THE INTERN AND THE CHALLENGING CLIENT

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ABSTRACT

The symptomatology and clinical treatments for physically and sexually abused children and adolescents are addressed in this article, with a special focus on adolescent clients who live with domestically violent and substance abusing families. A case presentation provides a detailed look at an intern's experience confronting the multitude of issues occurring simultaneously in the life of an adolescent client. A retrospective look at the intern's lack of experience and supervision while treating this adolescent client highlights the need for research into the overwhelming experience of interns in underfunded, understaffed and undersupervised domestic violence and sexual assault agencies.

Introduction

There is a great deal of trust involved in the disclosure of any serious dysfunction at home, be it sexual abuse, domestic violence, or substance abuse. Disclosures of abuse often take place in the context of a domestic violence agency or a sexual assault center where resources are limited and the staff may be overworked. Given the understaffed nature of such agencies, social work interns are sometimes treated more like staff than interns and called to treat challenging trauma cases, either with limited supervision, or in some cases, with no supervision at all. This use of interns calls into question the capacity of the graduate social work student to meet the clinical needs of the client adequately, particularly those who present with psychiatric trauma from sexual or physical abuse in the complicated context of domestic violence. At the very least, the social work graduate student is bound to feel overwhelmed and concerned about her ability to serve a client with these presenting issues.

In my first year of graduate school, I considered this question of adequacy to serve as I worked with an adolescent client who not only had lived with a violent, substance-abusing father but also revealed that she had been sexually abused. I continued to reflect on my role of clinician

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Smith College Studies in Social Work, 70(1), November 1999.

with this particularly challenging client, as my subsequent classes and field work provided me with new insights and understanding of the complex issues present in such a case. In response to these ongoing thoughts about my first-year clinical work, I recently sought relevant research about the struggle to serve clients as a mental health intern with much less experience than the average clinician. I spent hours pouring through data bases specific to social work and psychology, reading abstracts and doing keyword searches. While research could tell me what factors resulted in a good fit between supervisors and student interns, what affected a good fit between the schools and the agencies, as well as information about the experienced clinician's work with trauma, I found no studies that addressed either the specific difficulties I had encountered, or the experience of the client seeking services from an intern. When I turned to fellow social work students and faculty for such information, that query did not yield helpful information. I concluded that there was a great need for research concerning the clinical work of graduate-level mental health workers. In particular, I became interested in the challenges an intern faces in serving an adolescent client who has experienced both sexual and physical abuse. This paper is a preliminary approach to this neglected topic. By presenting a case history of a compromised service effort, I hope to suggest some questions and issues which could be examined through empirical research.

I will begin this paper by summarizing the agreed upon symptomatology often present in children and adolescents who have experienced physical and sexual abuse, as well as the impact that stages of development can have on these symptoms. This information represents some of the essential knowledge base a social work intern should have to begin working with abused children and adolescents. A description of the treatment process with an adolescent client, whom I will call "Alison," follows. In this clinical presentation, I offer a description of both the client and the process, as I seek to examine the choices I made and the interventions I employed in the context of the limited knowledge and experience I had as a social work intern. I will also address how systemic problems within the agency impacted on my efforts to provide this client with adequate support and services. Finally, I will reflect on my decisions and work with this client in light of the additional knowledge and experience I have today, seeking to clarify whether I might have helped this client further had I known then what I know now, as I complete my masters degree in social work.

The Impact of Abuse

Not surprisingly, physical abuse can affect all aspects of a child's development, including physical, cognitive, behavioral and socioemotional (Wekerle & Wolfe, 1996). Wekerle and Wolfe list physical signs of abuse as ranging from external symptoms, such as bruises, scars and lacerations, to internal symptoms such as head injuries, bone fractures and abdominal injuries. Cognitive delays often present themselves in poor academic performance and are thought by researchers to be "due to limited stimulation received in the home from parents who are overly concerned with the child's behavioral appearance and obedience which impairs the child's need to explore, attempt new challenges, and to be exposed to a variety of cognitive and social stimuli" (Wekerle & Wolfe, 1996, p. 499). Behavioral developmental signs of abuse in children and adolescents can include: "heightened aggressivity and hostility toward others, especially authority figures, and angry outbursts, sometimes to minor provocation" (Wekerle & Wolfe, 1996, p. 500). It is these more socially undesirable symptoms that often bring physically abused children and adolescents to the attention of a teacher or counselor. Another behavioral symptom described by Wekerle and Wolfe is called "compulsive compliance," which they define as "a child's ready and quick compliance to significant adults, which occurs in the context of the child's general state of vigilance or watchfulness of adult cues" (p. 500). The socioemotional development is another area of symptomatology that brings children and adolescents into counseling, often at the request of concerned teachers and parents. These socioemotional symptoms include: depression, low self-esteem, an unusually high incidence of suicidal and self-destructive behavior, and "impairments in the expression of positive feelings or outlook" (Wekerle & Wolfe, 1996, p. 501).

