DEVELOPING AN ASSESSMENT PROTOCOL FOR SEXUALLY ABUSED ADOLESCENTS IN TREATMENT PROGRAMS: A SINGLE CASE STUDY OF THE PROCESS

By

INGRID KASTENS

B.S.W., University of British Columbia, 1980

A THESIS SUBMITTED IN PARTIAL FULFILLMENT OF

THE REQUIREMENTS FOR THE DEGREE OF

MASTER OF SOCIAL WORK

in

THE FACULTY OF GRADUATE STUDIES

SCHOOL OF SOCIAL WORK

We accept this thesis as conforming

to the required standard

THE UNIVERSITY OF BRITISH COLUMBIA

September 1989

In presenting this thesis in partial fulfilment of the requirements for an advanced degree at the University of British Columbia, I agree that the Library shall make it freely available for reference and study. I further agree that permission for extensive copying of this thesis for scholarly purposes may be granted by the head of my department or by his or her representatives. It is understood that copying or publication of this thesis for financial gain shall not be allowed without my written permission.

Department of Social Work

The University of British Columbia
Vancouver, Canada

Date Sept. 19, 1989.

ABSTRACT

This thesis evolved as part of a practice-thesis combination option for the completion of the degree of Master in Social Work. The purpose of combining research with practice was to allow for a learning experience in each area. Both the practice and research were conducted within Nisha Children's Society. (Nisha Society is a non-profit organization dedicated to the provision of high quality professional treatment and counselling services for adolescents and families. See Appendix A for a more detailed description.)

The major work of the thesis focused on developing a practical and useful assessment process designed to give a better picture of sexually abused adolescents who end up in treatment programs. Not a great deal is known about which sexually abused adolescents will require intensive treatment programs, and which ones will not. It is of concern that the professional community does not have a good picture of who the sexually abused adolescents who have serious emotional and behavioural problems really are in terms of socio-demographics, developmental status, and emotional health. A need exists to clarify which instruments would provide the most crucial information. There is also a need to clarify the role of personal attributes and the role of characteristics of the environment as they both impact on the stress-coping and resiliency attributes of adolescents in treatment. In order to effectively counsel or plan for sexually abused adolescents, we need to better understand

sexual abuse as one of several possible pre- and/or co-existing sources of individual stress or trauma.

The assessment design used an ecological or stress-coping model of abuse framed within a normative developmental perspective. The thesis focused on developing the assessment protocol, rather than on the impact of child sexual abuse on adolescents. Thus a very large and time consuming part of the research has been the selecting of the seemingly best suited measures. The measures and framework chosen, and the rationale for these choices are described in detail within this report. The final chapters of this thesis focus on the findings of the "trial run"/single case study and the implications for social work.

CONTENTS

I must begin by paying tribute to those who helped get me through:

To my friends and family who understood and encouraged me and continued to love me without demanding a whole lot in return.

To Ruth, Penny, Shelley, Laurie, and especially Tom, and all my supporters at Nisha who provided valuable and much appreciated support, feedback and encouragement.

To the teens and families who have shared their stories and insights with me over the years.

To Kathryn, who always had yet another idea for me to pursue.

To my computer, with whom I have developed a deep love-hate relationship.

My heartfelt thanks to all of you.

Ingrid

CHAPTER ONE: INTRODUCTION

This research draws on the work of researchers Bagley (1984, 1985) and Finkelhor (1986, 1987) in the areas of sexual abuse, Rutter (1981, 1985) in the area of resiliency, and on the comprehensive child sexual abuse literature review undertaken by Wachtel (1988). In his report Wachtel writes that "despite the assessment frequently found in the literature that we still can say very little that is conclusive about the effects of child sexual abuse, there does seem to have been considerable recent advance both in conceptual clarity and in building up an empirical knowledge base. The literature can be read as posing increasingly pointed questions in an attempt to tease out child sexual abuse effects" (p. ii).

In the early days of child sexual abuse awareness in North America, social service professionals and researchers searched for widespread general effects (Peters, 1976) However, it was noted that survivors of child sexual abuse displayed quite a variety of effects. This led to the study of the importance of distinguishable differences (Alter-Reid, 1986).

In 1981 Mrazek and Mrazek studied the nature of the abuse (eg. relationship to the abuser, duration, frequency, force). Age, gender and other attributes of the child sexual abuse survivor were also studied (Augustinos, 1987; Finkelhor, 1982; Friedrich, 1987; Gomes-Schwartz, 1985;

Marten, 1985). As well, demographic information was studied (eg. race, socio-economics). Then there were studies of the significance of the circumstances surrounding the disclosure (Adams-Tucker, 1986; Gold, 1986; Pelletier and Handy, 1986). Eventually researchers began to test clusters of factors. Gold (1986), and Seidner and Calhoun (1984) noted that the subjective experience of the sexual abuse appears to be of significance. As though the picture were not cloudy enough already in terms of separating out the effects of sexual abuse, in 1985, Olivier wrote about the generally abusive situations surrounding child sexual abuse (eg. co-existing parental pathology, parental alcoholism, physical abuse, neglect). It is due to the above outlined complexity around the problem of child sexual abuse that this thesis takes an ecological or stress-coping model within a normative developmental perspective. This model came out of Wachtel's (1988) sexual abuse literature review. As noted, he in turn drew on the sexual abuse writings of Finkelhor and Browne (1986), and on other literature in the areas of stress-coping and resiliency (eg. Rutter, 1985). This model will be described in detail in the following chapter.

Definition of Child Sexual Abuse

The best definition I have come across of child sexual abuse was found in a proposal for demonstration project funding submitted by Marymound Inc. to Health and Welfare Canada:

"Child sexual abuse is a sexual act imposed on a child who lacks emotional, maturational, and cognitive development. The ability to lure a child into a sexual relationship is based upon the all-powerful and dominant position of the adult or older adolescent perpetrator, which is in sharp contrast to the child's age, dependency, and subordinate position" (Sgroi, 1983, p.9). We believe that a child is unable to consent to sexual acts with individuals where there is a three year age difference between the perpetrator and the victim (Finkelhor, 1979). Our definition of child sexual abuse also includes sexual acts coercively imposed on individuals, regardless of an age difference between victim and offender." (Marymound group, 1987, p.3).

Purpose of the Research

Perhaps the foremost question which needs to be addressed within this thesis is, why bother to assess at all? The answer to this is that how helping professionals assess, and how we begin to see people's difficulties, impacts on the kinds of solutions we seek. The purpose of assessment is to make the intervention more effective and more tailor-made for the individual or family. For example, an assessment might tell us that certain individuals might do

better without an intensive, intrusive residential approach. Other individuals, for example, might not benefit from insight oriented interventions since assessment might tell us that they have not yet developed the cognitive abilities required for this approach. Thus assessment which allows for multiple assessment tools, also allows for differential treatment. The rationale for multiple assessment tools is further discussed later on in this thesis.

The purpose of this research is to discover how we can better assess the clinical and social concerns presented by abused and troubled adolescents in treatment programs. While troubled adolescents represent a relatively small proportion of the population at large, they are heavy consumers of mental health and other specialized resources. A need exists to clarify the role of personal attributes and characteristics of the environment as they impact on stress-coping ability. There is a need for a practical and clinically useful assessment procedure for sexually abused adolescents.

To date, much of the research has been pre-theoretical, methodologically questionable, and limited with regard to comparability of findings (Parry, 1988). What is needed are studies which relate to the immediate clinical and social needs of these high profile, troubled, abused teens, and studies which offer a clear conceptual rationale.

CHAPTER TWO: LITERATURE REVIEW

The Prevalence of Sexual Abuse

Of all the research on sexual abuse, the results from prevalence studies have been the most impressive. Until recently most clinicians, policy makers, and social scientists doubted that people would be willing to report histories of sexual abuse to survey researchers. Yet as far back as the 1800's it was recorded that women were reporting sexual abuse to Freud:

> Almost all my women patients told me that they had been seduced by their fathers. I was driven to recognize in the end that these reports were untrue and so came to understand that the hysterical symptoms are derived from fantasies and not from real occurrences," (Freud, 1938, translated to English in 1966, p. 584).

We have hopefully come a long way since then. It has become clear that people will not only report histories of sexual abuse, but also that they will do so in large numbers (Finkelhor, 1986). In 1984, Badgley conducted and published a Gallup Canada random sample survey of the prevalence of sexual abuse. A stratified probability sample was drawn for the entire country of Canada. Professional interviewers went door to door, asked respondents to complete a self-administered questionnaire, and waited as it was completed. The sample consisted of 1006 females and 1002 males from 210 Canadian communities. 34% of females and 13% of males reported unwanted sexual acts before the age of 18.

Until lately the explosion of literature and statistics on child sexual abuse has largely been a North American interest. Only recently are we beginning to also hear reports of widespread prevalence of sexual abuse revealed in other countries (Rush, 1980; Finkelhor, 1984).

Societal Awareness

The past decade has seen growing public and professional awareness of the increasing number of reports of child sexual abuse, with emerging pictures of the possible longterm, perhaps multi-generational, impact of such abuse. The reason that the issue of sexual abuse has only relatively recently entered the public spotlight with such magnitude is largely because the problem was taken on by a coalition of groups who are well experienced in promoting social problems - specifically the women's movement and the children's protection movement (Finkelhor, 1984). More recently, government support and the media have also helped to increase societal awareness regarding the problem.

Thus far much has been stated regarding what is known about sexual abuse The remainder of this chapter will focus on the perspectives/models/bodies of literature which were combined within this thesis (ecological theory, normative developmental theory, resiliency theory) in an effort to better understand the needs of sexually abused adolescents in treatment programs.

Why an Ecological Model?

An ecological or stress-coping model seems a logical approach to deal with the breadth of information and writing on the subject of child sexual abuse and its effects. A systems viewpoint seems to be essential in examining the problem we call emotional disturbance. Apter (1982) states that "ecologists typically do not consider emotional disturbance a physical disease located solely within a child, but prefer to look at a disturbed ecosystem, in which disturbance can be more profitably viewed as a "failure to match" (p. 57). Especially in the case of severely troubled youth, it seems clear from a reading of the current literature that the targeted child is seldom, if ever, the whole problem. In order to be effective, diagnosis and treatment of troubled children must be much more comprehensive and functional than it has been in the past. It seems clear that we can benefit by gathering data from as many sources as possible; that is, we need to be inclusive instead of exclusive in what information we utilize in our thinking about the youth we attempt to serve.

Over recent years Germain (1981), Tufts (1984), Chandler (1985), Rutter (1985) and others have attempted to single out pertinent aspects of the environment for research, assessment and intervention. This type of ecological or stress model has previously been applied to physical child abuse theory (Garbarino & Gilliam, 1980).

Recent theoretical writings on the importance of seeing the effects of abuse as changing over time have been

published by Bagley & Young (1987), and Tufts (1984). These developmental approaches are very compatible with an ecological model.

Sometimes an ecological model is described as a people-in-environment approach. Germain (1981) writes that "a concern for person-in environment is the distinguishing and unifying characteristic of social work," (p.323). She gives a good description of an ecological perspective as focussing

> on the natural life processes of adaptation, stress, coping and the environmental nutriments required for release of adaptive capacities. All human beings, indeed, all organisms, engage in continuous and reciprocal adaptive processes with their environments. All experience a variety of stressful situations across the life cycle. They cope with them with varying degrees of effectiveness that depend, in part, on internal resources and, in part, on the nature of the environment. Even internal resources, however, depend in good measure on the qualities and properties of past and present environments....Little is known so far about what constitues a nutritive environment, given the variability of people's needs, capacities, and aspirations and their lack of knowledge about the reversibility of ill effects of noxious environments (Germain, 1981).

Ecological assessment strategies represent efforts to utilize more information in the development of effective programs for troubled children. Hobbs (1975) has documented the inadequacy of our current categorization system and the limited diagnosis-intervention, child-only focus on which it is based. Focusing all our attention on the child while ignoring the family, school, and community that surround him

or her can make the identification and remediation of difficulties almost impossible.

In 1977 Bronfenbrenner wrote that "much of American developmental psychology is the science of the strange behavior of children in strange situations with strange adults." Bronfenbrenner was talking about the ways in which we study children affecting the kinds of programs we develop for them. Small studies lead to narrow programs, and the ecological viewpoint stresses the need to go beyond such narrow visions of behavior and development and to find ways to focus on the interaction of children with critical aspects of their environments.

In summary, we must give up our search for a magical answer to the problems presented by troubled children. Instead we must learn to think in terms of troubled systems and increase our understanding of the reciprocal person-environment interaction patterns. An ecological approach adopts a more dynamic perspective than one that considers only single-source, single-direction, single-target influences: we need to think about the interaction of effects between individuals and their circumstances. This perspective focuses on the interplay between person and environment, encouraging us to note how characteristics of the environment may influence the persons living in it. It is this dynamic view of the changing relations between persons and the environment in which they live that guides the analyses we pursue here.

The responsiveness of the environment to the needs of the child may influence the meaning the child makes of events; the meaning will influence the child's response; and the child's behavior will influence how the environment responds. Trauma and repair are dynamic, ongoing processes in which the individual interacts with the multiple systems that are the elements and context of life (Moore Newberger and De Vos, 1988).

Why a Developmental Perspective?

Not only does this thesis take an ecological approach, but it does so in light of a developmental perspective. In essence the thesis makes an effort to integrate the two frameworks. This marriage of frameworks requires us to consider the need to examine competence at multiple levels of analysis, the importance of underlying developmental processes, how environmental conditions influence the development of the processes and their behavioral manifestation, and how individuals can influence the social context in ways that will affect their own further development. Whatever the stress or event, children's reactions to specific crises are seen to differ in relation to developmental stages. Human feeling and behavior is perhaps best understood as a function of multiple domains interacting and evolving over time. The meaning a child makes of experiences is critical for understanding how that experience affects the child. This has strong implications for clinical practice - for example, a therapist cannot change the precipitating events, but may help to alter beliefs about the self and others that may have been distorted by the cognitive processes. This entire latter concept is once again core to the theory behind I-level (see chapter three of this report).

Hilliard (1973) writes that

> dissimilar basic theoretical assumptions about the nature of development result in three general categories of developmental theory: learning theories; maturational theories; and cognitive-developmental theories. The basic assumption of learning theory is that what is most significant in development is the environment and who we grow up to be has to do mostly with the learning conditions and the information available in our environments. The basic assuption of maturational theory is that what is most significant in development is the organism (the individual) and that who we grow up to be has to do mostly with our genetic make-up. The basic assuption of cognitive-developmental theory is that what is most significant in explaining development is both the environment and the organism and that who we grow up to be has to with the interaction between the genetic make-up of the organism and the environment (p.1).

This thesis takes a cognitive-developmental approach. From a developmental perspective adolescence is generally viewed as a transitional period bridging childhood and adulthood (Hopkins, 1983). Biological changes, primarily in the form of sexual maturation, mark the onset of this period (Petersen and Taylor, 1980) which eventually calls for changes in the adolescent's psychological development and social behavior. These alterations, with their swift onset and demands for adjustment, make the period of adolescence one of extreme vulnerability (Hopkins, 1980). Ebata (1986) notes that adolescence has stereotypically been viewed as a chaotic, tumultuous period. Although recent studies have tempered and modified this view (e.g., Douvan and Adelson, 1966; Offer and Offer, 1975; Garbarino and Kelly, 1986) much more attention has been paid to the problems of adolescence -

to destructive behaviour or maladjusted individuals rather than to well-adjusted, fully functioning youth. Clearly, the majority of adolescents do well in social, academic and peer-related endeavors, despite what may be normative mood variation and problems (Larson, 1980; Rutter, 1976). We can think of the range and variability in normal and dysfunctional patterns of development as part of a continuum of adjustment and psychological well-being that are developmental outcomes, or products of growth and socialization. Traditionally, psychologists have focused on maladjustment and have considered mental health as freedom from aberrant dysfunctional, or pathological symptoms. More recently, however a greater focus has turned to examining the degree to which an individual functions successfully in the world and on the skills and abilities necessary for competent functioning.

It is for these above mentioned reasons that an I-level (Interpersonal Maturity Level) interview is included in the assessment package for this thesis. Not only does the I-level interview assess cognitive-developmental level, but it also allows for an assessment of strengths by nature of its open ended format. As well, I-level theory is respectful of whatever coping skills/mechanisms have enabled the adolescent to get by thus far inspite of sometimes very difficult life (ecological) situations. I-level as an assessment and treatment planning tool is further discussed in chapter three of this paper.

Assessment, therefore, must target more than merely the presence or absence of problems. Assessment must also take into account the degree to which individuals adapt to the presence or absence of skills, characteristics, and abilities that allow them to meet environmental demands and challenges. An emphasis on assessing social adaptation is also important in that it gives an indication not only of the kinds of resources and opportunities that are available to the individual that may promote development of skills but also to stresses and obstacles that may hinder or prohibit the development of these skills (or encourage the development of behaviors that are less desirable yet may be "adaptive" given the particular situation). Once again, I-level addresses all of this.

The presence of psychopathology in adult populations has been related positively to the occurence of both positive and negative life events (Myers, 1974). Thus, for example, a change of residence or obtaining a new job, regardless of whether or not it was desired, may be stress-inducing. Adolescents in treatment programs have commonly experienced frequent changes in residence and schools.

Adolescent Development

Until recently literature regarding adolescent development was based on the work of Eric Erickson (1968). He theorized that adolescents need to develop a sense of industry and identity in order to be able to develop satisfying relationships. Within this framework it is believed that a sense of industry is developed through success at work or school, and a sense of identity is developed by means of the process of disengagement from the family (Deutch, 1967; Blos, 1979). This model of the need to separate is currently being challenged (Miller, 1976, 1984; Gilligan, 1982; Surrey, 1987). These writers propose that development occurs within relationship, and suggest that relationship differentiation is a process marking adolescence.

Other characteristics associated with adolescence include fluctuating moods; strong sexual feelings; fluctuations between dependency/independency; "hanging-out"; experimentation with drugs, alcohol, sex, intimacy; rebellion against family; strong involvement with a peer group; intellectual/cognitive growth; moral growth; ability to plan for the future (Bosomworth, 1980; Scofield, 1987).

Adolescence is a time of change and involves a quickening of pace of life events. The many new physical, psychological, and social experiences common to individuals during this stage may explain the high rates of problems adolescents encounter. Coddington's work (1972) verifies the extreme levels of life events experienced in adolescence. It

is for these theoretical reasons that the Adolescent Family Inventory of Life Events (A-FILE) was included as one of the measures in this research project. (See description of A-FILE in chapter three and Apppendix K.)

