group format will be utilized for discussion, processing of material presented and questions concerning offender issues conducted by the speaker. The training staff member provides guidance and facilitates discussion.

Materials: None.

12:00 noon End of Day Five

Four Premises: A Model

TABLE 3-1 Continued

	LEVEL OF EXPLANATION	
	Individual	Social/Cultural
Premise III: Factors Contributing to Overcoming External Inhibitors	Mother who is absent or ill Mother who is not close to or protective of child Mother who is dominated or abused by father Social isolation of family Unusual opportunities to be alone with child Lack of supervision of child Unusual sleeping or rooming conditions Child who is emotionally insecure or deprived Child who lacks knowledge about sexual abuse Situation of unusual trust between child and offender Coercion	Child pornography Male inability to identify with needs of children Lack of social supports for mother Barriers to women's equality Erosion of social networks Ideology of family inequality Unavailability of sex education for children Social powerlessness of children
Premise IV: Factors Contributing to Overcoming Child's Resistance		

From *Child Sexual Abuse: New Theory and Research*
by David Finkelhor. New York: Free Press, 1979

Four Premises: A Model

TABLE 3-1
Preconditions for Sexual Abuse

	LEVEL OF EXPLANATION	
	Individual	Social/Cultural
Premise I: Factors Related to Motivation to Sexually Abuse		
Emotional congruence	Attained emotional development Need to feel powerful and controlling Re-enactment of childhood trauma to undo the hurt Narcissistic identification with self as a young child	Male role requirement to be dominant and powerful in sexual relationships
Sexual arousal	Childhood sexual experience that was traumatic or strongly conditioning Modeling of sexual interest in children by someone else Minimization of sexual acts Biologic abnormality	Child pornography Erotic portrayal of children in advertising Male tendency to misattribute all emotional needs
Illusionage	Oedipal conflict Castration anxiety Fear of adult females Traumatic sexual experience with adult Inadequate social skills Marital problems	Repressive norms about masturbation and castration
Premise II: Factors Contributing to Overcoming Internal Inhibitors	Alcohol Psychosis Impulse disorder Scidity Failure of internal inhibition mechanism in family dynamics	Social toleration of sexual interest in children Weak criminal sanctions against offenders Ideology of patriarchal prerogatives for fathers Social toleration for deviance committed

Day Six

Special Issues with Male Survivors/

Strategies and Goals for Treatment - Part I

9:00-9:15 Arrival/Check in

9:15-11:00

Objectives

1. To provide information regarding the differences between male/female survivors.
2. To review the traumagenic dynamics model as the framework for treatment of the chemically dependent sexual abuse survivor.
3. To provide information regarding the process of treatment and goals of therapy according to Eliana Gil, Ph.D., et.al., in relation to the chemically dependent and relapse.

Content Themes

While many issues raised by men who are survivors of sexual abuse resemble those cited by women, there are certain differences in the socialization process which are especially characteristic of male survivors. These differences are: dissonance between the male role expectation and the experience of victimization; shame and gender shame; and identification with the perpetrator and fear of continuing the cycle of abuse. Our culture

champions the male image as decisive, take, charge, in control of his destiny. The man is seen as powerful – not powerless. Such a man is not a victim! As a result, a male victim of sexual abuse may deny or struggle with the reality of his victimization—which defines himself as unmanly—inadequate. While shame related to sexual abuse is common for both male and female survivors, sexually abused men who are thus shamed experience an additional stratum which Dimock, Hunter and Struve (1991) call "gender shame". This refers to a sense of shame about oneself as a member of a class of "men". This "class shame" elicits profound ambivalence and confusion in terms of male survivors' identities as men and their identification with men. Perhaps the single most salient issue for the male survivor is the fear of perpetrating. There is a sense among male survivors that they are virtually fated to perpetuate the abuse.

The traumagenic dynamics model by D. Finkelhor, PhD., will be reviewed as a framework for treatment. The implications for treatment include "traumatic sexualization," "betrayal," "stigmatization," and "powerlessness." The theoretical foundations and goals of therapy for adult survivors of child sexual abuse have been described. A strong consensus exists among Briere, Courtois, Gil, Sgroi, and Herman, about the most useful theoretical models and goals of treatment. In general, the process of resolution therapy for adult survivors tends to be longer term, in order to deal with the generally pervasive effects of abuse; this is because of the intensity of the affect inherent in trauma.