The symptoms of physical and sexual abuse are often similar and difficult to separate given their propensity to occur in the same home; however, physically abused children and adolescents are more likely to present cognitive/developmental delays and interpersonal conflict, while "the characteristics of the sexually abused child cluster generally more toward trauma-related emotional and behavioral problems" (Wekerle & Wolfe, 1996, p. 504). As is the case with symptoms of physical abuse, the presentation of symptoms secondary to sexual abuse may vary and change as children move into adolescence. Reported symptoms seen in child sexual abuse victims include: sleep disturbances, anxiety, withdrawal, behavioral problems, depression, school difficulties, self-destructive behavior, substance abuse, difficulty in trusting others, poor self-esteem, feelings

of isolation and stigma, a tendency toward revictimization, dissociation, and sexual dysfunction (Cunningham, Pearce & Pearce, 1988; Murphy, Kilpatrick, Amick-McMullan, Veronen, Paduhovich, Best, Villenponteaux & Saunders, 1988). Specifically among adolescents, symptoms of abuse appear in the form of: depression, self-injurious behavior, running away, precocious sexual behavior and eroticization, and substance abuse (Gil, 1996).

Various research has suggested that not only does sexual abuse create emotional and behavioral symptoms but that it may substantially impact the physical development and health of victims. According to Wekerle and Wolfe, "Acute physical symptoms or signs noted among child sexual abuse victims include headaches, stomachaches, appetite changes, vomiting, sensitivity to touch in specific areas, genital complaints and urinary tract infections" (1996, p. 504) Some research has suggested that severe and chronic sexual abuse of a child may accelerate the onset of puberty, bringing on menstruation as early as 5 and 7 years old, with pregnancy occurring as early as 9 years old (Gil, 1996). A study by Cunningham, Pearce and Pearce (1988) surveyed women and found that those with a "history of sexual abuse had significantly more frequent complaints of a variety of medical problems, such as pelvic pain and asthma." Substance abuse is a common symptom of sexual abuse that also impacts the physical and emotional health of victims from adolescence on in to adulthood. In a journal article by Glover, Janikowski and Benshoff (1995) the authors explain the relationship between sexual abuse and substance abuse:

> Failure to treat the effects of sexual traumatization leads to the emergence of other symptoms. For example, addiction to alcohol or drugs may develop as a result of ineffective coping strategies used by people to numb feelings, suppress memories, and escape the pain of the childhood assault. Addictive behaviors may then become serious problems in their own right (p. 47).

It is agreed by researchers that the developmental stage at which any type of abuse begins affects the child's response, and additionally, impacts and commonly interferes with the healthy completion of developmental tasks (Gil, 1996). Gil draws on the work of Finkelhor (1995) to describe how symptomatology in adolescence is affected by the onset of abuse at different developmental stages. According to Finkelhor, "risks may vary across the course of development based on the characteristics of the children themselves (i.e., their suitability as targets and their ability to

protect themselves) and the characteristics of the environments they inhabit (i.e., the presence of people who want to victimize and the presence of capable guardians)" (Gil, 1996, p. 23). Finkelhor extrapolates further, saying "the impact of victimization can be affected by the child's stage of development in each of the following ways: as a result of the developmental tasks or developmentally critical periods the child is facing at the time of victimization; as a result of developmentally specific cognitive abilities of children that affect their appraisal of victimization; and as a result of differences in the form of symptoms expression available to the child at particular stages of development" (Gil, 1996, pp. 23-24).