The multiplicity of biological and social changes confronting adolescents may create new demands that have the potential for triggering off many new behavior problems. The triggers are multiplied for adolescents who have experienced child sexual abuse. Due to the character of behavior and mood in adolescence, there is the risk that early signs of disorder and problems may be dismissed as predictable changes of "normal" adolescence (Weiner, 1970).

In conclusion, "adolescence is an important time in the development and demonstration of competence. It calls forth both the desire to function successfully in the world and the need to feel good about that ability. Often deficits that were only potential in childhood become real in adolescence, when demands for socially desirable characteristics and skills increase markedly in school and the world of work" (Ebata, 1986). While changes in individual behavior may influence family functioning, such changes may also require restructuring environmental conditions to be more conducive to the development of adaptive capacities.

Resiliency

The literature on resilient children, youth and adults (Rutter, 1985), provides some focus to the indicators which might be of significance in examining developmental outcomes of abused adolescents. Those who fare well in terms of developmental outcome despite evidence of severe risks and stressors in their lives are characterized by the following: a positive outlook, a feeling of responsibility/control over what happens to them, well-developed social skills, good ability to problem solve, and the presence of a significant caring human relationship. Working against resilience are the presence of factors indicative of a non-supportive environment including family dysfunction and disruption, and experience of multiple placements in care or in treatment (Parry, 1988, building on Rutter, 1985).

Rationale for Selection of Issues

Given the background discussed in this literature review, a number of important issues arise.

As has been stated, the focus on providing better assessment, and thereby more appropriate and differential interventions, for sexually abused adolescents who are in treatment programs is important, because while they may represent a relatively small proportion of the sexually abused population, they are heavy consumers of mental health and other specialized resources.

This thesis takes the viewpoint that sexual abuse is one of several sources of individual stress. Therefore, data collection should include some open-ended formats to include more than information specific only to the sexual abuse area. Also, the ambiguity in existing sexual abuse literature regarding the influence of individual factors may indicate that it is a combination of factors, not the influence of any individual one, which is important. This view is consistent with the interactive nature of the ecological model of this thesis.

Another issue which makes this research somewhat unique is that according to the literature review, most sexual abuse studies to date have involved adult survivors. There is a scarcity of studies focusing on earlier developmental stages. Yet normal development and changes in life tasks are known to be significant in determining the impact of stress on coping ability. Therefore, research studies should begin to measure stress impact in terms of developmental coping,

delays, distortions and recurring impact. Developmental theory recognizes change over time. As cognitive and emotional growth occur, perceptions or subjective experiences alter. Therefore it is important to look at both subjective experiences, as well as the "factual" elements.

In summary, research should look at both the individual and the environment and study positive and negative factors which strengthen or weaken the individual's coping ability. Since assessment is most commonly undertaken to determine problem areas, many of the popular tests tend to be formatted for description of deficits. Therefore, open-ended format instruments (e.g. structured interviews) and modified versions of existing measures need to be included to assess strengths as well as deficits.

The research questions proposed by this thesis included the following:

1. What would constitute a comprehensive assessment protocol for use with sexually abused adolescents? Which instruments would provide the most crucial information? The objective was to more efficiently assess the well being and needs of sexually abused adolescents in treatment programs so that helping professionals can better plan for them and their emotional health (provide better differential treatment based on sound assessment).
2. What are the practical and clinical strengths and weaknesses of the measures used? Where are the unnecessary overlaps between measures?

CHAPTER THREE: METHOD

Conceptual Model

In chapter one, ecological theory, developmental theory, and resiliency were discussed. Measurement instruments and areas of measurement focus have been determined within this framework, and from within a core of standardized measures. A central issue which has been kept in mind throughout has been the importance of identifying factors pertaining to coping abilities. The particular measures and specific information items fall into three general categories: socio-demographics, (age, gender, family constellation, etc.), indicators of developmental status (I-level Assessment), and indicators of emotional health (self-esteem, depression, sense of control, social skill, interpersonal maturity). A range of assessment strategies have been used (ie. structured interviews, psychometric tests, observation, file review).

Based on the literature review, and as outlined above, the assessment package chosen during the process of this research includes measures to assess the individual, the family, the environment, and strengths within these systems. This measurement package was then tested in a single case study. The relevance of single case studies is discussed in the following section.

Single Case Design

A major concern for both researchers and clinicians is the generalizability of research findings into the clinical setting. Psychology has traditionally preferred quantitative research for this reason. However, there is also a place for single case research, particularly in clinical settings. Case studies provide an important knowlege base that is unobtainable through traditional quantitative research.

Although there are many advantages to quantitative research, some of the limitations as noted by Hersen and Barlow (1976) include: ethical objections to waiting lists or no intervention control groups; difficulties in collecting homogeneous groups; the obscuring of individual outcomes in group averages; and the use of pretest and posttest only measurements, which obscure progress or deterioration during treatment.

One major advantage of single case designs is that they provide an alternative to traditional large designs about which various ethical and legal considerations are often raised (Hersen & Barlow, 1976).

Single case designs also make it more feasible to involve practitioners in research. The advantages of this are obvious. Research often does not utilize the common sense knowledge of the practitioner, and the practitioner may not be as influenced by preconceived theoretical hypotheses (Olsen, 1976). Practitioners are also in a position to obtain information or data that can normally only be obtained

in the context of a relationship.

Another positive feature of single case research is its flexibility of design in response to ongoing change and client needs. A case study approach is also useful when the subject is studied in its real life context; where boundaries between the phenomena and the context are not clear; and where multiple sources of data are used (Yin, 1986).

By far the most common case study methods are those used to evaluate the effectiveness of treatment. In the circumstance of this thesis, a case study method was used to evaluate an assessment protocol. In other words, this is a case study of an assessment process and not a case study of change over time. In terms of assessment case studies, they "can be distinguished from more traditional therapeutic interventions in that their primary purpose is to provide an example of the application of various psychometric instruments for either diagnosis or description of cognitive and social behavior" (Kratochwill, Mott, & Dodson, 1983). In the case of this research, such data is gathered to assist in understanding problems or strengths that may have important implications for intervention. The important point to keep in mind is that the the assessment results need to be translated into interventions, and not just diagnoses.

In terms of <u>validity</u>, although it is generally believed that the validity of single case and other studies can be improved by the use of objective measures, this does not exclude subjective measures from consideration. Indeed, the desirability of using subjective measures of behavior or

experience in addition to objective assessment is becoming increasingly recognized as a good check (Kazdin, 1977; Wolf, 1978). Due to their depth and unhurriedness, single-case studies are particularly conducive to being supplemented by subjective data.

Yin (1986) states that the strength of case studies lie in their ability to use multiple sources of data as evidence. He believes that this technique adds to validity.

In general, and in this situation in particular, the single-case design should not be viewed as a substitute for group designs, but rather as a catalyst to start the process of checking hunches and applying notions from theory to create new information bases.

Rationale for the Measures Selected

Due to the multiple theoretical areas included in the comprehensive perspective taken within this thesis, the literature review became a large and time consuming part of the actual design of this study. Not only did the literature review cover the theoretical frameworks included in the previous chapter, but it also included reviewing in detail many times more measures than were ever included in the assessment package decided on during the course of this research. Many of the measures were piloted as it was ethical and useful to do so in the course of the author's day to day practice. As well, the author spoke with other professionals who were piloting some of the measures elsewhere, such as at The Maples Adolescent Treatment Center in Burnaby, B.C.

Measures for the assessment protocol were chosen keeping in mind the overall goal of getting a clearer picture of sexually-abused adolescents in treatment programs in terms of developmental status and emotional health. An attempt was made to balance the use of measures which are well known and established in the field, versus using measures which made the greatest sense based on reliability, validity, clarity, brevity, norms, and clinical experience of what would be acceptable and not too intrusive to these adolescents. These decisions were made after also interviewing and taking into account the experience of several social workers and psychologists who have familiarity with similar populations (such as at The Maples Adolescent Treatment Centre), and have

used some of the measures which were considered or included.

Reliability

Reliability has been defined as "the accuracy or precision of an instrument" (Selltiz, Wrightsman & Cook, 1976, p.580). In its broadest sense, "instrument reliability indicates the degree to which individual differences in scores are attributable to true differences in the property or characteristic being measured and to errors of measurement" (Anastasi, 1968, p.8). One of the functions of the "trial run" within this thesis was in fact to begin to address factors affecting reliability. For example if an adolescent were not convinced that her answers would remain confidential, or if she felt uneasy about revealing her true feelings (perhaps due to the social desirability factor), the interview or measure would not provide a reliable assessment of her experience.

Validity

Defining validity involves two aspects: "1) the instrument actually measures the concept in question, and 2) the concept is measured accurately" (Grinell, 1981, p. 104). Although all measures were selected keeping these two aspects in mind, once again, one function of the trial run was to address the issue of validity based on the clinical experience of conducting the assessment.

Clarity

All instuments were chosen based on the author's ten years of social work experience with sexually abused adolescents, and by reading through each of the measures to

assess whether all of the items included would make sense to such a population. All pencil and paper tests were administered verbally to allow for clarification if needed. This also meant that poor reading ability would not compound the results.

Brevity

Brevity was balanced along with all other factors mentioned. The assessment package used in this thesis is by no means all inclusive. Many other variables could be or were considered. However, in the interest of not allowing the assessment to become abusive in length, compromises and omissions had to be made.

Norms

A problem issue kept in mind in the selection of this measurememt package was that many of the "norms" for American tests seem as though they would not apply for Canadians (for example, items pertaing to religosity, or items which could be perceived differently within the Canadian Native culture). Once again one of the purposes of the trial run was to begin to address some of these issues as they arose. The general issue of cultural relativity or usefulness of "tests" in a multicultural society was a concern and is further discussed in the concluding section.

The Measures Included in the Single Case "Trial Run"

Measures of attributes of individual adolescents cover: developmental status (Interpersonal Maturity Level Assessment), outlook (Beck Hopelessness Scale; Kovacs Depression Inventory), sense of control (Nowicki-Strickland Locus of Control Scale), self-esteem (Hare Self-Esteem Scale; Rosenberg Self-Esteem Scale), and presence of a critical relationship (Family Assessment Measure; I-Level). Two self-esteem and two depression/hopelessness measures were included in this study. The reason for this was that a clear choice could not be reached as to which measure seemed preferable for adolescents. One of the functions of the "trial run" was in each case to select one of the two measures as being superior for the target group in question.

Measures of the environment focused on specifics of supports such as stability of home and surrounding environment (Family Inventory of Life Events; Adolescent Family Inventory of Life Events; placement history of the adolescent). Interviews (Harborview Sexual Abuse Impact Checklists) and file reviews were used to collect data on indicators of revictimization such as ongoing prostitution, "unhealthy" relationships, and other self-destructive behaviors. An Eco-Map was used to collect data to assess family resources, connections, and the nature of connections. In terms of assessing school issues, an open ended short essay format was used with the adolescent who participated. The reason for this was that a) she liked the idea, and b) she had started but basically not attended at

four schools within the past year. Thus teachers did not know her well enough to comment on their observations from school. It is the writer's experience that this sort of school pattern is typical of sexually abused adolescents in treatment programs, thus it would likely be rare that a teacher could complete a meaningful assessment as part of an assessment package.

On the following pages a rationale for each area selected will be presented, and the actual measures used will be described. The multiple sources of data used were the adolescent herself, her mother, the Ministry of Social Services social worker, and file review.

The Importance of Assessing Self-Esteem

The achievement of a favorable attitude toward oneself has been regarded as important by a number of personality theorists, including Murphy (1947), Horney (1945, 1950), and Adler (1917).

The term "self-esteem" refers to the evaluation a person makes and customarily maintains with regard to her or himself. "Self-esteem" expresses an attitude of approval or disapproval and indicates the extent to which a person believes her or himself capable, significant, successful, and worthy.

It is generally believed that at some time preceding middle childhood, a person arrives at a general appraisal of her or his worth, which remains relatively stable and enduring over a period of several years. This appraisal can presumably be affected by specific incidents or by environmental changes but apparently it reverts to its customary level when/if conditions resume their "normal" course.

Self-esteem may vary across different areas of experience and according to sex, age, and other role-defining conditions. For example, it is conceivable that a person could regard self as very worthy as a student, moderately worthy as a daughter/son, and not at all worthy as a baseball player.

There are several lines of evidence in psychological literature pointing to the importance of self-esteem. Clinicians observe that persons who are plagued by doubts of

their worthiness can neither give nor receive love, apparently fearing that the exposure that comes with intimacy will reveal their inadequacies and cause them to be rejected (Fromm, 1939).

As far back as 1954, Janis found that a person with low self-esteem is less capable of resisting pressures to conform and is less able to perceive threatening stimuli.

Studies of creative persons show that they rank quite high in self-esteem (Rutter, 1985). Presumably, a belief in one's perceptions and the conviction that one can impose order on a segment of the universe is a basic prerequisite for significant creativity. Persons with high self-esteem are also more likely to assume an active role in social groups and to express their views frequently and effectively. Less troubled by fears and ambivalence, less burdened by self-doubt and minor personality disturbances, the person with high self-esteem apparently moves more directly and realistically toward his or her personal goals.

In the next section two self-esteem measures will be described.

Rosenberg Self-Esteem Scale (RSE) (See Appendix B)

Author: Morris Rosenberg

Purpose: This scale measures the self acceptance aspect of self-esteem.

Description: The RSE is a 10-item scale. It was originally designed (1962) to measure the self-esteem of high school students. The items were developed by reducing a larger pool of items and selecting items which differed significantly in the numbers of people answering each way. The scale has been used with many different groups including adults from various occupations. One of its greatest strengths, and one of the reasons the RSE was chosen for purposes of this research, is that it is well known, and there has been a large amount of research conducted with a wide range of groups on this scale over the years.

Administration and Brevity: This scale was designed specifically with brevity and ease of administration in mind. It is suitable for oral or self-administration, and requires approximately 5 to 10 minutes.

Norms: The original research on the RSE was conducted on 5000 American high school students. Since that time further research has involved thousands of adults and college students from a variety of occupations and professions. A high score indicates low self-esteem.

Reliability: The RSE has good internal consistency (a Guttman scale coefficient of reproducibility of .92). Excellent stability is shown by two studies of two-week test-retest reliability (correlations were .85 and .88).

Validity: This test correlates significantly with self-esteem measures such as the Coopersmith Self-Esteem Inventory (a much lengthier inventory). As well, the RSE correlates in the predicted direction with measures of depression, anxiety, and peer-group reputation, showing good construct validity by correlating with measures with which it should theoretically correlate and not correlating with those with which it should not.

Comments:

Positive Points: The items are fairly clear and easy to understand, and the scale is brief. It has high reliability for such a short scale.

Negative Points: Not much recent work has been done with the RSE.

Primary Reference: Rosenberg, M. (1979). Conceiving the Self. New York: Basic Books.

Hare Self-Esteem Scale (HSS) (See Appendix C)

Author: Bruce R. Hare

Purpose: To measure self-esteem in school age individuals.

Description: The HSS is a 30-item measure of self-esteem in school age children 10 years old and above. The HSS is made up of three 10-item subscales (peer, school, and home). The total score of all 30 items is the overall self-esteem measure. The reasoning behind concluding that the total of the three subscales equates a general assessment of self-esteem is that peer, home, and school are the main areas of interaction in which individuals develop a sense of self-worth.

Administration and Brevity: The HSS can be administered individually or in groups, orally or in writing. The test is suitable for self-administration, and requires approximately 10 minutes.

Norms: The HSS was originally researched on 250 American high school and elementary school students. The mean ranges from 90.4 to 95 with a group mean of 91.1. A high score indicates high self-esteem.

Reliability: Internal consistency information does not seem to exist to date. Test-retest correlations show fair stability (a three-month correlation of .74 for the general scale).

Validity: The HSS seems to have excellent concurrent validity (the general scale correlated .83 with both the Coopersmith Self-Esteem Inventory and the Rosenberg Self-Esteem Scale).

Comment: This scale is appealing because it allows an individual to show strength in one area without necessarily scoring as having healthy self-esteem overall. The obvious clinical advantage is that this allows for building on areas of strength. The Piers-Harris and the Coopersmith self-esteem measures also contain subscales covering certain areas of life. However, the HSS was chosen for this research project because of its brevity and clarity of items.

Primary Reference: Hare, B.R. (1985). The HARE general and area-specific (school, peer, and home) self-esteem scale. Unpublished manuscript, Department of Sociology, SUNY Stony Brook, Stony Brook, New York.

The Importance of Assessing Depression/Hopelessness

According to Aaron Beck (1974), hopelessness is a core characteristic of depression, and serves as the link between depression and suicide.

Depression has been diagnosed in approximately 20% of child and adolescent psychiatric clinic referrals (Costello and Angold, 1988). Among sexually abused adolescents depression, suicide attempts, and risk taking behaviour is much higher.

There is still considerable uncertainty about the status of depression as a syndrome in childhood and adolescence (Angold, 1988; Rutter, 1986). In these circumstances, and given that adolescents, like adults, may well sometimes report normal unhappiness rather than pathological symptoms in response to a questionnaire, there is no substitute for the time-consuming task of making a clinical assessment based upon the widest available range of information. Questionnaires, however, can offer useful insights into an adolescent's mental state, and a point of departure for discussions of feelings and behaviour. A depression questionnaire can have uses with adolescents whose presenting problems are not primarily affective. Given clinician's tendency to focus on information likely to confirm their diagnosis (Cantwell, 1988), it is helpful to be reminded by questionnaire responses of the need to probe for affective symptoms in adolescents presenting with conduct, relationship or learning problems. Such questioning can also be useful in forging a treatment alliance.

The Hopelessness Scale (HS) (See Appendix D)

Author: Aaron Beck

Purpose: To evaluate depression and negative expectations about the future.

Administration and Brevity: This test is suitable for oral or self-administration, and requires approximately 5 to 10 minutes.

Construction of the HS: Two sources were utilized in selecting items for the 20-item true-false Hopelessness Scale. Nine items were selected from a test of attitudes about the future. The remaining 11 items were drawn from a pool of pessimistic statements made by psychiatric patients who were adjudged by clinicians to appear hopeless.

Norms: The sample on which norms were based was made up of 47% men and 53% women. 62% were white and 37% were black. The mean age was 33 years, and the mean educational attainment was grade 11. A high score indicates depression, and a score of 10 or more has been correlated to suicide attempts.

Reliability: A population of 294 hospitalized adult patients who had made recent suicide attempts provided the data for determination of the internal consistency of the HS. The internal consistency of the scale was analyzed and yielded a reliability coefficient of .93. The item-total correlation coefficients ranged from .39 to .76.

Validity: Concurrent validity was determined by comparing HS scores with clinical ratings of hopelessness and with other tests designed to measure negative attitudes about the

future. Correlations of .60 to .86 have been obtained. The correlation with the pessimism item of the Beck Depression Inventory (DI) (Beck, 1967) was .63. The HS correlated more highly with this item than with any of the other items on the DI.