Briefly, the therapy process can be thought to encompass the following goals, stages and issues: 1) the decision to heal and make the commitment to treatment; 2) the emergency stage - post traumatic symptoms may appear but these reactions are seen as "normative" to the recovery process; 3) memory retrieval - both memory and affect of the abuse are retrieved, that is, nightmares, flashbacks, memory fragments, perceptual disturbances; 4) believing it was real; 5) the acceptance stage; 6) recounting the abuse - breaking the secrecy of many years; 7) resolving issues of responsibilities, self blame and complicity; 8) the recognition, labeling and expression of feelings; 9) grieving, 10) cognitive restructuring of distorted beliefs; 11) disclosure, confrontation and other issues involving the perpetrator and others; and 12) self appreciation, self determination and behavior changes.

The relapse of chemically dependent clients is a notorious and frustrating problem. Recent literature supports the view that chemically dependent clients who have been sexually abused are more at risk for relapse. Traditional approaches to substance abuse treatment may be both problematic and exacerbating when treating clients who have been sexually abused. Most traditional approaches use a confrontational approach and focus exclusively on substance usage. Addressing and working with sexual abuse issues with clients who are chemically dependent is fundamental to the process of obtaining quality recovery and hence relapse prevention. Because research indicates that most chemically dependent women who have been sexually abused, and that unresolved sexual abuse issues may be a precipitant to relapse, addressing sexual abuse should be a routine aspect

of substance abuse treatment. It appears that direct, routine and repeated inquiry into sexual abuse history of chemically dependent clients facilitates their awareness of the abuse. Many authors of recent research indicate that if the sexual trauma of a chemically dependent client is not addressed relapse is highly probable.

Activities

This material will be presented in a didactic format. Case examples will be used from practice to illustrate different responses of male and female survivors; how the traumagenic model fits into chemical dependency dynamics by using case examples showing how the impact of sexual abuse upon the chemically dependent individual, if left unaddressed, commonly results in relapse.

Materials: *None*

11:00-11:15 Break

11:15-12:00 Group Format

Objectives

1. To illustrate interviewing and process techniques in the initial or second session with an adult survivor who is also chemically dependent.
2. To facilitate a discussion and to offer the trainees the opportunity to ask questions as well as offer observations on the role play.

Content Themes

Most of the literature recommends addressing the issue of sexual trauma directly and being proactive in the discovery of abuse. The longer abuse goes untreated, the greater the repression and more ingrained the symptoms become. Substance abuse is a primary example of symptomatology. Also, sobriety alone will not cure the effects of childhood sexual abuse. Many sexual abuse survivors will not offer information about the abuse unless specifically questioned about it. Systematically asking the question upon intake and at different phases of treatment, as well as addressing the issues openly so as to create a comfortable environment for such disclosure is recommended. Education via the "Education Series" Format, which has become the cornerstone of alcoholism treatment through the years, is an ideal vehicle for transmitting education on sexual abuse to clients.

To offer the opportunity to the trainees to participate in a role play situation (also through observation of the role play), to gain an experience, to ask questions, comments to make observations and have input about the session will facilitate and integrate the information for them.

Activities

A role play will be performed which illustrates an intervention into an initial or second treatment session with a chemically dependent individual who had been sexually abused as a child. The simulated session will take approximately ten minutes. The case situation involves a chemically dependent female sexual abuse survivor who has indicated upon

intake that she experienced sexual abuse by her alcoholic father when she was a child.

Client is presently in out patient treatment having experienced two relapse episodes attaining six months sobriety with each attempt. Following this, discussion will take place for the trainees to comment, make observations and process the session.

Materials: *Case Scenario of Role-Play* (handout 14)

12:00 noon End of Day Six

HANDOUT #14

Role Play - Therapist: Trainer - Client: Trainee

Case Summary: Jane, a 33 year old chemically dependent female, presents herself after intake, for an Outpatient Treatment appointment with the therapist. Jane is married and has two children ages 5 and 8. Her spouse is non-alcoholic. Jane was raised in an alcoholic family; her father was the alcoholic. She has had two previous detoxes and AA involvement. The longest period of sobriety has been several months in the last two years. Jane disclosed upon intake, when asked for the first time, that she was sexually abused by her father when she was 8 years old. She stated that when she puts down the drugs and alcohol memories of the abuse begin to surface.

Day Seven

Strategies and Goals for Treatment, Part II/

Vicarious Traumatization and Therapist Self Care

9:00-9:15 Arrival/Check in

9:30-11:00

Objectives

1. To review and further provide information for the sexual abuse victim who is chemically dependent regarding treatment goals and the process of treatment
2. To introduce conceptual framework and the treatment model of S.Sgroi while highlighting issues related to chemical dependency and relapse.