Just as Finkelhor describes what factors contribute to the impact of abuse on development, Gil (1996) provides a number of specific risks and impacts pending in cases of the sexually abused adolescent. Gil precedes this discussion, however, by pointing out that given the array of mitigating factors involved in each child's development and the abuse, it is crucial to be aware as a practitioner that different children are impacted to various degrees. That is, not all children who have been abused appear to be symptomatic, and in the same vein, the presented risks and impacts of abuse will not manifest themselves in the lives of all who have experienced it (Gil).

The first potential impact Gil mentions, "learned helplessness," is a risk for adolescents who have lived with either sexual or physical abuse (p. 24). Gil explains that learned helplessness compromises adolescents' ability to protect themselves and is a particular risk for adolescents who have experienced chronic abuse. Learned helplessness refers to the adolescent's belief that it is an exercise in futility to try and protect her or himself (in any situation) because she or he has not been able to stop the abuse. Symptoms specific to adolescents who have experienced sexual abuse include: disturbances in sexual functioning and orientation; precocious puberty; impaired respect for their own sexual boundaries and limits, as well as those of others; impaired self-reference, definition of self, identity problems; and severe mental illness such as multiple personality disorder, borderline personality disorder, dissociation, and atypical depression (Friedrich, Jaworkski, Huxsahl & Bengston, 1997; Gil, 1996). Other results of disrupted development due to physical or sexual abuse are: inability to experience personal control or to see external resources due to low self-esteem and sense of entitlement; disrupted attachments that are characterized as either avoidant or ambivalent; disrupted cognitive processes; impaired morality (Friedrich et al., 1997; Gil, 1996).

Not dissimilar from the other symptoms and disruptions in development that have already been presented, adolescent victims of physical and sexual abuse may exhibit symptoms of Post-Traumatic Stress Disorder (PTSD) (Gil, 1996). According to Goodwin, this level of post-traumatic stress in incested adolescents is evident in several symptomatic behaviors including: chronic anxiety, fears about the meaning of and threat of emotional and physical intimacy, re-enactment of the trauma through self-mutilation, promiscuity, unwanted pregnancy, and other disturbances in their attempts to forge close relationships, such as flashbacks during sexual intimacy, substance abuse, nightmares, and emotional numbness. Incested adolescents may also face grief about the premature loss of their sexual innocence, as well as guilt about the incest, and problems with victim-aggressor styles of relating in relationships (Goodwin, 1987).
It is important for practitioners to be aware that victims of abuse may be experiencing PTSD and to view the client's behavior in the post-traumatic context. In addition, if an adolescent who one does not know to have been physically or sexually abused is evidencing a number of these behaviors, it may be prudent to explore the possibility that the client has been abused.

The Case Presentation

Alison was the first adolescent client I worked with in my career as a social worker. I was given the information about Alison and notification of her appointment with me the day I was to see her. My supervisor was not in the office that day, and I was unable to seek advice or consultation before meeting with Alison. I was confident I could work well with adolescents given time and experience, but I was also aware that my own turbulent adolescent history made it critical that I be aware of how my own experiences might influence my reactions with an adolescent client. In *Treating Adolescents,* Hans Steiner and Irvin Yalom address personal reactions to the adolescent client:

> Most clinicians find it difficult to engage with adolescents. The reasons for this are complex, but one usually ranks high among them: therapists often want to forget their own most difficult period of development... There is an immediacy in this work that is usually not found in working with adult patients. Consequently, it is common to get caught by surprise and rediscover unfinished business within ourselves (1996, p. xv).

This quote summarizes well the difficulties clinicians of any level of

experience are likely to have working with adolescents and highlights the importance of thorough supervision in adolescent cases. The clinician, particularly a relatively new intern, who engages in an adolescent case without supervision is working at a disadvantage.

Alison was a twelve-year-old seventh grader whose mother scheduled her appointment at the domestic violence agency where I was an intern. According to her mother, Alison had witnessed her father being verbally and physically abusive to her sister and verbally abusive to her mother. She added that Alison's father had kicked Alison in the ribs and had been living out of the home for the past few months since this occurred. I was told that charges were pending and Child Protective Services had been notified. According to her mother, Alison's father had threatened to commit suicide and Alison had stated she would blame herself if he did. Furthermore, I was informed that although Alison's father wanted to see her, she was making excuses because she was afraid of him. The mother reported her main concern was that Alison would never be able to trust men.