Comments: This measure has been evaluated in a number of studies and has been found to be reliable, sensitive, and easily administered. The items are relatively clear, although they assume a certain level of insight and ability to think about the future (a developmental skill). Thus the scale may not be valid for concrete thinkers who are developmentally "stuck". The Maples Adolescent Treatment Centre is using the HS in their assessment unit (a similar population to that for whom this assessment protocol is intended) and they are finding that they are obtaining more clinically valid data than they were obtaining from the Beck Depression Inventory with the same population. It was for this reason that the HS and not the well known Beck Depression Inventory was tried here. Both scales were developed with adult populations.

Primary Reference: Beck, A.T., Weissman, A., Lester, D., Trexler, L. (1974). The Measurement of Pessimism: The Hopelessness Scale. Journal of Consulting and Clinical Psychology. Vol. 42. 861-865.

The Children's Depression Inventory (CDI) (See Appendix E)

Author: Maria Kovacs

Purpose: To assess depression in children ages 8 to 17 years.

Administration and Brevity: The CDI is a 27 item scale requiring 10 to 15 minutes to complete. It was originally designed to be administered to young people individually. The examiner may read the items aloud while the child/adolescent follows along on his or her own copy. For older children or children who do not have reading difficulties, the child/adolescent may complete the inventory on his or her own. The examiner is to remind the child or adolescent to answer about his or her feelings during the past two weeks. It should take no more than 5 minutes to score the CDI.

Scale Construction: Dr. Kovacs initially collaborated with Dr. Aaron Beck, the developer of the Beck Depression Inventory for adults. The Beck Depression Inventory served as a model for the development of the CDI (Kovacs & Beck, 1977). The CDI was intended as a research instrument, and it continues to undergo further evaluations with various childhood populations.

Beginning in 1975, 10- to 15-year-old youths were asked to help word the items on the Beck Depression Inventory so that they could be understood by children their own age. As well, the Beck item pertaining to sexual interest was replaced by an item on loneliness, and five items concerning school and peer functioning, and an item on self-blame were added. The final version of the CDI was published in 1977

following testing with a group of 8- to 13-year-olds seen at a child guidance clinic, a comparison group of "normal" children, and a group of fifth and sixth grade children. A review of the literature did not mention the size of these samples.

Each of the 27 items describes a different symptom of childhood depression, including disturbances in mood and hedonic capacity, vegetative functions, self-evaluation, and interpersonal behaviors. The CDI assesses all the diagnostic criteria in DSM-III (American Psychiatric Association, 1980) except psychomotor agitation or retardation.

Norms: At the present time, normative data pertaining to the scores yielded by the CDI and their relationship to depression in youth are still evolving (Carlson & Cantwell, 1980; Esveldt-Dawson, 1983; Kovacs, 1980/1981/1983; Kovacs & Beck, 1977; Mullins, Siegel, and Hodges, 1985) . This is largely due to the fact that clinicians and researchers have only recently reached general agreement regarding the classification of childhood depression as an affective disorder. Furthermore, there has only recently been concensus regarding the diagnostic criteria for depression in this population (Swartz, 1986).

Kovacs (1980/1981) initially reported that a CDI score of 9 was an average score in nonpsychiatic samples. She found that a score of 19 classified individuals within the depressed range. This was reported to represent the 90th percentile for normal children and adolescents.

Reliability: The CDI has been evaluated through internal consistency and test-retest methods. Kovacs (1983) reports an acceptable internal consistency (coefficient alpha = .86) in a sample of children and adolescents with diverse psychiatric diagnoses. Similar alpha coefficients are reported by numerous other investigators.

Kovacs reports a moderately high test-retest correlation coefficient of .82 over a one-month interval. Again similar results are reported by other investigators.

Content Validity: The CDI has good content validity if the DSM-III diagnostic criteria for Major Depressive Disorder are used as the appropriate content domain to be assessed.

Concurrent Validity: Kovacs (1983) reports a significant correlation between depressive CDI scores and low self-esteem as measured by the Coopersmith Self-Esteem Inventory (r = -.59).

Comment: The CDI's appeal for this assessment package is that it is currently thought to be the most commonly used measure of child and adolescent depression, and that its items are conceptually clear and simple.

Primary Reference: Kovacs, M. (1983). The Children's Depression Inventory. Unpublished Manuscript, University of Pittsburgh.

The Children's Nowicki-Strickland Locus of Control Scale (N-SLCS) (See Appendix F)

Authors: Stephen Nowicki, Jr., and B. Strickland

Purpose: To measure whether an individual believes in an internal or an external control of his or her life.

Administration and Brevity: The N-SLCS is a paper and pencil assessment of the locus of control. The scale consists of 40 questions that are answered by marking either yes or no. This scale requires approximately 15 to 20 minutes to complete.

Test Construction and Norms: The scale derived from 102 items based on Rotter's (1966) definition of internal-external control. The items described reinforcement situations across areas such as affiliation, achievement, and dependency. School teachers helped in the construction of the items. The 102 items along with Rotter's definition of the locus of control were given to a group of nine clinical psychology staff who were asked to answer the items in an external direction. Items on which there was not complete agreement among the judges were dropped. This left 59 items. The 59 item form of the test was then given to a sample 152 American high school and elementary school children. Controlling for IQ, internals performed significantly better than externals on achievement test scores. Test-retest reliabilities for a six week period were .75 for those in the 12 to 15 year old group. Item analysis was computed to make a somewhat more homogeneous scale and to examine the discriminative performance of the items. The results of this analysis, as

well as comments from teachers and pupils in the sample led to the present form of the scale consisting of 40 items.

The 40 item scale was given to 1,017 American third through 12th graders to gather reliability data, demographic measures and construct validity information. All schools were in a county bordering a large metropolitan school system, and most of the students were caucasian. Socioeconomic information obtained from school records and Hollingshead Index of Social Position (1957) rankings indicated that although the lower level occupations were somewhat over represented, all levels, except the very highest one, were well represented. Intelligence test scores for males and females ranged from means of 101 to 106 as measured by Otis Lennon scales. There were no significant differences across groups.

Means range from 11.01 to 18.80, and responses tended to become more internal with age.

Reliability: The N-SLCS has fair internal consistency of .68.

Discriminative Validity: Nowicki and Strickland (1973) reported nonsignificant correlations between locus of control scores and social desirability in grades three to twelve.

Intelligence is another variable that should be unrelated to LOC scores. Nowicki and Strickland (1973) and Nowicki and Roundtree (1971) report nonsignificant correlations between the N-SLCS scores and IQ scores.

It also seems that sex of the subject does not lead to different locus of control scores. The mean score of males and females is essentially the same when compared to

equivalent age levels (Nowicki and Duke, 1983).

Construct Validity: Nowicki and Strickland (1973) reported moderate relations between the N-SLCS and other measures of locus of control.

Social Class: Nowicki and Strickland (1973) reported a significant relation between N-SLCS scores and social class, with internality being moderately but significantly related to higher social class. This relation was also found by several others (e.g. Ludwigsen & Rollins, 1970).

Race: In terms of race, it has been found that blacks score more externally than whites (Marcus, 1975; Nowicki, 1976; Fryre & Carlson, 1976). The expected movement of scores toward a more internal orientation with age is not followed by the black subjects. In fact, in most cases black subjects became more external with age. It is difficult to separate the impact of lower social class on these race findings. Indians have also been found to score more externally than whites (Tyler & Holsinger, 1975; Hawk & Parsons, 1976). This makes sense in that it would be somewhat of an illusion for suppressed or powerless groups to score internally.

Gender: Males and females do not differ in any consistent fashion in mean response to the N-SLCS regardless of age or race (Nowicki and Strickland, 1973).

Achievement: Internality has been associated with academic achievement as well as with those behaviors associated with academic achievement, such as persistence (Nowicki and Strickland, 1973; Wyner and Blachare, 1976). The predicted relationship between internality and greater academic

achievement holds not only for American children but also for Danish children (Afedo & Fonsbol, 1975), Hungarian children (Rupp & Nowicki, 1976), and Mexican Americans (Cervantes, 1976a, b).

Helplessness: Mount (1975) in a study of helplessness and locus of control orientation reported correlations ranging from .35 to .47.

Constitutional: In addition to demographic and achievement data, constitutional differences are another source of data useful in assessing the validity of the N-SLCS. Emotionally disturbed adolescents were found to be more external (Kendall, Finch, Little, & Ollendick, 1976). Also, delinquent youth have been found to be more external than youth who are not in trouble with the law (Kendall et. al., 1976; Hendrix, 1975; Elenewski, 1974; Fenhagen, 1973; Stein, 1974; Ludwigsen & Haskins, 1976). Psychological maladjustment has also been related to externality (McClanahan, 1975). The most massive confirmation of this fact were results from a year long study of all institutionalized children in the state of Georgia (Thomas, 1974). A somewhat shortened form of the N-SLCS was given to 2000 institutionalized and 1500 noninstitutionalized children and adoescents. Those who were institutionalized were more external than their controls.

Personality: Locus of control has been related to other personality variables in a theoretically consistent fashion. For example, internality has been related to higher self-esteem (Gordon & Wilbur, 1973; Gordon, 1976; Roberts,

1971), higher self-concept (Cervantes, 1976; Morris, 1976; Gordon, 1976), higher moral development (Grotsky, 1973), lower anxiety (Kendall, Keardorff, Finch & Graham, 1976), and less interpersonal distance (Duke & Nowicki, 1974; Morris, 1975; Ude, 1975).

Primary Reference: Nowicki, S. & Strickland, B. (1973). A Locus of Control Scale for Children. Journal of Consulting and Clinical Psychology, 40, 148-154.

The Interpersonal Maturity Level Assessment (I-Level)

(See Appendix G)

Authors: The I-level was developed over the early 1960's by Dr. Marguerite Warren and her colleagues at the California Youth Authority (CYA) for use in the Community Treatment Project funded by the National Institute of Mental Health.

Purpose: To assess the cognitive and moral development of adolescents (developmental coping, delays, distortions). I-level attempts to explain how the stage of developmental growth at which a youth is functioning may influence or determine his or her behaviors. The two basic goals of an I-level Assessment are to obtain: (1) The interviewee's perception of the world - his or her view of self, others and of relationships among these perceptions (i.e., Interpersonal Maturity Level); and (2) the interviewee's way of responding to his or her perceptions of the world - typical patterns of adjustment/coping (i.e., subtype within Interpersonal Maturity Level). (3) Based on the above, to make recommendations about worker-client matching and a treatment plan that will make sense to the client, given their level of developmental maturity and given their adjustment/coping/survival patterns. I-level tries to explain "normal" and anti-social behavior for the purpose of prediction, prevention and treatment.

Origin and Development: I-level (short for Integration Level) began as a general theory of personality development. The

theory was developed by a group of psychology students at Berkley during the late 1950s. Its authors sought to integrate developmental, psychoanalytic, Lewinian, and social perceptual perspectives into a single dimension of personality development that described personal development in terms of increasing perceptual complexity and interpersonal maturity. Seven successive stages of development were specified, ranging from the least mature, that common to the new-born infant, to Stage 7, a hypothetical stage of development unlikely to be achieved by anyone.

I-Level in Brief

Very roughly, successful elementary school functioning requires Stage 3 development, successful high school functioning requires Stage 4 development, and successful/healthy/mature adult functioning requires Stage 5 development.

The four stages of development common to adolescents in treatment propgrams are as follows:

I 2 is a stage of very young children. Other people are viewed solely as sources of gratification. Gratification can not be delayed. Our society does not tolerate this kind of behavior in adolescents and therefore such youth are unsually in juvenile detention or treatment centres.

I 3 youths have learned that they have power. Their behaviours affect the response they receive from others. They are keenly interested in who has the power and what are the formulae they need to apply in order to get what they

want. This is a very concrete stage, and values have not yet been internalized. Our society does not tolerate level 3 behavior in adults, and as one Vancouver I-level trainer suggested, most level 3 adults would end up in jail.

I 4 youth are more aware of feelings and motives. They also operate from internalized values and morals which they apply in a rigid black and white manner. This is the phase of adolescence when one feels that one knows it all. Some adults never grow beyond this level, Archie Bunker being a classic fictitious TV example.

I 5 is a stage of development uncommon among adolescents in treatment programs. At level 5 one tends to see grey areas and is tolerant of viewpoints that differ from one's own.

Warren (previously Grant) (1961) further developed the classification system by adding to the theoretical model a set of nine "developmentally stuck" or anti-social subtypes. Although the I-level stages fit for the population in general, not everyone passes through the subtypes. Fitting the description of one of the subtypes is indicative of unhealthy emotional functioning. The subtypes define ways in which individuals respond to their perceived worlds, each containing clusters of traits derived from clinical descriptions of delinquent or troubled youths. Keeping brevity in mind, the three most common subtypes found among Vancouver populations of adolescents in treatment programs will be described below. These subtypes are not developmental. They describe patterns of response or adaptations to perceived worlds.

I 3 Immature Conformists, in an effort to seek approval, conform to whomever has the power at the moment. Thus commitments or promises are sincere, but mean nothing.

I 4 Neurotic Acting-out youth are internally conflicted due to negative self-image. They put on a facade of superadequacy. They have done everything bigger and better, and no wrong doings are ever their fault. These individuals are always on the go in an effort not to focus on the difficult inner feelings. They may become aggressive in one of their constant attempts to keep others at a distance. This need for distance should to be respected.

I 4 Neurotic Anxious individuals are also internally conflicted due to a negative self-image. Yet, rather than blaming others for all the problems that come their way, they tend to blame themselves. These individuals tend to be introspective. They frequently try to engage several others in their self-analytical attempts. The value of engaging several others is that if anyone gets too close to the "truth", the individual can move onto a safer confidant or counsellor who is more distant.

I level basically comprises four parts:

1. Developmental Theory: As noted, I-level is rooted in cognitive developmental theory. Concepts from developmental theories are used to facilitate the understanding and explanation of "normal" and problem behavior.

2. Diagnosis: I-level diagnosis, as noted, assesses the adolescent's developmental perception/understanding of self,

others, and the world around him or her. I-level diagnosis describes each youth as a unique individual with both strengths and vulnerabilities. The vulnerabilities were often previous strengths or ways of coping which the youth had to learn in order to get through a difficult life situtation. Different things are going to be important and make sense to different youth. If society is going to intervene, I-level recommends intervening in a way that makes sense to the youth. Describing what makes sense is the whole point of the diagnostic label.

3. Treatment: The reason that I-level has become so popular in child welfare and juvenile probation is that it provides more than just another assessment. I-level also provides practical differential treatment recommendations - that is, different ways of meeting the individual needs of each youth and intervening so that the youth will not get deeper and deeper into a cycle of anti-social behavior and be repetitively institutionalized. Since treatment program design emphasizes the uniqueness of each youth, the I-level treatment program provides a general framework and the individuality of the involved youth dictates the specifics.

4. Worker-Client Matching: I-level suggests that the relationship between a youth and his or her workers is a highly significant part of treatment. Thus, I-level describes different kinds of worker styles and has developed a method of classifying the worker for the purpose of matching youths and workers who have similar approaches to interpersonal interaction and can therefore more readily

develop a working compatibility. Just as a worker-client mismatch may lead to ineffective intervention with the youth, so it may also be harmful for the worker, making him or her feel a failure when it is actually his or her characteristic style of interaction that is not compatible with the youth's preferred way of relating to people, and the worker may be very effective with matched clients. I-level also recommends worker roles (e.g. therapist, tough big brother/sister, teacher, concerned peer) which can enhance the worker-youth relationship for the purpose of maximizing effective intervention. For example, an I 4 Na would feel most comfortable with a worker who can have a business-like approach to their relationship, and who can be active and presents as "cool" in the popular slang sense of the word. An I 4 Nx would feel more comfortable with a worker who likes to sit around and listen and be the counsellor. An I 3 cfm is best matched to a very nurturing, giving, clear, patient worker.

Administration and Brevity: A clinical semi-structured interview of about one hour in length is the original method by which an I-level classification is reached. (See sample interview questions in Appendix G.) All interviews are tape recorded to allow for later rating of the interview. Diagnostic ratings are obtained from the interviewer and an additional diagnostician. The purpose of the second rating is to determine the level of reliability being obtained and to control for selective hearing. This interview method is obviously very costly. First, training of a classifier

requires three weeks of intense training. Secondly, the interview and second rating takes a minimum of four hours. Much more time is involved if a written I-level report is produced.

The Jesness Inventory (Jesness & Wedge, 1983) paper and pencil method of classification offers a less expensive or less time consuming alternative of I-level classification, solving both the training and interrater reliability problems. However usually agency personnel are interested in obtaining the far richer set of data and themes arising out of the interview method.

Reliability: Reliability of I-level classifications has been tested in terms of interrater and test-retest reliability. Reliability studies have produced varying results ranging from 67% to 92% interrater agreement (Palmer and Wernner, 1972; Jesness, 1974; Harris, 1983, 1986). This variance is not surprising given that proper classification relies on training and experience. Harris (1988) writes that "problems in this area are well-known and the potential for correcting them exists."

Validity: Validity of the interview classification method has been addressed only in terms of construct validity. I-level theory closely resembles other theories of personality development such as Moral Development (Kohlberg, 1966), Conceptual Level (Hunt, 1971), and Ego Development (Loevinger, 1976). Jesness found that I-level was strongly related to Loevinger's (1976) ego-development continuum (r = .47). Werner (1975) tested the construct validity of I-level

in terms of clusters of profiles on the California Personality Inventory. He found higher I-level ratings (higher levels of developmental maturity) to be related to such personality characteristics as internalization of values, tolerance, independence, and flexibitity.

Norms: Although I-level later became a system for differentiationg among delinquent youths, it was initially a theory of normal personality development designed as a means of conceptualizing the extent of a person's ego development. Harris (1983) found that only 35% of a sample of males drawn from a general student population fit any of the I-level subtypes. This lends support to the predictable concept that the subtypes describe only a portion of the population, anti-social or troubled youths, and that the subtypes are not generlizable to the overall population. This is not surprising given that I-level theory has evolved to its current form as a treatment planning and evaluation tool for troubled youth. The levels or stages, however, were conceptualized to hold true developmentally for the general population including all ages. No data is available regarding the extent to which this is true.

Comments: I-level is clearly very complex. It takes into account both personality development and personality type. As noted, I-level is primarily useful as a treatment planning tool. It provides a wealth of information pertaining to treatment goals, predictable expectations within the treatment process, and helpful methods.

Primary Reference: Warren, M. & the Community Treatment Project Staff. (1966). Interpersonal Maturity Level Classification: Juvenile Diagnosis and Treatment of Low, Middle and High Maturity Delinquents. Sacramento: California Youth Authority.