Content Themes

Eliana Gil described "positive resolution" of the trauma, as being achieved when the trauma is processed in a realistic way and the affects associated with the abuse memories are experienced. Responsibility for the abuse is attributed to the abuser and not the self.

The abuse is understood as being in the past, not a danger in the present.

S. Sgroi has described recovery as a "spiral" rather than linear process, whereby the client is likely to go through one or more phases of perspectives in dealing with the abuse.

Recovery takes place within the context of relationships, it cannot occur in isolation.

Group therapy for sexual abuse issues is essentially useful in treatment. The core experiences of psychological trauma are disempowerment and disconnection from others. In renewed connections through the group process, the survivor creates the psychological faculties that were disformed and damaged by the traumatic experience. These faculties include the capacities for trust, autonomy and intimacy.

The treatment model suggested by Sgroi recommends same sex groups focusing on sexual issues and dynamics of sexual abuse. The model is offered as a fifteen week format (which can be adapted to one of a shorter or longer duration) and is a closed group for that particular module. The survivor can repeat the group modules as often as deemed helpful. The particular sessions relate to the implications for treatment as outlined in the traumagenic model; that is, inappropriate sexualization, betrayal, powerlessness, stigmatization, issues related to fear, trust, relationships, sexuality, self-esteem, etc. All of these issues can become topics used in this psychoeducational therapy group format. This model could easily be incorporated into the chemical dependency treatment milieu with individual therapy offered as well.

It is important to understand that the treatment program, as regards the originally identified addictive disorder, is a crucial ongoing support for recovery related to the childhood trauma. Abstinence is supported by this treatment. A significant contributor to relapse may be the failure to identify and treat underlying childhood sexual abuse issues. Abstinence from the addiction will initiate withdrawal from the effects of the

addiction, one of which has been to effectively block sexual abuse memories. These memories may surface immediately or at any point along the recovery continuum. An attempt to once again block these painful and often overwhelming memories may lead to relapse. When relapse occurs in connection with these memories, or when there is a threat to remaining sober due to these memories, a treatment process focusing on the abuse must be initiated. The initial task is to disclose the abuse. If clues are missed or the abuse is dismissed as unimportant, the person may return to silence and secrecy. At the same time, it is important to assess the readiness of the survivors to face these issues and to proceed sensitively. The original treatment setting provides a consistent, reliable base, as the exploration and working through of the trauma proceed in sexual abuse specific groups as well as individual treatment.

Activities

This material will be presented in a didactic format.

The film, "Healing from Incest" by E.Gil, Part 1 (20 minutes) will be used. This film contains discussions with clients in treatment for sexual abuse as well as chemical dependency which emphasizes the treatment process and recovery.

Materials

Film: "Healing from Incest" by E.Gil

11:00-11:15 Break

11:15-11:45 Group Format.

Objectives

1. To facilitate discussion and offer trainees the opportunity to ask questions, make comments and express feelings regarding the treatment model for sexual abuse survivors who are chemically dependent.
2. To provide a brief overview and framework of "vicarious traumatization" of the worker by the sexual abuse client and discuss recognition of this dynamic and ways of dealing with it; that is, in terms of "taking care of oneself", attending ongoing peer group supervision on a regular basis, etc.

Content Themes

The primary goal of this section of the training program is to offer a model for treatment for the chemically dependent who is also a sexual abuse survivor; deal with questions, comments, feelings about working with the dual focus of being a survivor and a chemically dependent individual as well as assessing and establishing treatment goals and strategies in working with both issues.

In dealing with the issue of "vicarious traumatization," it is important for the workers to identify their emotional reactions and attitudes towards working with some of the most emotionally difficult material that a client can bring into a session. To the extent that

trainees are aware of "vicarious traumatization" issues, they can better be able to integrate knowledge, feelings and thinking so as not to be overwhelmed themselves and to be better able to intervene in an objective fashion.

Activities

This material as well as the opportunity to comment will be held in a group format.

Materials

Letter by Wendy Maltz (handout 15)

Summary and Evaluation

1. Trainees will complete post-test.
2. Trainees will complete questionnaire.
3. Trainees will have the opportunity to provide verbal feedback.

Materials: *Post-test*

Reaction Questionnaire

12:15 End for day

HANDOUT #15

**Caution: Treating Sexual Abuse
Can Be Hazardous to Your Love Life**
by Wendy Maltz, M.S.W., LCS.W.

If you spend your days treating sexual abuse survivors, you may be noticing side-effects spilling into your personal life. Let's join our colleague, Jane, as she goes through a typical work day, and watch how the overflow occurs.

Good morning, Jane!