The intake form informed me that Alison lived with her mother and sister with whom she had "good" relationships yet feels sad that they fight a lot. Alison and her mother had lived in two different shelters in the past few years, each for a whole year, which Alison told me she liked. She wrote that she came to the agency to see a counselor because her parents are getting a divorce and her mother thinks it would be good for her. Alison said that while she does not talk to anyone when she is stressed, she yells when she is angry. Alison described feeling unsafe at school where some people wanted to beat her up because they think she told on them for smoking in the gym. Alison listed interests in reading, shopping, playing basketball, skating, and bike riding.

Alison was tall, heavy and well-developed for a twelve year old. She is dressed appropriately for the winter weather, wearing the over-sized clothes common among adolescents today. Alison's hair frequently falls over her eyes, obscuring her face. Although she makes good eye contact with me while speaking, Alison's closed body language and quiet voice give off the impression of a person who tries to avoid notice.

However, once she finished the intake forms, Alison told me she wanted someone to talk to because she has a lot of problems and went on to provide a great deal of information. She explained that she either feels left out of her family dynamics or trapped in the middle of them. For example, she feels isolated from her sister and her mother because her father has always beat them up and excluded Alison from his tirade, telling her,

"It's not *your* fault." Alison expressed a great deal of guilt and responsibility about this pattern of abuse in her home. Furthermore, she explained that her mother and sister come to her when they are fighting with each other, expecting her to side with them against the other. These were the only conditions under which Alison experienced attention from either her mother or her sister. Alison's parents were getting a divorce, which she was glad about because she does not like her father. Her worries, as she presented them to me, were about her weight, having troubles at school, and being unhappy with her new home and neighborhood. Alison, her mother, and her sister recently moved into an area where the only neighbors are much older and a depressing-looking factory is within view. Alison described anger as a big problem for her, as it tends to bottle up and then scare her when it comes out. Alison described a best friend whom she only sees or speaks to at school.

I recognized that Alison was facing a multitude of difficulties, and I felt that we needed to start by establishing some small successes in the areas where Alison did have some control. After discussing various possibilities with her, Alison and I came up with a couple of ways she could manage her anger and loneliness. The idea of a journal appealed to Alison but she had serious concerns about privacy, so I suggested she write down her feelings and then rip up and dispose of the paper. This appealed to her and became one of her goals. I also told Alison several ways she could release aggression and anger, besides writing in a journal, that had helped other kids her age, such as punching her pillow or riding her bike. Alison and I closed with an understanding that I would see her in three weeks, after Christmas vacation. In the meantime, I was only able to offer her the use of the agency crisis line. She was sad I couldn't see her sooner but I emphasized that she now had some new ideas about how to manage her feelings on her own. Alison and I had established the beginning of a safe and positive relationship, which she appeared to need very much. I noted Alison's ability to respond well to positive attention and to be open as strengths.

Alison reported some progress in the next session. She told me she had found a way to keep a journal privately and that it helped her express her feelings. She went on to tell me she had started to leave notes for herself on her locker at school so she would not forget assignments when she went home each day. This was in reaction to her mother's threat to take away Nintendo if her grades did not improve. Alison told me that one difficulty for her was that she did not have a bag or backpack in which to carry her books. I told her I could look into our donations for an acceptable backpack and congratulated Alison on her success with the journal

and her initiative at school. We also discussed ways that she could feel safe at school if other kids were threatening her. She reported that her best defense was hanging out with a girl who was known to be tough, and I pointed out that she was quite good at solving her problems.

Alison revealed some additional problems in the course of this session, primarily that she was having difficulty feeling rested, even after ten hours of sleep per night, and was feeling quite depressed. Alison also described conflicts about money. She had decided she wanted to baby-sit so she could have some money of her own, and with this purpose in mind, had found a family who needed a regular baby-sitter. Her mother and sister told her, however, that since she was needed to baby-sit for her niece (who lived with Alison), she was not allowed to baby-sit for other people. In addition to her mother's and sister's objections, Alison's father told her that he would not allow her to work. Alison also revealed to me that her father had become upset with her when she had told her mother she wanted to get counseling. She described both parents fighting with one another about her, in her presence, and then her father demanding to know why she needed to go.