The Sexual Abuse Impact Checklists (See Appedix I)

Developed by: The Sexual Assault Center at Harborview Medical Center, Seattle, Washington.

Purpose: To identify some of the effects of sexual abuse on children and adolescents.

Administration and Brevity: The checklsits can be administered verbally or can be self-administered. Approximately 20 minutes per checklist is required, or longer if pressing clinical issues arise (e.g. suicidal ideation, violent fantasies, placing self in dangerous situations, overwhelming guilt). There are three separate checklists, one to be answered by a nonoffending parent, one to be answered by the child's social worker, and one to be answered by the child.

NIMH Study (Norms): Conte, Berliner, and Schuerman (1986), used and revised the Impact Checklists in a large study funded by the National Institute of Mental Health. The study describes the effects of sexual abuse on a sample of 369 sexually abused children seen by the Sexual Assault Center at Harborview Medical Center in Seattle between September 1983 and May 1985. The age range was from 4 to 17 years. 76% were female and 24% were male. 82% were white.

Construct Validity: The items for the three impact checklists were derived from sexual abuse literature and a survey of experienced specialized therapists. When the checklists were tested with abused and nonabused populations, many items were dropped from the original checklists due to insignificant variation between groups. The items from the parent

completed checklist were factor analyzed resulting in eight factors: poor self-esteem, aggression, fearfulness, conscientiousness, difficulty in concentration, withdrawal, acting out, and anxiousness to please/tries too hard. Differences between abused and comparison children on these fctors are all statistically significant.

The 65 variables potentially associated with variation in the effects of sexual abuse on chldren and adolescents were reduced to 35 on the basis of low item correlations between child and parent scores, or between child and social worker scores, or (entered) because of clinical or theoretical interest.

High scores on the social worker completed Impact Checklist were positively associated with poor family functioning, exposure to more types of sexual behavior, physical restraint as part of the abuse, the victim fearing negative consequences to self, and the offender's denying that the abuse took place. High social worker scores were inversely related to a victim's having a supportive relationship with an adult or sibling. The victim's having a supportive relationship with an adult was also negatively associated with high scores on parent completed checklists. The number of problems in living experienced by the victim's family and the degree to which the victim sees self as responsible for the abuse were positively associated with high parent scores. These correlations are in keeping with sexual abuse literature and resiliency literature, lending support to the validity of the checklists. However, the

checklists are still in the process of being further developed and changed. No comparative data is available regarding the patterns of symptoms in other groups of traumatized or stressed children. This would be very helpful to understand the differential effects of other types of trauma.

Reliability: The reliability studies (Conte, Berliner, & Schuerman, 1986) conducted, as small as they are, seem to suggest that both social workers and parents are consistent in how they describe the child on their respective measures. At the same time it is generally recognized that different data sources, especially parent and professionals, are likely to view events and behavior differently in part because they use different perspectives to view behavior and in part because they see the child in very different environments and under different conditions.

Comment: The Harborview Impact Checklists are still evolving and more research is needed. However, these checklists are the most well researched and comprehensive measures of the effects of sexual abuse on children and adolescents to date.

Primary References: Conte, J. & Berliner, L. (1988). The impact of sexual abuse on children: empirical findings. In L. Walker, (Ed.), Handbook of Sexual Abuse of Children. New York: Springer Publishing Co.

Family Assessment

The assessment of family functioning presents many challenges. For instance, how much emphasis should be placed on examining the characteristics of individual members, their various interactions, or the family system as a whole? (Bodin, 1968)

Another consideration is the extent of focus on past events versus ongoing family behavior. Since each perspective may provide unique as well as corroborating information on areas of health-pathology in the family, there are obvious advantages in attempts to integrate these viewpoints. However, practical constraints and different theoretical orientations of staff often result in a more circumscribed approach being used for family assessments in a given setting (Fisher, 1982).

For the purposes of designing this assessment package, many known family measures were reviewed. However, virtually none were found to be satisfactory in terms of addressing known major family stressors such as violence, substance abuse, sexual relationships or socio-economic factors. The majority of the family measures reviewed also seem to be culturally or economically biased. In order to overcome some of the above mentioned concerns, a combination of three family measures was decided on for this project: the FAM (chosen in part because it is based on Canadian norms, and because it assesses strengths as well as just pathology); the FILE/A-FILE (chosen because it is a checklist of life and family stressors, and would therefore address the gaps not

addressed by the FAM); and the Morrison Center Family Problem Checklist (chosen because, although it is not one of the standardized "big name" family measures which are familiar in the literature within the field, the problem checklist does a good job of addressing very real common family strengths and problems).

The Family Assessment Measure (FAM) (See Appendix J)

Authors: Skinner, H.A., Steinhauer, P.D. & Santa-Barbara, J.

Purpose: To assess family functioning, including family strengths and weaknesses. The FAM is designed to be used in clinical and research settings as a diagnostic tool, as a measure of therapy process and outcome, and as an instrument for basic research on family processes.

Brevity and Administration: The General scale contains 50 items and takes approoximatelly 20 to 25 minutes to complete. The FAM may be completed by family members who are at least 10-12 years old.

Description: The FAM is a family inventory based on Canadian norms for clinical and non-clinical populations. This inventory provides information on seven basic factors in family functioning: task accomplishment, role performance, communication, affective expression, involvement, control, and values and norms. Also included are response style bias measures of social desirability and defensiveness. The following is a description of the seven factors of family functioning which are assessed by the FAM:

1) Task Accomplishment (or problem solving ability): A major function of the family is the successful achievement of a variety of basic, developmental and crisis tasks. This includes allowing for the continued development of all family members, providing reasonable security, and functioning effectively as part of society. The process by which tasks are accomplished includes: (1) task or problem identification, (2) exploration of alternative solutions,

(3) implementation of selected approaches, and (4) evaluation of effects.

2) Role Performance requires three various operations: (1) the assignment of specified activities to each family member; (2) the agreement or willingness of family members to assume the assigned roles; and (3) the actual carrying out of prescribed behaviors.

3) Communication: Central to the performance of these roles is the process of communciation, by which information essential to tasks and roles is exchanged. The goal of effective communication is mutual understanding, so that the message received is the same as the message intended. If the message sent is clear, direct and sufficient, then mutual understanding is likely to occur. However, the process of communication may be avoided or distorted by the receiver. Thus, critical aspects of the reception phase of communication include the availability and openness of the receiver to the message.

4) Affective Expression includes the content, intensity and timing of feelings.

5) Involvement refers to both the degree and quality of family members' interest in one another. Other important elements of affective involvement include the ability of the family to meet the emotional and security needs of family members, and the flexibity to provide support for family members' autonomy.

6) Control is the process by which family members influence each other (e.g. is the family predictable, inconsistent,

responsible, constructive, rigid, flexible, laissez-faire, chaotic?).

7) Values and norms include how tasks are defined and how the family proceeds to accomplish them. This may be greatly influenced by norms and values of the culture in general, and the family background in particular.

FAM Norms: Scores in the FAM profiles are normalized with each subscale having a mean of 50 and a standard deviation of 10. The majority of scores for nonclinical families should fall between 40 and 60. Scores outside this range are indicative of very healthy functioning (below 40) or considerable disturbance (above 60). Separate norms have been developed for adolescents which also have a mean of 50. Preliminary analysis of the FAM was conducted with 475 families in the Toronto area.

Reliability: Internal consistency reliability estimates for the overall rating on the General Scale is excellent (.93 for adults; .94 for children).

Validity: Validation studies are in progress.

Primary Reference: Skinner, H. & Steinhauer, P.D. (1983). The Family Assessment Measure, Canadian Journal of Community Mental Health, 2 (2), 91-105.

The Concept of Life Stress

In the last 25 years, there has been a proliferation of research based on the hypothesis that stress arising from an accumulation of life events plays a role in the etiology of various somatic and psychiatric disorders (Holmes & Rahe; 1967, Holmes & Masuda, 1974; McCubbin and Patterson, 1982). McCubbin and Patterson (1982) promote the concept that family life changes are additive and at some point, reach a family's limit to adjust to them.. At this point, one would anticipate some negative consequence in the family system and/or its member(s).

Family Inventory of Life Events and Changes (FILE)

(See Appendix K)

Authors: McCubbin, H., Patterson, J. & Wilson, L.

Purpose: The purpose of the FILE is to assess the above concept of the pile-up of normative and non-normative life events and changes experienced in the family unit (single parent, two parent, reconstituted, etc.) in the past year. Families usually are dealing with several stressors simultaneously and FILE provides an index of a family's vulnerability as a result of this pile-up.

Conceptual Organization: All events experienced by any member of the family are recorded since, from a family systems perspective, what happens to any one member affects the other members to some degree.

Brevity and Administration: The FILE is a 72-item self-report instrument requiring approximately 20 minutes to complete.

Reliability: The overall scale reliability (Cronbach's Alpha) for the FILE is .81. Test-retest reliability over a four week time lapse was computed as ranging between.72 and .77. This indicates acceptable reliability over time.

Validity: Validity assessments of FILE were made by correlating the FILE with a measure of family functioning, the Family Environment Scales (Moos, 1976). The hypothesis was that a pile-up of life changes would be negatively correlated with desirable dimensions of the family environment and positively correlated with undesirable characteristics of the family environment. As predicted, a moderately high correlation supported the construct validity of FILE in that strains within the family would be expected to impact upon the way the family unit functions together.

Norms are based on approximately 980 American couples (1,960 individuals) including couples across the family life cycle from young married couples to those retired.

Conceptual Dimensions of the FILE:

1) Intra-Family Strains combine two dimensions:

- Conflict - sources of tension and conflict between family members, including increases in normative sources of intra-family strain.
- Parenting Strains - increased difficulties in enacting the parenting role.

2) Marital Strains arising from sexual or separation issues.

3) Pregnancy and Childbearing Strains: Pregnancy difficulties or the addition of a new family member.

4) Finance and Business Strains:

- Family Finances - increased strain on a family's money supply.

- Family Business - strains arising from a family-owned business or investments.

5) Work-Family Transitions and Strains:

- Work Transitions - moving in or out of the work force.

- Family Transistions and Work Strains - changes occurring at work or moves made by the family or one of its members.

6) Illness and Family "Care" Strains:

- Illness Onset and Child Care - dependency needs arising from injury or illness to a family member or friend. This section also includes problems with child care, although normally child care is considered just to be a part of day to day family life.

- Chronic Illness Strains - the onset of or increased difficulty with chronic illness.

- Dependency Strains - a member or friend requiring more help or care.

7) Losses due to the death of a member or friend and due to broken relationships.

8) Transitions "In and Out" - a member's moving out or moving back home or beginning a major involvement outside the family.

9) Legal - a member breaking society's laws or mores.

Primary Reference: McCubbin, H., Patterson, J. & Wilson, L. (1980). Family Inventory of Life Events and Changes (FILE). St. Paul: Family Social Science.

Adolescent-Family Inventory of Life Events and Changes

(A-FILE)

(See Appendix L)

Authors: McCubbin, H., Patterson, J., Bauman E. & Harris, L.

Purpose: To record normative and non-normative life events and changes an adolescent perceives his or her family has experienced during the past 12 months. The A-FILE provides an index of an adolescent's vulnerability as a result of the family pile-up of stressful life events.

Conceptual Organization: As with the FILE, all events experienced by any member of the family are recorded since, from a family systems perspective, what happens to any member affects the others to some degree. Items on the A-FILE are grouped into six conceptual dimensions: 1) transitions (role or status transitions, geographic mobility), 2) sexuality (pregnancy, childbearing, onset of sexual activity), 3) losses (death, loss of property or income), 4) responsibilities and strains (interpersonal tensions and strains related to health care and finances), 5) substance use (use of drugs or alcohol, conflict about substance use, or a premature exit from school), 6) legal conflict (arrest or assault of a family member).

Brevity and Administration: The A-FILE is a 50-item self-report instrument requiring approximately 15-20 minutes to complete.

Norms are based on a sample of 500 American high school students.

Reliability: The total scale reliabilities are .83 and .80, indicating acceptable internal consistency. The test-retest reliability is .82.

Construct Validity: Three procedures were used to reduce the A-FILE to 50 items: (a) an analysis of the frequencies of occurrence of all the items, (b) factor analysis followed by tests of internal reliability and test-retest reliability, and (c) reference to prior research and theories regarding family life changes. Several infrequently occurring items were retained if they were considered major stressors (e.g. death of a parent). Caution must be used in this approach to data analysis and instrument construction in view of the fact that occurrences of each family life change are not uniform. Perhaps certain stressors should be given more weight or importance than others.

Additional Validity Checks: It was hypothesized that a pile-up of family life events would be positively associated with the use of cigarettes and alcohol and/or marijuana. Further research indicated support for this hypothesis. A second validity check on the A-FILE was made by hypothesizing that the greater the pile-up of recent family life changes, the less the adolescents believe their health behaviors are under their own control. This hypothesis was supported as measured by the Multidimensional Health Locus of Control Scales (Wallston, Wallston & DeVellu, 1978).

Primary Reference: McCubbin, H., Patterson, J., Bauman, E. & Harris, L. (1981). Adolescent-Family Inventory of Life Events and Changes (A-FILE). St. Paul: Family Science.

The Family Problem Checklist (See Appendix L)

Drafted by: The 1980 staff group, consisting of clinical psychologists and social workers, at the Morrison Center for Youth and Family Service, Portland, Oregon.

Purpose: to assess how satisfied or dissatisfied each family member is with how their family is doing in common areas of family strength or weakness (such as the use of physical force, relationships between parents, making of sensible rules, and methods of dealing with matters concerning sex).

Brevity and Administration: The Family Problem Checklist is a 22-item self-report requiring approximately 10 minutes to complete. It is appropriate for parents and children from the ages of 9/10 up.

Content: The checklist reflects the most common themes addressed by family practitioners at the Morrison Center in Oregon. Of all the family measures reviewed for this assessment package, these themes most closely address the "real" or relevant concerns/themes of the families who present for counselling at Nisha's Family Counselling Program in Vancouver.

Strengths: The checklist is clinically useful in identifying important family concerns or "red flag" items that may require quick attention, and that family members may not otherwise identify on their own initiative at the onset of counselling, such as matters pertaining to physical force or sex.

Drawback: Norms, reliability, and validity information have not yet been developed for the family problem checklist. Also, in families where denial exists, the actual baseline may not come until later on in treatment.

Primary Reference: Trute, B. (1985). Evaluating Clinical Service in Family Practice Settings: Basic Issues and Beginning Steps, Canadian Social Work Review.

Availability: The Morrison Center for Youth and Family Service, 3355 S.E. Powell Blvd., Portland, Oregon, 97202, U.S.A.

Other Ecological Measures

An Eco-Map was completed based on the format of Hartman and Laird (1983). This eco-map was completed via interviews with the family and social worker (see appendix M).

Purpose: to assess family resources, connections, and the nature of these connections.

Brevity and Administration: The eco-map took approximately an hour to complete. There are other similar formats for completing eco-maps. For example, family members could be asked to complete their own maps. Some families could do this very well, while other families might not be aware of their resources and connections.

Description: An eco-map is a descriptive clinical tool (rather than a research tool) which can highlight significant resources and connections (positive or negative) within a family. Unlike any of the other measures included, the eco-map is a visual tool which presents a picture. This can be quite revealing for individuals, families and clinicians. The eco-map will be discussed further in the "findings" section of this thesis.

Reference: Hartman, A. & Laird, J. (1983). The Family in Space: Ecological Assessment. In Family-Centered Social Work Practice. New York: The Free Press.

The "School Essay"

As has already been mentioned on page 13, no standardized teacher completed measure could be used as the adolescent who participated had not been in school for over a year. The adolescent involved liked the idea of writing a short essay telling how it came to be that she was refusing to attend school at this time. The findings or themes of this essay will be discussed in the following section. Also, a copy of the essay can be found in Appendix N.

CHAPTER FOUR: PRESENTATION OF FINDINGS

This section will describe the process and findings of having run one time through the previously outlined assessment protocol. For the purposes of this practice-thesis combination, time has not allowed for more data collection (a larger sample group) due to the complexity of the research topic, the large number of measures being used, and the enormous amount of time that went into researching a much larger pool of measures from which the included selections were made.

Case History

The adolescent who participated in this research is a 14-year-old part Native girl who will be referred to as L. She is the oldest of three children. Her brother is 8 years old, and her sister is 5 years old. The brother is a large, tough, active boy. He is in a special class for behavior and learning problems. Lately he has been bullying and stealing in the neighbourhood. The 5 year old sister is the "good" child in the family.

L often looks uncared for. She is somewhat overweight, and more often than not she wears torn or stained black clothes which portray a "tough" image. She often smells as though she or her clothes need a wash. L also has many lovely qualities. She can be fun loving, can have a good sense of humor, is artistic, can be skillful with small children and animals, is skilled with computers, and is a

good cook. Her weaknesses are that she is very skilled at power struggles, likes to think she is more streetwise than she actually is, is very "mouthy" and moody, has a volatile temper (something she no doubt witnessed in her past), and can be very good at maintaining a stubborn contrary stand. For example, when L does not want to do something such as going back to school, her suggestions for alternatives tend to be ideas such as killing herself, or supporting herself by dealing drugs as some of her relatives have done.

L has grown up with her mother who had been a single parent most of the time. They live in a very chaotic, run down, dirty East Vancouver house. Perhaps the home is symbolic of the chaos in this family's life.

Recently, L's father has rejoined the family. This situation was shaky at best as he was an alcoholic who had recently been released from jail. His relationship with L has been very inconsistent. L seeks his approval and attention, however, this has never been consistently forthcoming. Thus, L's feelings for her father roller coaster between love and anger.

The brother and sister each have different fathers. The sister's father had been a brief boyfriend of the mother's. The brother's father had lived common-law with the mother for two years before they married shortly after the sister (not his child) was born. The marriage was short lived as he was abusive of the mother and also, L told her mother that he had made some sort of sexual advance towards her. The men in the mother's life have been substance abusers and have been

abusive of both the mother and her children. In the end the mother always came to the defense of her children.

On another ocassion L informed her mother that an uncle had also made a sexual advance towards her. Not much is known about either of these situations as L has not yet wanted to talk about this with anyone. In both cases L's mother believed L and took steps to protect her. Charges were never laid. These incidents occurred about seven years ago.

The mother has a horrid history of physical and emotional abuse by her mother, and sexual abuse by her step-father. The step-father was charged and went to jail. L's mother became pregnant with L when she was a teenager. The family has received a multitude of services and has received Income Assistance since that time. The children have been in care for brief periods in the past. There is a history of child welfare complaints, usually involving unsafe and unsanitary housekeeping standards.