During breakfast, Jane tunes in her favorite morning television show, featuring a segment on sexual harassment, a movie review of The Prince of Tides, and a psychiatrist's account of how Jeffrey Dahmer seduced, murdered, cut up and ate his victims to gratify his sexual appetite.

"Want some eggs?" asks Jack, Jane's partner.

"Sure, but I'll skip the bacon today," she replies.

Taking a sip of coffee, Jane reads in the local newspaper that a woman only three blocks away was sodomized at gunpoint yesterday.

Driving to work, Jane hears on the radio how, when Mike Tyson had finished date-raping a 19-year-old girl, he asked her, "Don't you love me now?"

Ready for work, Jane? She has a relatively light schedule, with only six clients today. In the morning, Jane does an intake, then three sessions that focus on recovering memories of sexual abuse. She lunches with a fellow counselor who has just realized she was abused by her grandfather. In the afternoon, Jane sees two clients who discuss their sexual fears and acting-out behavior. Not a bad day.

Coming home early, Jane's just in time to watch the end of a talk show featuring women body builders who model lingerie in bars -- and don't feel exploited! "Surprising," she murmurs as she plops down on the couch and wonders how she would look in a blue lace teddy.

After dinner Jane switches on the T.V. again, and finds a rerun of "Something About Amelia." Great timing. One of her clients recently asked if she had ever seen it.

Now it's time to catch up on some professional reading. Her choices: an article on female sex offenders in the Journal of Interpersonal Violence, or two articles on ritual abuse in Treating Abuse Today. Which to read? Jane tackles all three.

Settling in bed, she listens as Jack takes a shower, shaves, puts on some cologne while crooning "Wild thing. . . You make my heart sing! . . ."

Jack scurries under the covers, sweetly kisses Jane's fingertips, and softly whispers in her ear, "Hey, wild thing, want to make love?"

Hearing a snore, Jack whimpers, "Wild thing?"

Course Evaluation -

Position/AgencyType: _____

OVERALL EVALUATION

Please answer the following series of questions about the training you have just completed. Your responses will be helpful for planning and in the development of future trainings.

For questions in which there is a five-point scale, circle the number which best corresponds to your response.

1. How much did you learn from this training?

1	2	3	4	5
not much		some		a great deal

2. How organized was the delivery of this training?

1	2	3	4	5
not very organized		somewhat organized		very organized

3. How useful will the knowledge and skills acquired in the training be to you?

1	2	3	4	5
not useful		somewhat useful		very useful

4. How comprehensive, or complete, was the workshop coverage of the topic?

1	2	3	4	5
incomplete		somewhat complete		comprehensive

What should be added ? _____

5. How was the pacing of this workshop?

too slow _____ just right _____ too fast _____

What would you like to have spent more time on? _____

6. Overall, do you think the goals of this training-- . . .
 . . . were achieved for you?

1	2	3	4	5
not at all		some-not		fully
achieved		achieved		achieved

Please explain a rating of 1 or lower: _____

7. Please rate the trainer:

1	2	3	4	5
poor		good		outstanding

Please give your own comments about the trainer: _____

8. I WOULD HAVE LIKED THE TRAINING BETTER IF ... (please fill in):

1. More time had been devoted to the topic dealing with _____

2. There had been more chance for _____

3. The trainer had been more _____

4. More information had been included about _____

5. Other (please describe) _____

9. In my view, the most effective part(s) of the training was (were): _____

10. OVERALL RATING OF THE TRAINING SESSIONS (circle one number):

1
poor

2
below
average

3
average

4
above
average

5
outstanding

THANK YOU!

Chapter VI: Conclusions, Implications & Significance

As noted, increasing evidence in the literature reveals a strong connection between a history of sexual abuse and the manifestations of addictive behavior. Studies have indicated that early sexual trauma may lead to early alcohol problems in women (Kovach, 1983; Nielsen, 1984; Young, 1990; Hurley, 1991; Briere, 1992). In addition, adults in mental health treatment who were sexually abused as children, describe their mistreatment in the context of parental drunkenness or drug intoxication (Briere, 1992). Thus, the association between alcohol and drug abuse and child maltreatment has become more common in the literature. However, the specific area of expertise which the professional develops during the course of training often establishes the manner in which he/she diagnoses and treats the problem. Alcohol and drug trained professionals will diagnosis and treat chemical dependency, while clinicians familiar with incest tend to more quickly diagnose and treat that problem.