Since the last session, Alison's father had come to the house to work on his boat, which he still kept at their house. Alison was upset because aside from asking her to get him a beer, he paid no attention to her. She believed he did not want to see her anymore because she asked him for her allowance. She told me that her father was often high and that he had frequently used drugs like marijuana and cocaine in their garage. She always knew when he was high because he acted differently, but she did not elaborate on what this difference in behavior looked like.

In this session, I asked Alison what she hoped to get out of seeing a counselor. She told me she just wanted someone to talk to because there was no one else since she had had a falling out with her best friend. We discussed ways in which Alison could get to know and plan time with other girls in her class. Alison discussed again her dislike of being in the middle of her mother's and sister's fights. I explained how triangulations develop between family members, and that if she felt safe doing so, she could ask her sister and mother not to talk badly about one another to her.

Lastly, I presented Alison with the option of going to a group for adolescents from violent homes, while she continued her individual work with me. I presented the group as an option for Alison because I was told to by the staff at my agency because they were in need of adolescents to fill up their adolescent group. We discussed her anxieties and hopes about such a group. As strongly suggested by the agency, Alison and I contracted three group sessions, after which she could decide whether or not to

continue.

Alison did not show up for her next individual appointment and for the next three weeks, she only attended group. Although I was not involved in the adolescent group, I did glean some important additional information from Alison's group progress notes that warrant attention here. In the first group session, Alison described the following examples of her father's abusive behavior: telling her mother he was going to kill the mother, bribing Alison with money for information about her mother, making fun of what Alison wears, keeping her from seeing her friends, not letting her get a job, throwing Alison's radio against the wall, and telling her nothing she does is good enough. In the second group, Alison discussed her father's substance abuse problem and the fact that she had witnessed him trying to rape her sister. Alison reiterates that she is afraid of her father and she is glad he has moved out. The next two groups involved more discussions about how Alison's father controlled and abused her family, with Alison saying that for her father to love her she would have to be flawless.

I called Alison to set up another appointment for the week of the third group. Unfortunately, Alison did not show up at the scheduled time but rather two hours later, at which time I was occupied with running a group for small children. I did ask Alison if she still needed a backpack, informing her that I had found one for her if she needed one. She had gotten one in the meantime and seemed surprised that I had made such an effort. I scheduled another appointment for her for the next week and wrote the agreed upon time on an agency business card for her. It was difficult to turn Alison away and she appeared very sad and disappointed. I reminded her that she would get to go to group between that time and when she would see me again. The next week, Alison phoned to tell me she could not come because her sister said there was no gas in the car or money to buy gas. Alison and I scheduled for the following week.

Alison started off the next session telling me she had told her sister that she no longer wanted to be in the middle of her arguments with their mother, after which, Alison's sister had refused to speak to her. Alison then wanted to explore the topic of boys and her concerns about her weight. Alison told me she liked boys but that she had never known nice men—she describes her mother's and sister's boyfriends as drug-using, drinking, violent men like her father. I asked Alison to tell me what characteristics she would like in her future boyfriends, and she rattled off, "nice, smart, respectful to me, not violent, stays away from drugs, and doesn't talk about me in mean ways to his friends." I endorsed that these were indeed good things to look for in a boyfriend. On the subject of

weight, I explained to Alison that it is normal for girls her age to gain weight and that it is a part of puberty. Alison seemed to appreciate this information and then told me that her doctor had said she was overweight. We discussed Alison's eating habits, and I found out that Alison does not like to eat meat, so we discussed what she needs to be eating instead of meat to get all of her needed nutrients. Alison told me that her mother buys a great deal of junk food and cooks mostly meat-based meals. I suggested she talk to her mother about going to the grocery store together so Alison could pick out the fruit, vegetables, and grains that she wanted to have at home. She seemed uncertain that her mother would respond to this attempt. While on the topic of weight, Alison told me her family has a lot of different indoor exercise equipment, and she would like to use it but is embarrassed to do so in front of her sister or mother. We talked about how she could exercise before they get home every day, and I suggested she try to do thirty minutes a day of any exercise she wants. Alison liked this plan; she tended to appreciate and respond well to concrete suggestions of how she could manage her problems.