During the two months prior to the research interviews, L was been placed at Chimo House (a residential treatment centre for adolescents experiencing severe emotional and behavioral problems). At the time that L came into care, her mother had reached the end of her rope in terms of L's volatile and threatening defiance. Not only was L engaging in outbursts at home, but she was doing so at school as well. L had missed large amounts of school. Her school history over the past couple of years was that either she was

refusing to attend, or the school was refusing to have her back due to problem behaviour or non-attendance. The last grade L actually completed and passed was grade six. It should also be mentioned that L appears to have a severe learning disability affecting her ability to read and write. No doubt this has an impact on L's refusal to attend school.

Thus at the time L was placed at Chimo House L's needs were considered to be too great to expect that the mother's patience could stretch any further, especially given the mother's own needs and scars predictably stemming from her own abusive history. Some of the mother's own struggles included agoraphobia, sleep disorder, recurring health difficulties, and a history of choosing alcoholic or abusive male partners.

In the following section L's results on the measures tried will be discussed. This assessment package was administered during four sessions over four weeks. Three sessions took place in the writer's office, which is private, quiet and comfortable. The fourth session took place in the privacy of a bedroom in L's Aunt's home in Surrey to where L had run (L has a history of running). L had known this writer for about five months as family counsellor to the family. The fact that a positive relationship already existed between us likely had a positive impact on L's ability to complete the assessment. As it was, L became easily bored and then could quickly become silly. In order

to improve validity, and to avoid L becoming frustrated with her learning disability, all paper and pencil tests were administered verbally by this writer. The sequence of interviews was as follows:

In session one L was seen on her own. The I level interview and the two self-esteem scales were administered.

In session two L and her mother were seen together. In this session the family problem checklist, the FAM, and the eco-map were administered. (L's father was not included in any of the sessions due to his mistrust of helping professionals, and due to his only very recent, and possibly short-lived re-involvement in this family.)

In session three L and her mother attended together, but were seen individually. The mother completed the FILE, L completed the A-FILE, and both completed their respective sexual abuse impact checklists. The two were then brought together to share their thoughts, and L was asked to bring a page or two on what she thought of school to the next session.

In session four L was seen individually again. This time she completed the Hopelessness Scale, the Children's Depression Inventory, and the locus of control scale.

In each session L and her mother were asked whether they were getting tired or bored, or whether they had the energy to complete another test before it was administered. Time was also allotted at the end of each session for processing any leftover thoughts or questions.

The results from these sessions are as follows:

Self-Esteem: L scored as having significantly low self-esteem on both the Rosenberg (RSE) and the Hare Self-Esteem Scales (HSS).

The HSS was clearly a more appropriate and useful measure to use with this adolescent. L found the wording of the RSE confusing and hard to understand. She repeatedly asked for clarification of items on the scale. The possible responses to the items were: strongly agree, agree, disagree, or strongly disagree. However, L gave only agree and disagree answers, stating at the end that she had forgotten she could use the other two possible responses.

The HSS provided more meaningful information regarding L. Although L scored as having significantly low home self-esteem and school self-esteem, she scored as having quite high peer self-esteem. This is obviously clinically useful information in terms of where to intervene and where to build on strengths. L found the items easy to understand with the exception of one item on the peer scale which she described as being a "stupid question".

Hopelessness and Depression: L scored as being depressed on both the Hopelessness Scale (HS) and the Children's Depression Inventory (CDI). However, neither of these scores were a "red flag" for a suicidal risk. L reported on both the CDI and the sexual abuse Impact Checklist that she thought about suicide, but that she would not do it.

The CDI was easier for L to understand and seemed to talk more about what was really going on in her life. Again, the items which L felt most strongly negative about were related to school performance.

On the HS, L did not score as depressed on items pertaining to affectively toned associations (hope and enthusiasm; happiness; faith; and good times). She did score as depressed on items pertaining to loss of motivation (giving up; deciding not to want anything; not trying to get something that is wanted) and she scored as depressed on items pertaining to future expectations. Some of her responses may have been impacted by the fact that the HS seemed to be conceptually too difficult for L. This is in keeping with the I-level assessment, which is discussed later in this section.

Locus of Control: L was assessed by the N-SLCS as having an external locus of control. She found this assessment device to be too long and too difficult to understand. Her impatience/minor frustration/lack of clear understanding may have impacted on some of her answers. Also, as noted, Nowicki and Strickland (1973) found internality to be significantly related to higher social class. As well, Tyler & Holsinger (1975) and Hawk & Parsons (1976) found Native Indian people to be more external. Both of these generalizations are true in L's case.

Interpersonal Maturity Level: Although the I-level interview seemed to be boring and a bit frustrating for L, it did produce a wealth of information pertaining to themes and how she understands people and the world around her. See Appendix O for a partial transcript, a statement of themes, an I-level rating (I 3 immature conformist), a summary of I 3 cfm characteristics, and treatment recommendations. In a nutshell, L interviewed as being developmentally delayed and still viewing the world in a very concrete "rules and fairness" fashion. Approval of those who are seen to have power is a central concern to L. Thus in L's world, the rules and the power change every time she walks out the door to be with her friends. Values are not yet internalized. Problems are seen as imposed by the outside world, rather than having anything to do with her own self. She does not yet know much about who she is, and she has low self-esteem. Since L does not really know who she is, it is hard for her to feel as though she "belongs" anywhere, whether this means knowing her place with a group of friends, or knowing her place in her family. L is not yet capable of taking the future into account in her plans. Her plans are based on her current wants. She handles crisis by escape/running away/substance abuse.

Recurring themes in the interview were: abandonment/feeling rejected/tossed out; fairness/proper treatment; growing up (not wanting to be a little girl, and yet still wanting a nurturing Mom); jealousy; blame/anger; feeling sorry for self.

Treatment recommendations according to I-level theory will be discussed in the concluding chapter.

Effects of sexual abuse as reported on the Harborview Impact Checklists: The social worker checklist noted significant problems in the areas of school; mood/affect; acting out/conduct disturbance; and self-concept. This is in keeping with what has been noted already.

The parent completed impact checklist described L as having a multitude of symptoms. There were 65 items which the mother could potentially haved rated as never, rarely, sometimes, often, very often, or don't know. Of the 65 items (known possible symptoms or effects of sexual abuse) the mother rated only 7 as "never", and 4 as "don't know". There were also 4 items rated as "rarely", however these were all items where even a rare presence could be significant (serious criminal problems; community conflict, e.g. vandalism; acts sexually promiscuous; sexually inappropriate). Of the remaining symptoms (all indicators of problematic functioning) the mother rated 21 items as being present very often, 15 items as being present often, and 14 items as being present sometimes. These ratings indicate extremely disturbed behavior.

There were two items which the mother found difficult to understand, and two items which the mother found to be "normal for teenagers" (i.e. drastic mood swings; eating differently than used to). Another constructive comment the mother made was that there were no positive items included.

This is a very interesting comment in light of the concept that every traumatic experience not only has a negative impact, but can also build on strengths and resiliencies within an individual. Recent Adult Children of Alcoholics literature by Woititz (1987, 1985) is beginning to pay attention to this concept.

The adolescent completed impact checklist was difficult for L. She needed clarification to understand many of the items and she found the checklist to be too long and therefore got bored and impatient. For these two reasons some of L's responses may not have accurately answered some of the questions as they were intended. She did not seem to have trouble with the potentially emotion laden content of the items, although a few of them made her giggle.

It is always difficult to know whether some of L's worrisome responses reflect the impact of sexual abuse, or the impact of other trauma in her life. In any case, it was important to take note that L responded "a lot of the time" to statements such as: I think about killing myself; I run away from home; I "space-out"; I have problems with eating; I get headaches and stomachaches.

Family Functioning: The Family Assessment Measure (FAM III) was completed by both L and her mother. See the FAM diagram later in this chapter for a profile of their scores. Both L and her mother scored in the family problem range for values and norms items. Also, L's score for affective expression, and the mother's score for role performance indicated

considerable disturbance. Niether of them scored in the family strength range for any of the seven factors. According to the FAM authors, problematic scores in the values and norms area indicate:

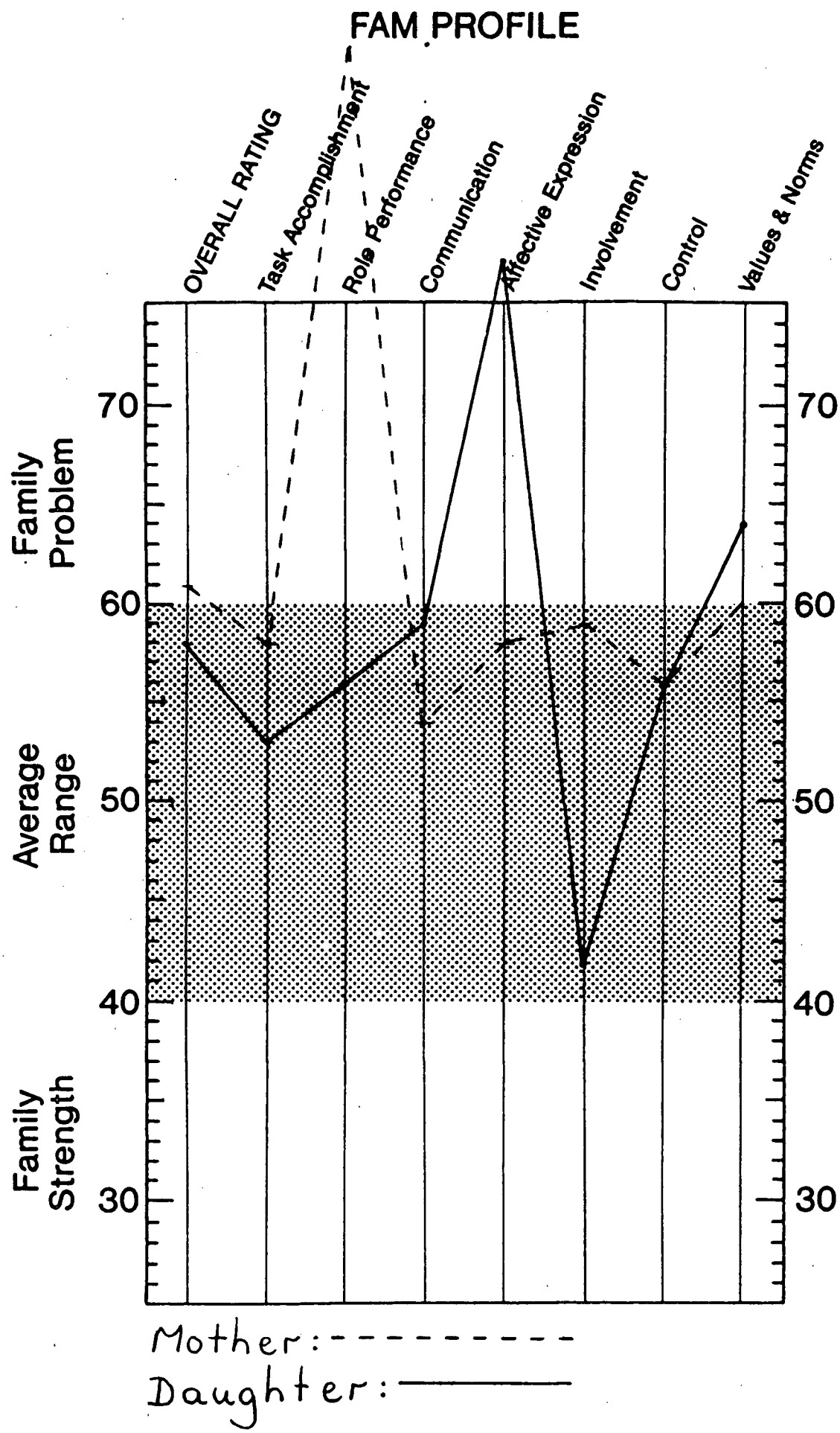
- components of the family's value system are dissonant resulting in confusion and tension
- conflict between the family's values and those of the culture as a whole
- explicitly stated rules are subverted by implicit rules
- degree of latitude is inappropriate.

Problematic scores in the affective expression area indicate inadequate affective communication involving insufficient expression, inhibition of (or overly intense) emotions appropriate to a situation.

Problematic scores in the role performance area indicate:

- insufficient role integration, lack of agreement regarding role definitions
- inability to adapt to new roles required in evolution of the family life cycle
- idiosyncratic roles.

Both the mother and L found some of the items on the FAM confusing, hard to understand, or repetitive. When I asked both mother and daughter whether the questions on the FAM would give a good picture of how things are in their family, neither of them found the questions to be particularly relevant.


FAM PROFILE
OVERALL RATING
Task Accomplishment
Role Performance
Communication
Affective Expression
Involvement
Control
Values & Norms
Family Problem
Average Range
Family Strength
70
60
50
40
30
Mother: - - - - - - - -
Daughter: ————

Life Stress: Both L and her mother scored in the top 10% of people experiencing high stress according to the norms of the Family Inventory of Life Events (mother) and the Adolescent Family Inventory of Life Events (daughter). The mother was experiencing the highest number of stressors in areas of intra-family strains, work-family transitions and strains, and family legal violations (L had recently been charged and taken to the Youth Detention Centre for assaulting a staff member at Chimo House). L was experiencing the highest stress in the areas of family responsibilities and strains, school strains and substance abuse, and family legal violations.

Both L and her mother found the items clear and easy to understand. When asked, both mother and dauthter found the items on the FILE and A-FILE to be more relevant to what really goes on in their family than the questions on the FAM.

In the case of L in particular, the A-FILE served as a clinically useful starting point for discussion and intervention. For example, during the process of verbally completing the A-FILE, L responded "yes" to an item that indicated she had begun to have sexual intercourse within the last while. Upon completion of the questionnaire, this allowed for discussion about decision making, choices, consequences, and contraceptives (which she had not been using).

Family Concerns: The Family Problems Checklist showed that being able to show good feelings (happiness, joy, pleasure) is a strength within L's family. The checklist also highlighted that this family is struggling in many areas including communication, responsibilities, anger, discipline, independence, sibling relationships, parent-child relationships, and finances.

When asked, both mother and daughter found the items on the problems checklist to be more relevant to what really goes on in their family than the questions on either the FAM or the FILE or A-FILE.

Resources and Connections: The eco-map showed that L's family does not have a lot of strong, positive connections or resources. Female friendships are the most positive outside resource to this family. The family's connection to all other outside influences is either tenuous, stressful, or non-existent. For example, spirituality or church support is not a resource due to the mother's past negative experiences with her Catholic upbringing. As well there were no Native culture supports in place for this family. Recreation is very limited for this family due to the mother's agoraphobia and due to lack of finances. However, the family does enjoy the use of their computer and their VCR, both of which can be positive resources. School has always been a stress in this family. The mother and both of the school age children have serious learning disabilities and have tended to get into trouble at school. As well, family relations are strained,

with the mother having absolutely no contact with any of her siblings, of whom she is the oldest. The maternal grandmother is both a stress and a resource within L's family. Many disagreements occur and unresolved resentments over past abuse still exist. However, L's mother is somewhat dependent on her mother to help her with the outside world in light of the agoraphobia. Poor housing and inadequate finances (income assistance) bring further strains. Perhaps relatedly, frequent illness of all family members and difficulty in accessing medical services (due to agoraphobia) is yet another source of stress.

School: As indicated on the eco-map, school is a stressful energy drain for L and her family, due to learning disabilities on the parts of the mother and the two school-aged children. The themes arising out of L's essay about school are as follows:

- feelings of not fitting in (feels older and more street wise);
- feels exposed and embarrassed (rumors, gossip and bad: reputation circulating);
- feels that the work is often too hard;
- feels misunderstood;
- feels ridiculed;
- sometimes feels stupid. (See Appendix O for school essay.)

CHAPTER FIVE - DISCUSSION OF FINDINGS

This chapter will discuss (1) the findings of this single case study, and also, (2) the assessment protocol in general.

The Single Case Study

The relationships between measures in the case of L very much followed predicted patterns. For example, Mullins, Siegel, and Hodges (1985) found a strong positive relationship between external locus of control and level of depressive symptoms ($r = .57$). As well, it was mentioned in the previous chapter that emotionally disturbed and psychologically maladjusted children tend to be more external (Kendall, Finch, Little, & Ollendick, 1976; McClanahan, 1975). L's beliefs in external control over her life also related in theoretically predicted ways with her feelings of hopelessness as measured by the Hopelessness Scale, and with the fact that she is of lower socio-economic and Native Indian background.

In terms of L's Native Indian background, she once again followed the predicted pattern in terms of self-esteem. Howell (1979) found that Native Indian children scored as having significantly lower self-esteem than children of other ethnic groups.

As far as self-concept and self-esteem are concerned, in a study of self-concept of learning disabled adolescents, Rosenberg and Gaier (1977) found that normally achieving

students scored significantly higher on self-esteem. This too fits for L, as she scored particularly poorly in the school section of the Hare Self-Esteem Scale.

In terms of self-esteem and depression or hopelessness, in a study conducted by Kazdin, French, Unis, & Esveldt-Dawson (1983), Children's Depression Inventory scores correlated positively with hopelessness and negatively with self esteem. The case study of L did not deviate from the above theoretically expected directions.

As well, a moderate correlation of .47 was found between the Children's Depression Inventory and negative life stress events. This too fit for L. Certainly she had experienced many negative life stress events, including sexual abuse, poverty, chronic parental illness, many moves, high turnover of alcoholic or abusive "stepfathers", and difficulties in school.

As noted in the sexual abuse literature review, child sexual abuse frequently exists in generally abusive situations (e.g. co-existing parental pathology; parental alcoholism; neglect; physical abuse). Again, L's case history reveals that she is no exception in this regard (e.g. agoraphobia on her mother's part; alcoholism on her father's part, and reformed alcoholism on her mother's part; the neglect that always accompanies alcoholism; previous physical abuse from her mother and current physical abuse from her father).

The previously noted Harborview Sexual Assault Center research also found that high sexual abuse impact scores were positively associated with poor family functioning. As well, research on the Harborview Impact Checklists found that high impact scores were related to poor self-esteem and acting out behaviour (both correlations were true for L).

As previously noted, the resiliency literature describes those who fare well despite evidence of severe risk factors in their lives as characterized by a positive outlook, a feeling of responsibility/control over what happens, well-developed social skills, good ability to problem solve, and the presence of a significant caring relationship. This profile is in opposition to L. Her score on the Hopelessness Scale was indicative of a negative outlook; her ratings on the Locus of Control Scale and the I-Level indicate that she does not feel in control of what happens in her life; the I-Level assessment also suggests poorly developed social/interpersonal skills and poor problem solving ability.