While more research is needed to clarify the complex relationship between alcohol abuse and drug abuse and incestuous behavior, the literature does suggest that we should explore both sets of behaviors when either abuse occurs (Barnard, 1984, Jones, 1989, Barnard, 1990, Briere, 1992). As noted also, due to the high rates of recidivism in the

drug and alcohol addicted population, as well as the idea that childhood sexual abuse correlates with addictions, the issue of sexual abuse as a relapse trigger has become more recently acknowledged in the addiction field, as evidenced by the literature (Root, 1989, Young, 1990, Hurley, 1991).

While the literature does challenge professionals to develop programs and training strategies to work with this population, i.e., the chemically addicted clients who has been sexually as a child, no new information appropriate to this area of training treatment professionals has emerged (Barnard, 1984, 1990, Neilsen, 1984, Liles 1987, Faller, 1988, Jones 1989, Woodside, 1991, Graziano, 1992, Stevens, 1992).

Therefore, in response to the lack of training in the addiction field and to support the literature which challenges professionals to implement training curricula, a formal Sexual Abuse Training curriculum for Chemical Dependency Workers was developed from this study. Thus, a need was identified from the literature so that a formal curriculum was created and further developed from this qualitative study for use by the Addiction field.

Significant Findings from Data

These major findings of the analyzed data indicated that a majority of the course members interviewed, together with a sample of their supervisors, were in agreement, with a very high rate of satisfaction overall, but that the course could be enhanced by offering the following changes:

1. More information and treatment strategies on the offender
2. Additional case examples be given throughout the training
3. An experiential role play offering a treatment scenario of a sexually abused, chemically dependent client be included

It is important to note that the consistency of the members' and supervisors' responses validated each other. Thus, these three modifications were crafted into a formal curriculum innovation, which this investigator developed, as a result of this study for use within the addiction field.

A finding of interest, as noted above, is the extent to which the course members consistently appreciated and were enthusiastic to participate in the group process piece which is included at the end of each course session. The opportunity to engage peers in discussion is apparently an important element in the curriculum. This group experience enables on-going clarification, support, validation and problem-solving opportunities. There was an extremely strong consensus to continue the group process piece which, of course, validates this effective feature of the curriculum.

Some comments throughout the interviews and the evaluations indicated the inclusion of more case examples from practice or "how to" requests. While some more case examples were infused into the curriculum, mention needs to be made that one of the most effective learning tools is ongoing supervision. All members are invited to attend a monthly group

supervision led by the course facilitator where specific cases are presented and worked on by the group; this group supervision becomes the "how to" sessions.

It is significant to mention; as previously noted, that all supervisors within the Nassau County Service Delivery system also received this training prior to their supervisees and avail themselves, from time to time, of taking part in this group supervision. In addition to the monthly group supervision, the idea of providing quality supervision at the agencies had been taken into account, prior to the implementation of the social workers' training. Training the supervisors first was seen as a strong support for the workers who attend the training; i.e., having supervisors who *also* were knowledgeable about the topic in order to appropriately supervise their workers.

This study, together with the results of the evaluation, facilitated the creation and development of a formal Sexual Abuse Training curriculum for the addiction field. This model can be utilized to offer special needs training to workers who work with addiction. As noted, increasing evidence reveals a high correlation between a history of sexual abuse and the manifestation of addictive behavior.

Development of this curriculum model begins to answer the challenge to professionals to develop such training programs and strategies to work with this population, since no new information appropriate to the area of training treatment professionals to both incest and addiction dynamics have emerged within the existing literature.

While this contribution of a Sexual Abuse Training curriculum for the addiction field adds to existing understanding within the addiction field, the study's limitations preclude any claim that this curriculum innovation is the preferred strategy for training workers in the addiction field to the issues of sexual abuse. Use of this model, however, may clarify and enhance the successful implementation of a Sexual Abuse Curriculum for the addiction field.

Recommendations

Effectively confronting child abuse requires constructing bridges between those working with child sexual abuse and those involved in working with chemical dependency. A comprehensive plan in response to the pervasive concern about sexual abuse needs to offer rich resources for developing such a plan for this high risk population. Some of these resources can be found in the following areas of Public Policy / Education - Training and Research.

Public Policy & Education

According to former U.S. Surgeon General Julius Richmond, "The shaping of policy involves three critical areas: the development of a knowledge base, the development of political will and the development and implementation of public policy" (Richmond, Kotelchuck 1983).

At this time, information on sexual abuse and chemical dependency is growing as a result of work by clinicians and researchers. However, while more investigation needs to occur in the areas of offenders, as well as sexual addiction, as noted above, and more effective treatment strategies developed to deal with recidivism in both sexual offenders and drug and alcohol abusers, there is also a need to examine the connection between both types of abusers and behaviors. There continues to be a need to educate the general public about the special problems and risks associated with the connection of sexual abuse and family alcohol and drug abuse.