In the last few minutes of our scheduled time together, Alison told me how she had been sexually abused by one of her mother's old boyfriends when she was eight years old. She spoke calmly and detachedly about how he had made her and his daughter kiss in the closet and touch each other in the bathtub. Alison's anger was directed at the other girl involved rather than at her mother's ex-boyfriend. I suggested that he had been responsible for her safety, and she continued to say that the abuse had been the fault of the other girl, who was seven years old. Alison told me details of the other girl, how she was bigger than Alison was at the time and that she was a bully. Alison expressed confusion over whether or not this encounter meant she was a lesbian. I told her that what had happened to her had not been her choice or her fault and that it did not indicate anything about her sexuality nor did it indicate anything about who she was as a person. I empathized with the confusion and pain this episode of sexual abuse must have created for her. Alison changed the subject and began to tell me how her father had tried to rape her sister, and did I think her sister could come in for counseling without her mother knowing? I explained that the agency could provide her sister with confidential counseling, and that if she needed an appointment, she could call our toll-free number anytime. Alison then told me then how much she liked to jump rope, but that she no longer has a rope. I told her I would see if we had any in the donation boxes that I could give to her next time she came in.

Alison never came into the agency again, either for group or individual counseling. I called her the next week to find out why she had not shown

up for group or our scheduled appointment. Alison told me her sister had gotten a new job that required her to work afternoons and evenings, and therefore she no longer had transportation to the agency after school. She told me she'd had a big fight with her mother the day before about the situation but that her mother had told her nothing could be done about it. Alison sounded very depressed. Our agency had recently decided to be open for appointments on Saturday mornings, so I asked Alison if she thought her sister could bring her in on Saturday mornings. She told me her sister did not work then and that she would ask her if she could do that. I told her to call me back after speaking with her sister. Alison did not call back.

The afternoon following Alison's last individual appointment, I was able to meet with my supervisor about her case for the first time.

Upon Reflection

It is important to discuss what impact abuse has had and was having on Alison's life before examining what type of treatment plan would have been most helpful. I was aware at the time that Alison's depression, low self-esteem, weight problems, poor academic performance, anger and social difficulties were all related to the trauma she had witnessed at home, including the sexual abuse she had experienced. I also entertained a strong suspicion that Alison had been incested by her father and I will elaborate on how both the information she revealed and the symptomatology she presented suggest this possibility.

Alison presented many symptoms common in survivors of physical abuse that were mentioned earlier in this paper. I suspect her bad grades may have had to do with undetected cognitive delays, which could be attributable to the lack of stimulation Alison described in her neglectful home environment. Alison described angry outbursts she could not understand or control, which are described by Wekerle and Wolfe (1996) as common behavioral signs of physical abuse. Looking back, I wonder if some of Alison's agreeable disposition and constant cooperative nature with me could be partially the result of compulsive compliance. I do not doubt that she was a generally sincere person, I simply wonder if the vigilance and watchfulness of adult cues, as described by Wekerle and Wolfe, may not have been what I initially observed in identifying her as a young person who knew how to be unobtrusive and escape notice. Compulsive compliance would certainly have been useful in a home where a child is only spoken to for support or to be yelled at, and is otherwise neglected. In keeping with socioemotional symptoms of physical abuse, Alison not only described herself as depressed but appeared depressed in her pos-

ture, affect and energy level.

In addition, Alison presented a number of symptoms common to survivors of sexual abuse, which are similar to symptoms of physical abuse, including: sleep disturbances, anxiety, withdrawal, depression, difficulties at school, difficulty in trusting others (particularly men), poor self-esteem, feelings of isolation, depression, and an accelerated onset of puberty as marked by her full figure at the age of twelve. In the course of our time together, I did not get enough information to know if Alison had been experiencing PTSD symptoms. As well, I do not know if Alison will develop the entire cluster of PTSD symptoms common in adolescent survivors of sexual abuse (as described earlier in this paper), but I do believe she expressed two of the symptoms described by Goodwin earlier in this paper. Specifically, Goodwin describes the adolescent as de-idealizing her parents and experiencing "herself as an entity separate from her parents" with guilt about the incest replacing fears of retaliation. Whether Alison was sexually abused by her father or only by her mother's ex-boyfriend, this description would be one way of making sense of Alison's frequent descriptions of guilt.