On the positive side, the mother does currently appear to be "a significant and caring person" in L's life. This positive factor is unfortunately complicated by L's inability to accept her mother's caring without constant doubt and testing (as assessed in the I-Level interview). L's uncertainties about her mother's caring could be related to numerous co-existing factors (e.g. the mother's previous alcoholism and related neglect; previous physical abuse of L during the time that her mother was still a maturing

teenager; the mother's inability to meet L's needs due to her own high level of unmet needs).

Not surprisingly, L fits the literature's profile of a non-resilient child (a non-supportive environment including family dysfunction and disruption; and multiple placements). Case history and the Family Assessment Measure indicate family dysfunction. Although L has not had multiple placements (she has been in care a few times for brief periods), the family has engaged in a multitude of moves and thereby disruptions in services and workers.

Comments on the Process of Assessment

Cognitive Considerations

A problem with many measures (particularly for adolescents who are still developing and maturing at differing rates) is that a specific level of insight is required for each assessment tool. Otherwise the result will not be valid. For example, an individual could answer "like me" to an item such as "I can make up my mind without much trouble" but in fact be completely unable to do so. In the case of L, she had trouble perceiving what was being asked in some of the items on the Rosenberg Self-Esteem Scale, the Nowicki-Strickland Locus of Control Scale, the Beck Hopelessness Scale, and possibly the Family Assessment Measure. Her apparent difficulty with understanding what was being asked by some of the items makes sense in light of her rating on the Interpersonal Maturity Level Assessment. This assessment rated L as still being developmentally at a concrete stage (unable to take the future into account, unable to put herself in someone else's shoes, unable to understand the reasons behind people's behaviors). The I-Level assessment is one measure where no particular cognitive or developmental level is a pre-requisite since this in fact is what is being measured. In other words, in the I-Level interview, "not understanding" is useful information. With most other measures, not understanding the question throws off a valid assessment.

Cultural Considerations

Culturally loaded questions also seem to appear on most assessment measures. Particular ethnic, cultural, religious or socio-economic groups or subgroups could have values and perceptions significantly different from those inherent in statements on, for example, certain self-esteem or family functioning scales. An adolescent whose value it is to be "tough and cool" might not find it "cool" to answer positively to "my teachers are usually happy with the kind of work I do" (a statement on the Hare Self-Esteem Scale). In other words, the above statement may not validly measure self-esteem. As noted previously, many well known family assessment measures are particularly guilty of being culturally loaded toward white, middle-class American values. In instances where certain measures may be found invalid for assessing what they were designed to measure among members of a particular group, that finding is in itself important in describing the attitudes and functioning of the group. The above examples illustrate the need for collecting as much information as is practical and possible about the individual being assessed. Behavioural observations from parents or other significant persons can serve as a good source or check. The Harborview Sexual Abuse Impact Checklists were designed in this way to triangulate data collection from the child, parent, and social worker.

The Importance of Supplemental Measures and Observations

The majority of measures/tests/assessment tools rely largely or entirely on a peron's self-rating or self-appraisal. While many factors such as depression or self-esteem generally remain consistent over often long periods of time, momentary or short-lived changes can and do occur. Sudden, drastic changes in a person's family or school situation may temporarily inflate or deflate factors such as depression or self-esteem. This can be especially true in adolescence which can quite normally be a time of mood swings. For example, a student from an intensely achievement-oriented family who receives a "bad" grade could score significantly more poorly on a self-esteem or depression measure the day after receiving the grade than he or she would have scored the day before.

Answering the Research Questions: Recommendations of Useful Measures

As a quick reminder to the reader, the research questions were as follows:

1. What would constitute a comprehensive assessment protocol for use with sexually abused adolescents? Which instruments would provide the most crucial information? The objective is to more efficiently assess the well being and needs of sexually abused adolescents in treatment programs so that we can better plan for them and their emotional health (provide better differential treatment based on sound assessment).

2. What are the practical and clinical strengths and

weaknesses of the measures used? Where are the unnecessary overlaps between measures?

Having completed only one "trial run" with the assessment protocol under investigation in this thesis, a few preliminary comments can cautiously be made in answer to these questions.

As has been discussed in the chapter on method, a measure of self-esteem appears to be an important part of assessing an individual's general well being. In terms of such a measure, the Hare Self-Esteem Scale appears to be practical and clinically useful. In the case of L, the HSS alerts the clinician that L needs support with home and school issues, and that perhaps her greater strength in the area of peer functioning can be built upon to help her to overcome some of her other low self-esteem issues. The Rosenberg Self-Esteem Scale did not provide as clinically useful information, and its results may not have been as valid in L's case since she found the RSE harder to understand.

Relatedly, often people who express a sense of worthlessness and self-dislike are also depressed (Beck, 1967). As has been addressed more thoroughly in chapter three, a depression questionnaire can be very useful with individuals whose presenting problems are not primarily affective. In the case of L, the Children's Depression Inventory was clearly more clinically useful and cognitively appropriate than the Beck Hopelessness Scale. Unlike the HS,

it was possible to gather themes from L's responses to the CDI (e.g. that she was feeling particularly down about school). Even as an adult reading through both scales, this writer found the CDI items to appear definitely simpler to comprehend. Thus it does not appear that the CDI would be inappropriate for more mature adolescents than L.

Because the various approaches to assessing depression in child and adolescent populations have appeared relatively recently and, therefore, are not yet well developed, no single instrument should be used to identify or diagnose depression, although a clinical interview coupled with an assessment instrument could prove to be very useful.

The Nowicki and Strickland Locus of Control Scale did not seem to provide new and useful information. Locus of control tends to reveal itself in the I-level interview, as could be seen in the I-level results discussed in chapter four. The N-SLCS seemed to be cognitively frustrating and too lengthy for L. As well, it did not reveal any other new themes or information. It seems a locus of control measure is not needed alongside an I-level assessment.

There exist few known adolescent measures of moral and cognitive development. In spite of how time consuming an I-level interview is to conduct, rate, and second rate, this measure has been included in this assessment protocol for a number of reasons. Many of these have been referred to throughout this paper. As well, I-level is one of the few

measures which assesses not only problems, but strengths as well. Also, I-level theory is very respectful of whatever coping mechanisms/skills an adolescent may have developed to get through often difficult life situations.

The interview guide format allows the interviewee more control than any of the other measures included in terms of spending more time covering areas of particular concern to him or her, or raising related issues of his or her own. It has been the clinical experience of this writer that no other assessment tool is as conducive to allowing the adolescent to tell his or her story and highlighting themes. As well, no other measure included in this package is as practical when it comes to not only assessing the adolescent, but also providing theoretical recommendations for treatment based on the assessment. The treatment recommendations in the case of L are outlined later on in this chapter.

Not only does the I-level interview provide treatment recommendations, but it also overlaps with virtually all the other areas being assessed in this research project. For example, often the I-level interview will provide themes or information pertaining to self-esteem, self-concept, locus of control, affect/depression/outlook, the adolescent's perception of family functioning, the adolescent's perception of school functioning, peer relations, cognitive ability, and history of moves or placements (see Appendix G for I-level interview guide). For this reason the I-level interview can act as a clinical check for the validity of other assessment scores or outcomes within this assessment package.

In terms of a measure of the impact of sexual abuse, it is clear that not only does the actual sexual abuse differ, but not all children will react to the experience of being sexually abused in the same way. Consequently it appears to be important for treatment purposes to assess the different reactions victims have to the experience of sexual victimization. However, behavioural reactions to sexual abuse as measured by the checklists are only a part of the potential impact of childhood sexual experiences. Future research and practice should discover ways to understand and measure other psychological processes (such as beliefs) which are influenced by childhood sexual experiences. Nevertheless, the checklists provide clinicians with a good starting point for discussion and relationship building. Ideally the parent and child completed checklists should alway be administered by a skilled clinician who has set aside the time to help the clients process the potentially emotion laden content of these checklists.

As noted, although these checklists are still undergoing research and revisions, the Harborview parent, social worker, and child completed impact checklists seem to be the most well known and researched tools available for the above mentioned purpose. The information these checklists provided was unique in this assessment package, as it generally did not overlap with information obtained from other measures, other than in terms of correlations. A point to keep in mind in regard to the Harborview impact checklists is that they cannot distinguish between the impact of sexual abuse, or the

impact of other trauma, or still other or multiple factors.

Hopefully the current research and revisions will, among other things, result in a briefer version of the checklists. In the case of L, she became frustrated by the length and repetitiveness of the questionnaire.

In terms of family measures within an assessment package, a critique of existent family measures in general has already been addressed. Adding to that, according to the research of Kazak, Himmelberg, McCannell and Grace (1988),

> the appeal of self-report paper and pencil measures of family processes is strong, but very imperfect. It would be ideal if we were confident that they are really able to measure a family's emotional closeness, or their collective feelings about independence. We urge, however, that family researchers keep clear in their minds that, at best, these instruments assess individuals' perceptions of the family system of which they are a part. Furthermore, as our research indicates, the norms by which scores on these measures are evaluated may be incongruous for persons in different life stages, family circumstances or from different backgrounds. Self report measures can promote a sense of detachment of the researcher from the people being studied, in that something is given to the "subject" and interaction between researchers and subjects is minimized. The loss of this interaction, and the failure to acknowledge research as an interactive process, is problematic for the field of family psychology. Boss (1987) clarifies the often hidden interactions that are common to both good research and therapy. With respect to family normality, it is important that we ask the people we study about their notions of normality, and that we accept our biases as an integral part of the data that we collect, be it in a research setting or a therapy session. (pp. 284-285)

Keeping all this in mind and given the available choices, the FAM seems to be useful for research purposes. It is one of the known standard family measures, and it is easy to compare individual's perceptions of their family on the graph. The FILE and A-FILE could also be useful, especially as starting points for discussion or intervention, as was illustrated using the example of L in the previous chapter. One can however wonder how certain items were chosen for inclusion on either the FILE or the A-FILE, but not both. For example, "physical or sexual abuse or violence in the home" is an item on the FILE, yet the A-FILE does not allow adolescents as clear an opportunity to report such problems. Also, although no one instrument can cover all possibilities, a common loss such as miscarriage was not mentioned as a strain on either inventory.

In terms of clinically useful tools for assessing families, the Family Problems Checklist provided a very useful supplement to this assessment package. As a clinician, it was this checklist, rather than the FAM or the FILE or A-FILE which would have given this writer the best indication of where intervention most needed to happen with the family described in this case study.

In terms of an <u>assessment of school issues</u>, some of this information was obtained from the I-level, the Hare Self-Esteem Scale, and the Children's Depression Inventory. Still, the school essay format used within this assessment protocol provided some other useful insights into L's

perceptions, which in turn begins to clarify where intervention needs to start. The essay format had the additional benefit of highlighting just how poor L's spelling and punctuation skills are, and how difficult it must be for her to have such poor writing skills at her age.

A teacher rating would have been useful if L had been in a school program within the last while.

In summary, having run once through the measures included in this thesis, I would now recommend the following measures as being most useful for the purpose of a thorough assessment of sexually abused adolescents in treatment programs:

- I-Level Assessment
- Family Problems Checklist
- Harborview Sexual Abuse Impact Checklists
- Hare Self-Esteem Scale
- Kovacs Children's Depression Inventory
- a school assessment
- Eco-Map

The assessment protocol and model, as presented, is seen to include major relevant factors affecting adolescents' psychosocial functioning. This assessment model is in no way intended to supercede good clinical interviews. If one wants to know what is really going on for a client (adolescent or otherwise) there is no substitute for taking the time to really listen.

In terms of how all this relates to treatment, perhaps this can best be demonstrated through the case of L.

For example, In L's case, treatment recommendations based on I-level theory would include the establishing of a clear, safe, and caring environment. This would include developing a special caring relationship between L and her key worker. The key worker needs to be warned that L has learned to survive by testing relationships to check out whether she will be abandoned once again. The worker also needs to be warned that for the first while this would be a non-reciprocal "give, give, give" relationship on the part of the worker. L is virtually a "bottomless pit" in need of daily positive strokes (hugs, praises, encouragement). Any consequences need to be of a short duration and with the continual message of concern and encouragement. Those working to help L need to keep in mind that L protects herself by looking for proof that she is not cared for.

Actions will speak louder than words for L. Taking her out for an ice-cream will mean much more to her than insight oriented counselling, which at this point would be over her head.

Abusive or thoughtless behaviour would be an expression of L's trying to cope with feeling insecure and threatened. These feelings need to be addressed in an upfront manner.

Role playing, as well as labelling one's own feelings, and helping L to identify and label hers, are good techniques to help L learn about feelings and other points of view. Crises may be avoided by anticipating the anxiety, labelling

it, and rehearsing how the upcoming situation could be handled.

The obvious benefit of the I-level assessment and the resulting treatment recommendations is that sharing this model with those who are working with L, helps to make the whole process less frustrating and more understandable to both L and the caregivers (in this case the child care counsellors at Chimo House).

In terms of how the family assessment measures and the eco-map relate to treatment, these need to be discussed together. Based on these assessment tools it was recommended that the mother seek a good therapist to help her with her multitude of life struggles which are related to her past abuse. Rather than running here and there for bandaids and bits and pieces of couselling, it would be preferable for the mother to seek counselling from one long term source in order to deal with her larger abuse issues. This in turn would assist the mother in dealing better with L when she returns home, and would help the mother not to allow L to "push emotional triggers". Although there is lots to work on in this family, there are also lots of strengths. There is much love and caring between the mother and her children. When they are not feeling put down or threatened, both L and her mother have open and pleasant personalities. The mother seems open to non-threatening help and is willing to look at her part in problem situations.

As long as L's father is in the picture, there are no doubt times when he could be encouraged to become involved in the counselling, although there are also issues which the mother will want to work on individually.

As well as encouraging the mother to work on the larger issues, the key worker at Chimo House took on the role of meeting regularly with L and her parents to help them work on communication skills and being clear in their relationships with each other.

Another valuable piece of information to those working with this family is that the eco-map showed friends to be a source of strength for the family. This resource can certainly be encouraged and drawn on in times of need.

The Harborview Sexual Abuse Impact Checklists related to treatment in that they highlighted for the clinician L's tendency to act in self-destructive ways (e.g. to cope with life stress by running away or to make suicidal gestures). Being aware of this allows for an upfront discussion about choices, consequences, and to make a safe and simple plan for how to handle feelings such as anger, frustration, fear, or sadness. The impact checklists are therefore good in alerting the clinician to "red flag" issues which require immediate attention and safe back-up plans within the eco-system.

If the Hare Self-Esteem Scale had highlighted only L's need for improved self-esteem, this may have been somewhat redundant, as this also showed itself in the I-level and the school essay. However, the value of the HSS was that it highlighted that L's self-esteem in relation to peers was actually quite good. This is valuable information to those working with L, since this strength can be built on to assist L with her more general feelings of low self-esteem. There are many ways to build self-esteem, some of which have been previously mentioned in the I-level and family treatment sections. However, this is a topic on its own and will not be explored further in this thesis.

The Children's Depression Inventory is significant to treatment as it again highlighted and verified the important themes of suicial thoughts and poor school self-esteem. The importance of finding out about suicidal thinking is obvious and has already been discussed. The importance of learning about poor school self-esteem will be discussed in the following section.

In L's case, the school essay was an important piece of assessment. It not only highlighted how difficult it is for L to write well, but it also highlighted that L feels stupid, lost with the school work, out of place, more street wise than the other students, embarrassed of family secrets, and picked on. Thus L protected herself from having to cope with all of these stressors by sabbotaging school placements and

refusing to attend school. It is obvious that L needs a very special and encouraging school placement where she can begin to have little successes and where she will feel that she fits in. A comprehensive treatment plan for L also needs to include teaching L social skills including relationship skills and problem solving skills so that she does not end up so easily "flying off the handle" with teachers and fellow students. It is possible that L may not be able to attend school successfully until some of her self-esteem and social skill needs begin to improve.

The treatment recommendations discussed on the previous pages were shared with the Chimo House staff and with L's mother (including giving her a list of names of good psychiatrists for herself since she has no way of paying for private counselling). The results of the assessment were also shared with L in a simple way, keeping in mind her concrete thinking. She seemed pleased that her behaviour appeared to make sense, and that nobody thought she was "bad" or crazy.

Questions Remaining for Future Research

1. Would this assessment package fit for sexually abused or otherwise traumatized boys of similar age? There is an emerging body of literature pertaining to sexually abused boys (Lew, 1988; Sonken, 1988), and the ways in which gender influences the assessment process need to be explored.

2. Would a projective picture test be a helpful addition to this package in order to side step defenses to a greater degree?

In conclusion, the development of any assessment model is approached with the awareness that the conceptual description of the model is only the first step. The model must then continue to evolve through attempts to use it in practice. It is the author's conviction that only through attempting to practice within a developmental and ecological framework will helping professionals begin to generate the additional data necessary to meet the complex demands of effective and responsible social work practice with adolescents and their environments.

To restate the above from a slightly different perspective, "the model suggests that intervention (with sexually abused adolescents) will often require co-ordinated remediation in various life sectors, not just in ones narrowly related to sexual abuse. This places a renewed emphasis on co-ordinated case management and the fostering of a true response network" (Wachtel, 1988).

"And, finally, the ecological focus on (developmental) universal life processes reminds social workers that supporting people's strengths and reducing environmental barriers to growth and adaptation are their foremost concerns" (Germain, 1981).

In terms of some further conclusions for social workers in particular, as mentioned in the introduction, in order for social workers to effectively counsel or plan for sexually abused or other troubled adolescents and their families, we need to better understand sexual abuse or other trauma as one of several possible pre- and/or co-existing sources of individual stress. We need to be able to better assess possible sources of stress and resiliency. At times it may even be appropriate for social workers to look at themselves as a positive or negative stressor in their clients' lives. For example, Wachtel (1988) notes that the literature indicates that disclosure is a significant and separate factor in affecting an individual's ability to cope with sexual abuse. Often this important disclosure experience occurs in the presence of a social worker.

This thesis took a normal developmental framework into account. As social workers, this framework allows us to be optimistic that over time change can occur in perception or subjective experience, as both cognitive and emotional growth occur. A normal developmental framework also tacitly gives social workers a responsibility to prepare clients for the recurring impact of a particular stress, such as sexual abuse, as an individual is faced with changing life tasks which might trigger stress once again.

REFERENCES

Adams-Tucker, C. (1982). Proximate effects of sexual abuse in childhood: a report on 28 children. American Journal of Psychiatry, 139, (10), 1252 - 1256.

Alter-Reid, K., (1986). Sexual abuse of children: a review of the empirical findings. Clinical Psychology Review, 6, 249 - 266.

American Psychiatric Association. (1980). Diagnostic and Statistical Manual of Mental Disorders. (3rd ed.). Washington, DC: Author.

Anastasi, A. (1968). Psychological Testing, 3rd ed. New York: Macmillan Co.

Augoustinos, W. (1987). Developmental effects of child abuse. Child Abuse and Neglect, 11, 15 - 27.