Public awareness efforts need to relate substance abuse issues and child abuse issues to issues of interpersonal violence in order to educate the community to better understand the overall relevance of each specific issue. In developing educational messages, the public must be aware not only of the high risk problems that exist with alcohol and drug addiction, but that these problems are treatable! Although problems exist, solutions, help and hope also exist. A nationwide public education campaign would facilitate the present interest in the topic. It could give both the public and professionals added impetus to reach out and help. Educational messages can also be the motivating force in encouraging victims to seek out the help they need and deserve.

Raising public awareness about the problems, vulnerabilities and opportunities to help these victims may help improve the lives of millions. Public awareness is central to the advancement and continuation of public policies affecting support for research,

prevention and treatment. A national public education campaign could bring addiction and sexual abuse issues further "out of the closet" to be more openly discussed and treated (Woodside, 1991). Positive media presentations can be a significant step in creating positive efforts for prevention and treatment.

Training and Coordination

The training of professionals to both drug and alcohol abuse and sexual abuse, as well as the coordination between service providers that is essential to quality delivery of all services have been difficult to achieve due to the following reasons:

- the lack of adequate funding at federal, state and local levels for training and the low priority professional academic institutions give training in substance abuse and child abuse;
- the lack of trainers' knowledge about issues of gender and cultural competence; the lack of attention given to populations with special needs;
- the tendency to look at problems categorically rather than holistically.

Thus, a comprehensive prevention and treatment plan would create a "blueprint for action" which would ensure improved training for professionals including child and sexual abuse and substance abuse information which would be added in undergraduate, graduate and post-graduate education as well as training programs for paraprofessionals.

This training would ensure at least, a level of identification of the problem of substance abuse and sexual abuse, which appear to occur frequently together. Specifically:

- a. School of Social Work curriculum should be infused with case examples of substance abuse and sexual abuse clients, both as children and as adults who present for treatment.
- b. Due to the high prevalence of addictive disorders in the general population, a course on Addictions in Schools of Social Work, with several sessions included on sexual abuse should be required for all Masters level students.
- c. In addition, in all courses related to child development in Schools of Social Work, the inclusion of substance abuse as well as sexual abuse issues and information should be included for all Masters level students in order to assure a strong network between substance abuse, sexual abuse and child development issues.
- d. Specialized training, i.e., a Post-Masters Certificate in Addictions be offered with a sub-specialty in identification and treatment of sexual abuse problems among this population.
- e. A Sexual Abuse Training Curriculum, as the one developed from this study, be offered as in-service training to all workers in alcohol and drug service delivery systems on a regional and/or a national level.
- f. Since the Addiction field has a preponderance of chemical dependency counselors who are paraprofessionals, a "mini" version of the Sexual Abuse Training curriculum can be modified; i.e., a nine-hour training, to teach identification,

intervention and referral to an appropriately trained masters level Social Worker, for consideration as an in-service training course for the paraprofessional population. Additionally, training programs for paraprofessionals could also modify their curriculum to include information on the identification of sexual abuse in the chemically dependent population as well as being a relapse trigger for these clients. In addition, training in substance abuse and child sexual abuse be mandated for doctors, lawyers and judges, and other mental health workers, school administrators, teachers, day car providers. Coordination is extremely difficult given the territorial and political issues that get played out in this area. However, a community-based coordinating council from all relevant agencies can be a helpful start in assuring coordination.

Research and Conclusion

Our knowledge remains imperfect. There is much we need to learn to improve prevention and treatment concepts and strategies. It is clear that researchers and practitioners need to work together with mutual respect to ensure that the most important research questions are addressed and that research findings are used to develop or enhance programs.

Program evaluation efforts can make important contributions to the development and implementation of short-term continuing education programs. Learning designs of many continuing education programs do permit formative evaluations which can be very useful

in both the planning and implementation of curriculum development, as well as ongoing program development utilized for continuing education of professionals (Fellin, 1994).

Without undue generalization, it does appear that continuing education can effectively enhance professional and organizational performance in the area of sexual abuse and addiction. The two major components of this project are the interviews conducted with former course members who participated in the Sexual Abuse Training program, and the newly-developed Sexual Abuse Training Program for Chemical Dependency Workers curriculum package. They make separate, equally important contributions to the profession. One advances the conceptualization of evaluating the needs of social workers in the addiction field working with incest survivors, through making operational a curriculum to expand their further concepts of treatment with survivors; the other advances the repertoire of the effective implementation of a curriculum model updating an area of current and critical concern to the profession.

As a result of this study, a start has been made in discovering which teaching methods on sexual abuse training appealed to these advanced professionals in the addiction field, as well as learning that more knowledge and skills are needed at the point of service delivery to increase worker effectiveness in the areas of both advanced offender treatment as well as sexual addiction. Sexual addiction is an exceptionally new area in the literature, but the need for advanced study in integrating chemical dependency, sexual

abuse and sexual addiction paves the way for updating curriculum development toward the end of even further increasing treatment effectiveness.

As this project has reached its end, a contribution has emerged that is, hopefully, sufficiently significant to be a beginning for the critical thinking of others so that expansion of knowledge and improvements in practice can be implemented for more effective client care.

Interview Guide - Appendix A

Thank you for taking the time to see me. Before we begin the interview, I would like to explain in greater detail its purpose and answer any questions you may have about the study.

(Statement said to Workers who participated in the Fall 1993 incest course:)) I would like to mention, however, that since the incest training ended last December and that life is full of busy things, at times, you may not remember the training in detail or you may not have found it useful: that's OK and I won't be offended.

The purpose of this study is to gather information for a doctoral dissertation about Social Workers who have participated in the Incest Training Course, which you were involved in during the Fall of 1993 (or 1994). My attention to this topic comes from my own experience in working with this population and social action efforts within the Nassau County Service Delivery System to train Social Workers on the issue of childhood sexual abuse and the chemically dependent individual.

I have asked you to participate because I would like to get your perspective on the incest training course which you were involved in with other Social Workers in the Fall of 1993 (or 1994).

The information you give me is confidential and will be presented anonymously in the dissertation. Neither the tape nor my interview notes will be shared, the agency will not be named, nor will any individual interviewed be identified by name. The interview will take about 1 1/2 hour. I appreciate your participation in the study and will send a final summary report to you, if you wish. Before we begin the interview, do you have any questions?

Basic Demographic Data: - What is your age? Sex? Race/Ethnicity
 - How long have you worked in the field of addiction.
 -How long have you had your Social Work degree

CORE QUESTION: "How has the incest/sexual abuse training changed your practice with clients?"

1. Can you describe your current practice with your clients.
 (Probes: demographics of caseload, description of modality(individual/family/group), length of treatment - short or long term cases)

2. What was it like for you to be involved in the training.
 (Probes: How did you feel about the experience. Was the group process piece helpful to you, in what ways.

3. What feelings did you experience prior to the training if you encountered a client who was sexually abused.

(Probes: Were you comfortable or uncomfortable with what was presented by the client; did you explore further or change the topic)

4. How has this training been effective for you in working with sexually abused victims now.

(Probes: how did you feel about the nature of the work, hearing violence as reported by clients as children prior to the training as opposed to after the training. What do you do differently. Are your coping mechanisms different).

5. As a result of the training, how do you now identify these issues with your clients.

(Probes: What questions do you now ask; what symptoms have you learned to identify; what of the family history alerts you to the abuse.

6. Compared to your practice prior to the training, in what ways do you now raise this issue with your clients.

(Probes: How is this question asked to clients, how is it explored; what do you say; how are these questions dealt with by your clients).

7. In your experience, what factors contributed to a lack of identification of sexual abuse with clients.

(Probes: Did your own sensitization issues play a role due to the

strongly emotionally charged material; lack of education; lack of training or skills.

8. In terms of the training, can you identify certain "milestones" that helped you change your practice. Can you identify a particular session, or a part of a session you really found most useful.

9. If you were to single out a "most important" moment for you in the training what would it be.
(Probes: a change in attitude, beliefs, behavior, a certain lecture, discussion, film).

10. As a result of this "moment," how has your practice changed.

11. What do you see as the benefits of the training program for you. (Probes: features that you liked, how were they experienced.)

12. If you were developing a similar training, what features would you like to see added or deleted. (Probes: changes in the structure, speakers, discussions, group processes).

13. Did you prefer films, discussions, experiential exercises or lectures.

14. What have you learned about sexual abuse since the training?
(Probes: Have you read other articles, books, etc., or seen movies

or other films).

15. Have you been to other trainings since the incest course?
If so, what was your experience with them?

16. Have your views about the course changed over time. In
what ways.

Interview Guide (for Supervisors) - Appendix B

Thank you for taking the time to see me. Before we begin the interview, I would like to explain in greater detail its purpose and answer any questions you may have about the study.

The purpose of this study is to gather information for a doctoral dissertation about Social Workers who have participated in the Incest Training Course which your worker(s) were involved in during the Fall of 1993 (or 1994). My attention to this topic comes from my own experience in working with this population and social action efforts within the Nassau County Service Delivery System to train Social Workers on the issue of childhood sexual abuse and the chemically dependent individual.