Badgley, R.F., (1984). Sexual Offences Against Children: the Report of the Committee on Sexual Offences Against Children and Youth. Ottawa: Dept. of Justice & Dept. of Health and Welfare.

Bagley, C. (1984). Mental health and the in-family sexual abuse of children and adolescents. Canada's Mental Health, (2), 17 - 23.

Bagley, C. (1985). Child sexual abuse: a child welfare perspective. In B. Wharf & K. Levitt, Child Welfare in Canada. Vancouver: U.B.C. Press.

Beck, A., (1974). The measurement of pessimism: the hopelessness scale. Journal of Clinical Psychology, vol. 42, 861 - 865.

Bodin, A.M. (1968). Conjoint Family Assessment. In P. McReynolds (Ed.), Advances in Psychological Assessment, Palo Alto, Cal: Science and Behaviour Books.

Bronfenbrenner, U. (1979). The Ecology of Human Development. Cambridge, MA: Harvard University Press, 1979.

Carlson, G., & Cantwell, D. (1979). A survey of depressive symptoms in a child and adolescent psychiatric population: interview data. Journal of the American Academy of Child Psychiatry, 18, 587 - 599.

Chandler, L. (1985). Assessing Stress in Children. New York: Praeger.

Conte, J., & Berliner, L. (1988). The impact of sexual abuse on children: empirical findings, in L. Walker (ed.). Handbook of Sexual Abuse of Children. New York: Springer Publishing Co.

Conte, J., Berliner, L., & Schuerman, J. (1986). Impact of Sexual Abuse on Children. Final Report. Available from the authors at the University of Chicago, School of Social Service Administration, 969 East 60th St., Chicago, Ill.

Corcoran, K., & Fisher, J. (1987). Measures for Clinical Practice: A Sourcebook. New York: Free Press.

Costello, E., & Angold, A. (1988). Scales to Assess Child and Adolescent Depression: Checklists, Screens, and Nets. A paper available through the American Academy of Child and Adolescent Psychiatry, requests to Duke University Medical Center, Durham, NC.

Ebata, A. (1986). Social competence in adolescence. In J. Garbariono, Troubled Youth, Troubled Families. New York: Aldine. 161 - 170.

Epstein, N., Baldwin, L., & Bishop, D. (1983). The McMaster Family Assessment Device, Journal of Marital and Family Therapy, 9, 171 - 180.

Figley, C., & McCubbin, H., eds. (1983). Stress and the Family, Volume 2: Coping with Catastrophe. New York: Brunner/Mazel.

Fisher, L. (1982). Transactionl theories but individual assessment: A frequent discrepancy in family research, Family Process, 21, 313 - 320.

Finkelhor, D. (1984). Child Sexual Abuse: New Theory & Research. New York: Macmillan.

Finkelhor, D. (1986). A Sourcebook on Child Sexual Abuse. Beverly Hills: Sage.

Freud, S. (1986). The Complete Introductory Lectures of Psychoanalysis. New York: Norton.

Friedrich, W.N. (1987). Children from sexually abusive families: a behavioural comparison. Journal of Interpersonal Violence, 2, (4), 391 - 402.

Garbarino, J., & Gillian, G. (1980). Understanding Abusive Families. Toronto: Lexington.

Garbarino, J. (1986). Troubled Youth, Troubled Families. Toronto: Aldon.

Germain, C. (1981). The ecological approach to people-environment transactions. Social Casework, 6, 323 - 331.

Gold, E.R. (1986). Long-term effects of sexual victimization in childhood: an attributional approach. Dissertation Abstracts International, 46, (11), 4013.

Gomes-Schwartz, B. (1985). Severity of emotional distress among sexually abused preschool, school-aged, and adolescent children. Hospital and Community Psychiatry, 36, (5), 503 - 508.

Grinell, R. (1981). Social Work Research and Evaluation. Itasca, Illinois: F.E. Peacock Publishers, Inc.

Hare, B. (1985). The HARE general and area-specific (school, peer, and home) self-esteem scale. Unpublished manuscript. Dept. of Sociology, SUNY Stony Brook, Stony Brook, New York.

Harris, P. (1986). I-level and problems of reliability and validity. Differential View, 15, 1 - 6.

Harris, P. (1988). The interpersonal maturity level classification system: I-level. Criminal Justice and Behaviour, 16, (1), 58 - 77.

Hartman, A., & Laird, J. (1983). The family in space, In A. Hartman & J. Laird, Family Centered Social Work Practice. New York: The Free Press.

Hersen, M., & Barlow, D. (1976). Single Case Experimental Designs: Strategies for Studying Behavior Change. New York: Pergamon.

Hilliard, E. (1973). An Overview of the Interpersonal Maturity Level Classification System. Unpublished paper available through the International Differential Treatment Association, Montreal, Quebec.

Hobbs, N. (1975). The Futures of Children. San Francisco: Jossey-Bass.

Hodges, K., & Siegel, L. (1985). Depression in children and adolescents. In E.E. Beckham & W. Leber (eds.), Depression: Treatment, Assessment and Research. Homewood, Ill: Dow - Jones - Irwin.

Holmes, T., & Masuda, W., (1974). Life change and illness susceptibility. In Dohrenwend, B., & Dohrenwend, B. (Eds.), Stressful Life Events. New York: John Wiley & Sons.

Holmes, T., & Rahe, E. (1967). The social readjustment rating scale. Journal of Psychosomatic Research, 11, 213 - 218.

Jesness, C., & Wedge, R. (1983). Classifying Offenders: The Jesness Inventory Classification System. Sacramento: California Youth Authority.

Kazak, A., Himmelberg, P., McCannell, K., Grace, J. (1988). Perceptions of normality in families: four samples. Journal of Family Psychology, 277 - 293.

Kazdin, A. (1977). Assessing the Clinical or Applied Significances of Behaviour Change Through Social Validation. Behaviour Modification, 1, 427 - 452.

Kazdin, A., French, N., Unis, A. (1983). Child, mother, and father evaluations of depression in psychiatric inpatient children. Journal of Abnormal Child Psychology, 11, 167 - 180.

Kovacs, M. (1983). The Children's Depression Inventory. Unpublished Manuscript. University of Pittsburgh.

Kovacs, M., & Beck, A. (1977). An empirical-clinical approach toward a definition of childhood depression. In J. Schulterbrandt & A. Raskin (Eds.), Depression in Childhood: Diagnosis, Treatment, and Conceptual Models. New York: Raven Press.

Kratochwill, T., Mott, S., & Dodson, C. (1983). Case study and single-case research in clinical and applied psychology, In A. Hartman & J. Laird, Family Centered Social Work Practice. New York: The Free Press.

Lew, M. (1988). Victims No Longer: Men Recovering From Incest and Other Childhood Abuse. New York: Nevraumont.

Marymound Group. (1987). The Marymound Model: A Sequential Approach to the Treatment of Male Adolescent Sexual Offenders and Sexual Abuse Victims. A proposal submitted to Health and Welfare Canada, unpublished.

McCubbin, H., & Figley, C. (1983). Stress and the Family, Volume 1: coping with normative transitions. New York: Brunner/Mazel.

McCubbin, H., Patterson, J., & Wilson, L. (1980). Family Inventory of Life Events and Changes (FILE). St. Paul: Family Social Science.

McCubbin, H., & Patterson, J. (1982). The Family Stress Process: The Double ABCX Model of Adjustment and Adaptation. In McCubbin, H., Sussman, W., & Patterson, J. (Eds.), Advances and Developments in Family Stress Theory and Research. New York: Haworth Press.

Moore Newberger, C., & De Vos, E. (1988). Abuse and victimization: A life-span developmental perspective. American Journal of Orthopsychiatry. 58, (4), 505 - 511.

Moos, R., & Moos, B. (1976). A typology of family social environments. Family Process, 15, 357 - 371.

Mrazek, P.B., & Kempe, E. (1981). Sexually Abused Children and Their Families. Oxford: Pergamon.

Mullins, L., Siegel, L., & Hodges, K. (1985). Cognitive problem-solving and life event correlates of depressive symptoms in children. Journal of Abnormal Child Psychology, 13, 305 - 314.

Nowicki, S., & Strickland, B. (1973). A locus of control scale for children. Journal of Consulting and Clinical Psychology, 40, 148 - 154.

Nunnally, J. (1967). Psychometric Theory. New York: McGraw-Hill.

Oliver, J.E. (1985). Successive generations of child maltreatment: social and medical disorders of the parents. British Journal of Psychiatry, 147, 484 - 490.

Olson, D. (1976). Bridging research, theory and application: the triple threat in science, In D. Olson, Treating Relationships. Iowa, Graphic Publishing Company.

Palmer, T., & Werner, E. (1972). A Review of I-level Reliability and Accuracy in the Community Treatment Project. Sacramento: California Youth Authority.

Pelletier, G., & Handy, C. (1986). Family dysfunction and the psychological impact of child sexual abuse. Canadian Journal of Psychiatry, 31, (5), 407 - 412.

Peters, J.J. (1976). Children who are victims of sexual assault and the psychology of offenders. American Journal of Psychotherapy, 30, (3), 395 - 421.

Rabin, C. (1981). The single-case design in family therapy evaluation research, Family Process, 20, 351 - 366.

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

Rosenberg, M. (1979). Conceiving the Self. New York: Basic Books.

Rush, F. (1980). The Best Kept Secret: Sexual Abuse of Children. New York: McGraw-Hill.

Rutter, M. (1981). Stress, coping and development: some issues and some questions. Journal of Child Psychology and Psychiatry, 22, (4), 323 - 356.

Rutter, M. (1985). Resilience in the face of adversity: protective factors and resistance to psychiatric disorder. British Journal of Psychiatry, 147, 598 - 611.

Sellitz, C., Wrightsman, L., & Cook, S. (1976). Research Methods in Social Relations. 3rd Ed. New York: Holt, Rinehart & Winston.

Sgroi, S.M. (1982). Handbook of Clinical Intervention in Child Sexual Abuse. Lexington, Mass.: D.C. Health, 1982.

Shinner, H., & Steinhauer, P.D. (1983). The Family Assessment Measure, Canadian Journal of Community Mental Health, 2, (2), 91 - 105.

Sexually Exploited Children: service and research project final report. U.S. Dept. of Justice.

Sonken, D. (1988). Men Healing From Childhood Abuse. New York: Harper.

Trute, B. (1986). Evaluating clinical service in family practice settings: basic issues and beginning steps, Canadian Social Work Review.

Vondra, J. (1986). Socioeconomic stress and family functioning in adolescence. In J. Garbarino, Troubled Youth, Troubled Families. 191 - 195. New York: Aldine.

Wachtel, A. (1988). The Impact of Child Sexual Abuse in Developmental Perspective: a model and literature review. A report for Nisha Children's Society, 2478 West 21 Ave., Vancouver, B.C. Funded by Health & Welfare, Canada, project # 4569-1-238.

Wallston, K., Wallston, B., & DeVellu, R. (1978). Development of the multidimensional health locus of control scales, Health Education Monography, 6, 160 - 170.

Warren, M., & the Community Treatment Project Staff. (1966). Interpersonal Maturity Level Classification: Juvenile Diagnosis and Treatment of Low, Middle and High Maturity Delinquents. Sacramento: California Youth Authority.

Woititz, J. (1985). Struggle for Intimacy. Pompano Beach, Florida: Health Communications.

Wolf, M. (1978). Social validity: the case for subjective measurement, or how applied behavior analysis is finding its heart. Journal of Applied Behaviour Analysis, 11, 203 - 214.

APPENDIX A: THE SPONSORING AGENCY

Nisha Children's Society

Nisha Children's Society

Nisha Children's Society is a non-profit society dedicated to the provision of high quality professional treatment and counselling services for adolescents and families. Nisha Society formed in 1984 at the time of privatization of child care services in British Columbia.

Chimo House, Park House and Eagle High

Nisha operates three treatment programs for adolescents: two residential child care programs (Park House and Chimo House), and a day treatment/special education program (Eagle High). These programs provide service to approximately 60 teens per year. The population is approximately half male and half female, with an average age of 15.5 years.

Looking at the population from 1984 to 1986 it was found that 75.9% were known or suspected to have been sexually abused (31.7% known, 44.2% suspected). Of these cases, 59.5% were girls, 39.6% were boys. 40.5% of the population were suspected of sexual offending, and 2.5% were known to have sexually offended. Violent behaviour was documented for 59.5% of the population. Of the sexually abused adolescents, 91.1% were seen as depressed, 77.2% were known to have been physically abused, and 58.2% were substance abusers. The above figures were compiled from reports from MSSH social workers and from Nisha child care counsellors.

Adolescents referred to the treatment programs are experiencing severe emotional and behavioural problems in their family, community, and school functioning. The objective of the

treatment programs is to help adolescents function more appropriately in the community, to gain emotional strength, and develop values, behavioural controls and social skills which will enable them to move on to more normalized resources.

Theoretically, the Nisha treatment approach is based on seeing the disturbed child primarily as having the same normal growth and developmental needs as all other children. However, Nisha Society believes often the conditions that created the emotional disturbance have prevented the child from achieving the stage of development that is chronologically anticipated, or that these conditions have distorted the child's perception of reality.

It is the belief of Nisha Society that children have the right to maximize their potential. The emotionally disturbed child is not caught in an inescapable trap, but rather she or he can break through the limitations of the disturbance and proceed with normal development. This is worked towards through the provision of assessment, a safe and nurturing environment, skilled child care counselling based on individualized treatment plans, and outside counselling as appropriate.

Nisha Children's Society operates three other programs as well as those mentioned already. These are the Family Counselling Program, the Support Program for Teen Parents, and the Independent Living Program.

<u>The Family Counselling Program</u> provides counselling for teens and parents in conflict. The objective is to prevent teens coming into care unless child protection concerns arise.

The Independent Living Program provides life skills development for 16 to 18 year olds who are in the care of MSSH. The program assists adolescents in learning the practical tasks of independent living (accommodation search, homemaking, self-care, budgeting, job search, etc.). Counselling is provided to support functioning in responsible and self-actualizing ways.

The Support Program for Teen Parents teaches life skills (see above) and parenting skills and provides counselling for pregnant teens and teen parents.

APPENDIX B

The Rosenberg Self-Esteem Scale

Reference:

Rosenberg, M. (1979)

Conceiving the Self.

New York: Basic Books

APPENDIX C

The Hare Self-Esteem Scale

Reference:

Hare, B. (1985)

The HARE general and area-specific (school, peer, and home) self-esteem scale.

Unpublished manuscript, Dept. of Sociology

SUNY Stony Brook, Stony Brook, New York.

APPENDIX D

The Hopelessness Scale

Reference:

Beck, A., Weissman, A., Lester, D. & Trexler, L. (1974) The Measurement of Pessimism: The Hopelessness Scale. Journal of Consulting and Clinical Psychology. Vol. 42, 861-865.

APPENDIX E

The Children's Depression Inventory

Reference:

Kovacs, M. (1983) .

The Children's Depression Inventory. Unpublished Manuscript, University of Pittsburgh.

APPENDIX F

The Children's Nowicki-Strickland Locus of Control Scale

Reference:

Nowicki, S. & Strickland, B. (1973)

A Locus of Control Scale for Children.

Journal of Consulting and Clinical Psychology, 40, 145-154.

APPENDIX G

I-Level Interview Guide

Reference:

Ingrid Kastens for Nisha Children's Society. (1989)

Based on the work of Stuart Alcock and Marguerite Warren.

I-Level Interview Guide
For the Assessment of Teens in Nisha Treatment Programs

Please note that this is a guide. All the questions need not be asked every interview. It is important to delete and add as appropriate, and to follow the adolescent's lead, just persuing for more complexity or insight about any given topic. When things get too emotional to press on, it may be appropriate to go to a safer topic for a while.

Introduction

- I would like your ideas and opinions
- The way you see things
- It's OK if you choose not to answer some questions
- It's OK if you wish not to use names

Interests

- What are your interests or hobbies
- How did you get interested in that
- How is it you dropped your involvement in...
- What sorts of things do you do in your free time

The Present

- Where are you living now
- Can you tell me a bit about this place
- How is it someone ends up living there
- What is this place for
- How is it you came to live there
- Why there as opposed to...
- What would you change if you were in charge
- Why do you suppose they have the rules that they have
- What are the things that you like

People

- What are the staff like
- Do you have favorites
- What is it you like about them
- What is their personality like
- How do you suppose they came to be like this
- If you were hiring the staff, what sorts of qualities would you look for
- What sorts of staff people do you avoid? Why?

History and Moves

- Have you moved very much since you were born
- Could you briefly tell me about where you've lived and who you've lived with since you were born
- What's your recollection of why the moves happened
- What was you favorite place
- What did you like about it
- What happened that you had to move
- What was your least favorite place
- What didn't you like about it
- Have you ever run away
- What brought that on
- What things are really important to you wherever you live
- Where do you ideally hope to live in the future
- What things can you do to bring this about

Friends and Others

- What sorts of teenagers do you like to hang out with
- What sorts of teenagers do you avoid? Why?
- Do you have a large or small group of friends
- How do you get along with the kids where you live
- Do you have favorites
- What do you like about them
- How do you suppose they got to be that way
- Do you have a best friend
- What is it you like about this person
- Have you ever had an idol? Who? Why?

Boyfriend/Girlfriend

- Do you have a boyfriend/girlfriend
- What is it that attracted you to this person
- Who in your life (if anyone) has spoken with you about sex and contraceptives
- Where would you go for contraceptives

School/Work

- Can you tell me a bit about your school/work
- What are the teachers/employer like
- How do you suppose they got to be that way
- What does it take to be a good teacher/boss
- Who was your favorite teacher ever
- What did you like about her/him
- Who was your least favorite teacher ever
- What didn't you like about her/him
- How do you do at school
- Why do you suppose that is
- What is your favorite/least favorite subject
- Have you gone to a lot of schools
- Why do you suppose that is
- How is your attendance
- Why do you suppose that is

Legal Trouble (as applicable)

- Have you ever had run ins with the police
- Have you ever been charged
- What were the charges
- What happened in court
- How did all this begin in your life
- Were other people involved
- How do you feel about it now
- How do your parent(s) feel about it
- What do you plan to do in this regard in the future

Family

- Who is in your family
- Describe the person you consider to be your father/mother
- What is his/her personality like
- What is the nicest thing about him/her
- What do you wish you could change about him/her
- Any ideas about how he/she got to be like that
- How do your parents get along
- What kinds of things do they disagree about
- What does your Mom/Dad do when she/he is mad
- What does your family like to do together
- Is there anyone else really important to you
- What do you like about him/her...
- Who is your favorite relative
- What do you like about him/her...
- Do you have a favorite brother or sister...
- So all in all, who has really been there for you in life
- Who would you go to in an emergency
- What is the birth order of the kids in your family
- Which child do you think your parent(s) favor
- Any ideas about why
- What sort of contact do you have with your parent(s)
- How did this arrangement come about
- Are you happy with this

Self

- You've talked a lot about other people, how would you describe yourself
- What are your strong points
- What are the things about yourself you don't like
- How would your father/mother describe you
- What would your father/mother say they really like about you
- What bothers your father/mother about you
- How would your friends describe you
- Who do you take after in your family
- In what ways
- Have you or your parent(s) ever had any counselling before
- How did it go

Future

- What are your plans for the next six months
- What could you see yourself doing 10 years from now
- What kind of work do you hope to get into
- How did you get interested in this
- How can you make this possible
- Do you think you'll get married
- What sort of a person would you choose as a partner
- What do you think is most important in making a marriage work
- Would you have kids
- What would you do the same as/differently from you parent(s)
- What would you do if your kid got into trouble

Drugs/Alcohol

- What about drugs or alcohol in your life
- How much? How often
- How old were you when you first got involved
- Do you remember what else was happening in your life at the time

Abuse/Violence (as applicable)

- Do people get hit in your family
- Who hits who
- Does anyone get hurt
- Why do you suppose they do this
- Do you know what abuse is
- What about sexual abuse, has that ever happened to anyone in your family/you
- Who was told about it
- What happened...

Memories & Thoughts

- What do you remember about your early years
- What is your earliest memory
- What is the best/worst thing that ever happened to you
- What event(s) (happy or sad) do you remember as having the biggest impact on your life
- Over the years, what have you learned about other people
- Over the years, what have you learned about how to survive in life
- If you could have 3 magic wishes, what would you wish for

Concluding Interaction

- Thank you. Any questions?
- Is there anything else I should have asked about to get a better picture of how you see things

Interviewer's Impressions

Take note of postural cues, tics, restlessness. Did it feel as though the interviewer were pulling teeth? Was the interview difficult or relaxed for the adolescent? Immediate impression of I-level? Why?...

APPENDIX H

Harborview Sexual Abuse Impact Checklists

Reference:

Conte, J., Berliner, L. & Schuerman J. (1986)

Impact of Sexual Abuse on Children, Final Report

Available from the authors at The University of Chicago, School of Social Service Administration.

APPENDIX I

The Family Assessment Measure

Reference:

Skinner, H. & Steinhauer, P. (1983)

The Family Assessment Measure, Canadian Journal of Community Mental Health, 2 (2), 91-105.

APPENDIX J

Family Inventory of Life Events and Changes

Reference:

McCubbin, H., Patterson, J. & Wilson, L. (1980)

Family Inventory of Life Events and Changes (FILE)

St. Paul: Family Social Science.

APPENDIX K

Adolescent-Family Inventory of Life Events and Changes

Reference:

McCubbin, H., Patterson, J., Bauman, E. & Harris, L. (1981) Adolescent-Family Inventory of Life Events and Changes (A-FILE) St. Paul: Family Social Science.

APPENDIX L

The Family Problems Checklist

Available from:

The Morrison Center for Youth and Family Service

3355 S.E. Powell Blvd., Portland, Oregon, 97202.

APPENDIX M

Eco-Map

Reference:

Hartman, A. & Laird, J. (1983)

The Family in Space: Ecologocal Assessment. In Family Centered Social Work Practice. New York: The Free Press.

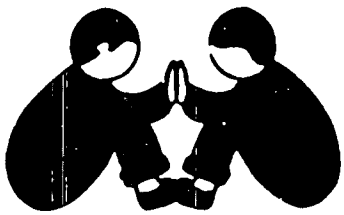
APPENDIX N

L's I-Level Assessment:

Partial Transcript

I 3 cfm Characteristics

Treatment Recommendations



NISHA CHILDREN'S SOCIETY
2478 West 21st Avenue, Vancouver, B.C. V6L 1K1
(604) 733-3603

I Level Interview (partial transcript)

L age 14

Date of Interview: Mar. 6, 1989.

Preamble: L was quite impatient in the interview. I believe that she found some of the questions to be frustrating since the interview revealed that she does not have the insight to really have understood the complexity of some of the questions asked. Due to L 's impatience I decided to make it easier for L by skipping over some questions and rushing through others.

Interview Content:

What are your interests these days? What sorts of things do you like to do?
I like to drink, I like to party, I like to have fun, and I hate school...well I like it a little bit...There's people there that I can meet...It's not like I'm stuck to the same friends I had. I can meet new ones...

Is Eagle High different from other schools that you've been to, or not really?
It's different. It doesn't have as many kids, and you know exactly what two rooms you go to...different group of kids, some are wacko, some are really bizarre...

Which ones are your favorites?
I don't know, I've only been there twice.

Do you like any of the adults yet, or is it too soon?
Too soon...I like Marianne. She was nice.

What was the nice part about her?
I don't know she seemed really nice.

I know school has been a real struggle for you. What are the parts that have been the struggle in the past?
Getting up in the morning, getting dressed, getting ready to go to school. If it's sunny outside I want to go and have fun. If it's raining outside I want to stay inside in my bed...Like if school started around noon I could probably make it...

How about school work? What do you think of that?
...After about 2 hours of it I get so bored of it (starts to yawn)...my brain's on overload...Like when I had to do all

those tests...I walked into the office with those tests and said I can't do no more because I could add 7+4 but it's just like looking at it and going what's that...That's just an example.

What's your favorite school you've ever gone to?
Eagle High...I always hated school. They always made me uncomfortable. They never do nothing. There's nothing to look forward to. I hate big schools with 40 kids to a class. You're lucky to ask one question before the end of the period...(At Eagle High) they explain it to you. They don't just tell you the answer and you don't got to wait 10 million hours...and there's food that's hot...

Have you ever had a favorite teacher?
My grade 5 teacher...

What was special about her?
She was really really nice. She spent time with everybody. She took us out for lunch one at a time if we were really good during the week...I think it was my grade 5 teacher. I don't know. I have a picture of her.

What do you think it takes to be a nice teacher?
If there's something not done and you have a reasonable excuse, not to make them stay after school, but to make sure they do it that night.

If you were hiring teachers what qualities would you look for?
As long as they're nice and as long as they're not old biddies...old, old teachers that are really really strick...

Do you have any ideas what makes some people like that (strict)?
That's the way they were raised.

From the way that you're being raised, what are you going to learn?
I'm raising myself. I feel like my Mom is tossing me around like if I was in a tossed salad. I don't feel like she wants me. Like when I go there she totally ignores me, when I phone there she totally ignores me. It's like Allen and Maggey and my Dad and my Mom are the perfect family. I have a chance to move to Alberta with my Aunt. I think I'm going to take it...She's moving to Alberta or Saskatchewan or Manitoba, somewhere, or Californie...I'm going to run away and live with her. Or I could always go with my friends...

How do you think your Mom feels about you?
I don't think she feels about me. I think she thinks L 's my daughter and I love her but I wish she wasn't part of my life any more, I wish there was just Allen and Maggey...Now that I'm in Chimo I'm just there until I can find another place to live (since L assumes Mom won't want her back home)...My Mom's jealous of my Aunt Carol because I do love her a lot and I'd do almost anything to live with her...That's just because my Aunt lives in the '80's. My Mom lives when her Mom used to beat

her...in her past...she (Mom) goes "well at least you don't got it as bad off as I did"...I don't think Allen or Maggey should be with her either. I think she has a mental problem. I think she should go to a psychic (meant psychiatrist).

How do you think the fact that your Mom was beaten has effected your Mom?
I don't know. My Aunt was beaten and it hasn't effected her. You can see sometimes that she's hurt, but she doesn't take it out on kids. She doesn't take it out on anybody, but she has disowned her mother, and I am disowning my mother because I don't like the way she treats me and I don't think the way she treats me is fair.

How would you like to be treated?
I'd like to be treated like a human being, not like a 4 year old little brat...She doesn't want me to grow up...Like Friday night I came to Chimo House totally pissed. I was higher than a kite and that was fine so they just told me to go to bed, and I didn't want to go to bed so they sent me for a walk and I went for a walk, came back, crashed. Next day I had a hangover and I went over to my Mom's house which was really stupid but I did, and she really got on me. She said I can't see her 'til whenever and I said fine I don't want to see you no more...She's really fucked up...She said "I don't want you turning out like your father," and I'm going to turn out like my father if she kicks me out and she doesn't talk to me...Even if she did talk about it, it's my problem. I'll do what I want to do...I want to divorce my parents, but you can't do that so I'm just going to leave my parents and get somebody else to adopt me...My Mom doesn't treat me proper.

What would proper treatment be?
My Aunt knows that I do what I do. Drugs and shit like that...She says "if you're going to do them don't come back 'til you're sober 'cause I don't want the kids to see"...My Mom's not like that. She beats me with it (meaning lectures)...My Mom carries it on for months and months...There's no way in Hell I'm going to quit just for my Mother...I wouldn't quit for nobody. I'm not going to change my personality just because somebody wants me to.

At this point in your life, how come you've chosen to do the drug stuff?
Because I want to...I'm sure everybody does it. For a long time I never knew that my Mom did drugs. I thought she was really good about that, until I walked into the bedroom one day and there she was toking up and then she was so stoned that she goes "I don't love you, get out of my sight"...My Dad's taught me to drink and my Mom's taught me to toke up...and I'm not going to go do treatment or anything for it because that's what I want to do...I know why I'm doing it but I'm not going to go around telling everybody...'cause I don't feel like it.

What about your Dad? What do you think about him these days?
My Dad's an asshole sometimes...most of the time. He's turning out to be like my mother. He likes my brother, he likes my

sister, he does car things with my brother, he takes my sister shopping, but he never does that with me...that's really fucking ridiculous. He used to treat me a lot better until he and my Mom got back together...My Mom is poisoning my father like my Mom has poisoned me.

Is there anything that you like about your Dad?
He's nice when he wants to be.

Is there anything you like about your Mom?
No...sometimes she can be nice but that's not often...only when I do things for her...I always have to do something to gain her respect. My sister and brother only have to be there to gain her respect.

Do you know what your Mom thinks of you?
I don't think she thinks of me. I don't think she likes me that much...'cause I'm turning out to be like my father.

Can you think of anything she does like about you?
No...she's jealous of me...of my life, of my looks, of what I do.

How can you tell?
The way she treats me...When I help her clean up she says..."that's really good", and then for Maggey it's a 2 hour discussion how good and how pretty her little girl is, and Allen, how strong her boy is. Me, I'm just like a dirty old shoe to be kicked around.

What do you think of Maggey and Allen?
I think they're brats...They're very spoiled, and I'm not jealous...I'm not jealous of nobody or nothing.

Do you think it's a bad thing to be jealous?
I think it's wrong...you should be happy with what you have.

Are you happy with some of the things you have?
I'm happy with almost everything except my parents.

What are the things in your life that you're happy about?
Everything, except I could lose some weight.
(couldn't elaborate)

Maybe I can ask you a bit more about your interests...?
I like to socialize...I like to go out with people shopping and go places where I haven't been, I like to travel. I've only travelled once...I went to Calgary...my Mom needed money...

Have you ever had a hobby
Me and my friend used to braid with yarn for hours...

Is there anything else that you're good at?
I'm good at singing. I'm good at acting. I'm good at cooking, baking, and I'm good at raising animals...(yawn) and I'm good at being tired.

Can you describe yourself...What's L like?
I don't know.

What are the things that you like about L ?
Nothing. I don't know.

Is there anything you'd like to change about yourself?
Everything.

Like what?
I'd rather live somewhere else far away, a far away planet. I wish I was an alien to be discovered on Mars.

If your Mom were describing you to me or a friend, what would she say?
Tell you that I'm a brat, that I never do as I'm told, I'm basically a bitch.

What are the things she really likes about you?
I don't know.

How about your Dad?
He'd probably say she's such a cute little girl...I hate that 'cause I'm not a little girl.

What is it you like about your Aunt Carol?
I don't know. She treats me different. Don't ask me how she treats me.

How do you like or not like Chimo House?
It's OK I guess.

If you were in charge...?
I'd make it a hell of a lot different

What things would you change?
I'd let there be smoking in the house, there'd be a TV...Blake broke it. The phone would be allowed out longer hours. There wouldn't be a curfew. You'd have to phone in (instead of a curfew)...I'd say "fine but remember you got school in the morning and if you don't go that docks off 25 cents off your allowance"...or a dollar, but I wouldn't make it too much...and if they didn't go to school or they didn't go to work, well I guess they're not going to have their knowledge now are they?

What are the things you like about Chimo House?
I don't know, and I hate that they never have juice...

How do you like the staff?
Some of them are OK.

Do you have favorite people?
I really, really like Judy.

What makes Judy such a good child care worker?
She doesn't take shit...like she says "fine don't help me, see if I care"...like reverse psychology...It's just Judy's personality, she acts real tough.

If you were running the school for child care workers...?
I'd make them all to be like Judy, and Cathy sometimes. No all to be like Judy and you.

How come?
Cause you both are really, really nice...
How much longer is this (interview) going to last? (getting restless)

Do you have a boyfriend right now?
Sort of. He's in YDC...

Not with this boyfriend, but do you think you'd ever get married in the future?
No. Too much of a hassle to get divorced.
(getting more restless and fidgeting more with the mike)

Do you think you'd ever like to have kids?
Yeah...two.

How would you raise them?
Properly...I'd alway be there for them to talk to me...I'd probably run a daycare...you can't be too strict but there has to be rules...I don't know. I'm not a mother yet.

What sorts of people do you tend to be friends with?
Party people.

How can you tell when you first meet people...?
The way they dress...definitely...I'm getting very bored...

Last question. If you could have three magic wishes, what would you wish for?
To be pretty, and to have lots of money, and for Kelly to be out of YDC.
(pretends to eat the mike)

Comments

- I got the impression that quite a few of L 's statements were fantasy (ie. claiming in the interview to have coincidentally bumped into Aunt Carol on the street in Surrey at which time the plan to live with her was decided; also, I can't see L 's Mom telling L . even while stone that she doesn't love L . Perhaps these are just a statements of how L feels and she wants others to know about these feelings/fears).

- L likes "nice" people, but could never elaborate on what this meant.

- Although L can be quite contrary, she can also be a pleaser (eg. her need to tell me as the interviewer that good child care workers are just like me...really nice).

- Because L does not really seem to have internalized some of her stated values, she sometimes contradicts herself in the interview (eg. Chimo House shouldn't have rules, but later L states that if she had kids "there has to be rules").

Themes

- Abandonment; feeling rejected, tossed out, unwanted; Feeling there isn't a place for herself in the family.
- Fairness, proper treatment (doesn't seem to see a connection between her own behavior and "fair treatment")
- Growing up; not wanting to be a little girl, and yet still wanting a nurturing Mom.
- Jealousy
- Blame
- Feeling sorry for self.

I-level Rating

- Although there is the ocassional glimmer of beginning level 4 insight in this interview, basically L gave a fairly concrete I-level 3 interview (I 3 cfm).

I 3 cfm Characteristics

- Therefore according to I-level theory, at this stage of her development, L is still concerned with who has the power and what are the rules. Thus in L 's world, the rules and the power change every time she walks out Chimo's door to be with her friends.

- L will do almost anything for peer approval.

- Values are not yet internalized.

- Problems are seen as imposed by the outside world, rather than having anything to do with her own self.

- L has low self-esteem, and otherwise does not yet know much about who she is. Because L does not really know who she is, it is hard for her to feel as though she "belongs" anywhere, whether this means knowing her place with a group of friends, or knowing her place in her family.

- L is not yet capable of taking the future into account in her plans. Her plans are based on her current wants.

- Handles crisis by escape/running away/substance abuse.

I 3 cfm Treatment Recommendations

- Establish a clear, safe, and caring environment.

- Any consequences should be of a short duration and with the continual message of concern and encouragement. Keep in mind that L is looking for proof that she isn't cared for.

- Work on establishing a special caring relationship between L and her key worker. L will test this to check out whether she will be abandoned once again. For the first while this will be a non-reciprocal "give, give, give" relationship on the part of the key worker. L is virtually a "bottomless pitt" in need of daily positive strokes (hugs, praises, encouragement).

- Actions will speak louder than words. Taking her out for an ice-cream will mean much more to her than insight oriented counselling which would be over her head.

- Abusive or thoughtless behavior will be an expression of L 's feeling insecure and threatened. These feelings will need to be addressed.

- Role playing as well as labelling one's own feelings and helping L to identify and label hers should be effective techniques. Crises may be avoided by anticipating the anxiety, labelling it, and rehearsing how the upcoming situation can be handled.

- Eventually negotiation will become a more and more realistic method of dealing with L .

Ingrid Kastens

APPENDIX O

The School Essay

Topic: How it Came to be that I am Refusing to Attend School. By L, Age 14

Why I dont like ~~sc~~ school I dont like ~~sch~~ school because I'm older then every one at my grade in some things like how to live on the streets + stuff + I have friends my age + my cousin say stuff like that I was abused sexually + that not one of there bissnes + I had lots of friends till my cousin Sam told them that I sleep around that my mom beats + that I hond around with people that do drugs shure I do but still she has no right to call me down but thats not the only thing that I hate in some subjects that work to fast + the teachers dont explain them to me even if I ask + the school work is some times to easy + most of the times to hard because the teachers dont explain it to my age is a person that goes around ~~to~~ beating little kids up + thats not true ~~to~~ + I dress the way people my age I do thing that people my age do so im like on alien in elemenly school + no one under stonds my point of view + I know I'm smart + I love art but I cant do anything when people sit there + mok fun of me I like School I make friends there but I can't make friends with 11 + 12 year olds + I can't make friends were my cosin le at first it was fun I liked them they liked me + bank I move back with my mom know one likes me I whold not let every one do that but I love my cousin alot + still do even know she hunt me but when shes older + even need help + if she + comes ~~soon~~ running to me I will do the some thing she did to me I will ~~sleep~~ slame the door in her face + I know I'm not stupe

it just I fell that way sometimes because
thats the way people make me feel I mean
just cause I can't spell very well dosent mean
I am stupid I mean I wright songes & poanes &
stories I'm good at art & drama & some math
& I don't sit around at home like I use to
~~but~~ I owalys have somthing to do I love going
out & I like the teen group me & Betty go to
me & Betty do every thing together I like Betty &
are friend & me & Betty only got in to one major
fight & that was solved in about 2 hours
but thats besides the point the point is I like
school & butt I can't learn at my own speed.
& thear is only some subject I'm not
good at like spelling, reading, scince, p.e. &
french but thats not bad ~~th~~ & I don't
get along with yonger kids even Som.

Written by J

APPENDIX P

Consent Form

APPENDIX Q

Approval of

The U.B.C. Office of Research Services