I have asked you to participate because I would like to get your perspective on the effects of the incest training course your worker(s) participated in with the other Social Workers in the Fall of 1993 (or 1994).

The information you give me is confidential and will be presented anonymously in the dissertation. Neither the tape nor my interview notes will be shared, the agency will not be named, nor will any individual interviewed be identified by name. The interview will take about 1 hour. I appreciate your participation in the study and will send a final summary report to you, if you wish. Before we begin the interview, do you have any questions?

Basic Demographic Data: - What is your date of birth.

- How long have you worked in the field of addiction.

- How long have you had your Social Work degree

1. What has been your experience, on the unit, with the issue of clients who were sexually abused as children.

2. What do you consider to be the aims of further training for Workers.

3. What did you think about the availability of the 21 hour incest training course for your workers.

4. Have you become aware of any changes in your Workers practice with the clients who had been sexually abused as children.
(Probes: What have you noticed; what differences have occurred; how

much change took place with workers functioning).

5. What do you think of these changes.

(Probes: Have they been beneficial to clients, to other workers on the unit)

6. Have any changes occurred on the unit itself, as a result of this training. (Probes: any specialized services i.e., new groups formed, etc. Are plans being made to do so).

7. Do you have any suggestions to improve the program for future trainings.

Re: 20 Question Pre-Test/Post-Test - Appendix C

Age: Sex: last four digits of SSN:

1. Many Children believe that sexual abuse was their fault. T F
2. Rigid roles and rules are often found in an incestuous family. T F
3. Many sexual abusers learn these behaviors in adulthood. T F
4. The child is never to blame for the sexual abuse. T F
5. Incest is considered to be a misuse of power. T F
6. Alcoholism and drug abuse are consistently found in incestuous families. T F
7. An offender is not usually considered to be a well-respected member of the family or society. T F
8. The taboo of incest in our society helps to prevent it. T F
9. Most likely, a boy who is molested by another male will become homosexual. T F
10. Children may feel pleasure when the incest occurs. T F
11. In our society, about 1 in 3 females and 1 in 7 males is sexually abused as children. T F
12. Approximately 5% of incest perpetrators are female. T F
13. The modal age of incest of female children occurs at age 7. T F
14. Boys and girls are abused about equally under the age of 8. T F
15. Fondling is the behavior most often cited in incest cases. T F
16. Group therapy is essential to the effective treatment of incest and alcoholism and needs to occur concurrently with individual therapy. T F
17. Sibling incest is more common than father-daughter incest. T F
18. Betrayal, stigmatization and powerlessness are concepts utilized in the Traumatic Model of David Finkelhor. T F
19. Suzanne Sgroi's incest model of five stages does not include a Disclosure phase. T F
20. The interactional patterns in the family teach the victim/perpetrator role to each family member whether or not that member had been sexually abused. T F

Re: Course Evaluation - Appendix D

Position/AgencyType: _____

OVERALL EVALUATION

Please answer the following series of questions about the training you have just completed. Your responses will be helpful for planning and in the development of future trainings.

For questions in which there is a five-point scale, circle the number which best corresponds to your response.

1. How much did you learn from this training?

1	2	3	4	5
not much		some		a great deal

2. How organized was the delivery of this training?

1	2	3	4	5
not very organized		somewhat organized		very organized

3. How useful will the knowledge and skills acquired in the training be to you?

1	2	3	4	5
not useful		somewhat useful		very useful

4. How comprehensive, or complete, was the workshop coverage of the topic?

1	2	3	4	5
incomplete		somewhat complete		comprehensive

What should be added? _____

5. How was the pacing of this workshop?

too slow _____ just right _____ too fast _____

What would you like to have spent more time on? _____

6. Overall, do you think the goals of this training-- . . .
 were achieved for you?

1	2	3	4	5
not at all		somewhat		fully
achieved		achieved		achieved

Please explain a rating of 3 or lower: _____

7. Please rate the trainer:

1	2	3	4	5
poor		good		outstanding

Please give your own comments about the trainer: _____

8. I WOULD HAVE LIKED THE TRAINING BETTER IF ... (please fill in):

1. More time had been devoted to the topic dealing with _____

2. There had been more chance for _____

3. The trainer had been more _____

4. More information had been included about _____

5. Other (please describe) _____

9. In my view, the most effective part(s) of the training was (were): _____

10. OVERALL RATING OF THE TRAINING SESSIONS (circle one number):

1
poor

2
below
average

3
average

4
above
average

5
outstanding

THANK YOU!

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