At this point, I would like to speak to my suspicions that Alison was being or had been incested by her father. It is important for the clinician to be aware that sexual abuse often occurs in homes where either domestic violence and/or substance abuse are a problem (Ammerman & Hersen, 1991). Specific to Alison's case, there was clear evidence that Alison's sister was incested by their father since Alison witnessed her father trying to rape her sister. This incident provides ample evidence that this man sees his daughters as objects for sexual aggression. Alison told me a number of additional problems her sister was having that suggested incest. Alison described her sister as a sexually promiscuous nineteen year old who frequently used drugs with her boyfriends and girlfriends. She cited her sister's promiscuity, resulting in three abortions, previous to the birth of Alison's niece, as well as her sister's drug abuse, as reasons why she had difficulty respecting her.

My other concerns come from more subtle cues involving Alison directly. I wonder about the fact that her father never hit her, treating her differently than the other two women and reassuring her she was not at fault. This behavior on his part resulted in Alison being isolated from her mother and sister, leaving her wide open for his advances. I also wonder if Alison's exclusion from his beatings wasn't part of her reward and incentive for the continuation of the incest, as bribes are common in adult perpetrations on children. The fact that her father had eventually lashed out

at Alison by kicking her in the ribs reveals that he is not above abusing Alison, and suggests that her requests for counseling could have been seen by him as her attempt to escape him and reveal the secret. The father's threats to kill himself and Alison's belief that if he did it would be her fault, suggest that there may be a pattern of Alison feeling responsible for her father's well-being, a feeling that naturally develops out of the secret between a perpetrator and victim.

Finally, once he moved out of the home, Alison avoided talking to him on the phone, made excuses not to see him, and stated she was afraid of him and did not like him. I did not know for sure that Alison was sexually abused by her father, but instincts told me that what Alison revealed about the abuse with her mother's boyfriend was just the tip of the iceberg, that this was a test to see how I would react. It is notable that Alison switched from the topic of her abuse to that of her sister's by her father and whether or not there were services available for someone with her sister's problems. In summary, Alison's father had a history of abusing his daughters in a number of ways, one of which included sexually attacking them, and both his daughters exhibit symptoms suggesting sexual abuse.

Regardless of the extent of physical or sexual abuse Alison had endured, there were a number of symptoms that would have required attention had the course of treatment continued. A literature search on treatment modalities with adolescents who have been abused revealed several treatment options, including: individual therapy, group therapy, substance abuse treatment coupled with a focus on the issues related to incest trauma, family therapy and pair therapy. In some cases, only one or two of these treatment modalities may be needed by a client, while in more severe cases a practitioner may believe that several or all of them are needed. I will briefly describe these different therapeutic options and through my description I will explain how the modality may or may not have been helpful to Alison. In presenting these treatment possibilities, I will also examine what could have realistically been attempted at the agency where I saw her and what would have been impossible for either practical or systemic reasons. I hope that this reflection on what was done and what might have been done, will be helpful to other students, clinicians, supervisors, faculty and researchers who examine how both beginning and experienced social workers can consistently provide clients with the highest quality of care.

Individual therapy is probably the most central component in an adolescent's recovery from physical and/or sexual abuse with the possible exception of group therapy. Gil (1996) recommends that individual ther-

apy precede group therapy in sequence, or group therapy can be done simultaneously with individual therapy once a one-on-one relationship has been established. As suggested by Gil, Alison's one-on-one treatment with me began before she joined the group. Alison seemed to be benefiting from the individual sessions—she reported that the coping strategies had helped her to deal with some of her stress and anger, and I believe her continued effort in her own treatment was driven by her relief at having someone to talk to. Ideally, more time would have provided Alison with a continuing "corrective experience" where she could learn healthy interactions and a "more optimistic view of the potential in human relationships" (Gil, 1996, p. 188). The benefits of individual therapy over group therapy, at least in the beginning, are that the adolescent can begin therapy in a relatively low-risk environment where issues of identity and self-esteem can be addressed; there is comfort in the therapeutic relationship (much needed by an abused adolescent); and the therapeutic relationship progresses more quickly in a one-on-one format (Gil). On the other hand, it is important for practitioners to keep in mind that to be meeting in private with an authority figure is going to be anxiety-provoking for a sexually abused adolescent. In fact, tolerating "positive attention and regard" with the provider might be the most difficult part of individual therapy, in that the adolescent client may be waiting for the other shoe to drop in the form of betrayal or some other form of violation (Gil, 1996). Therefore, it is possible that Alison withdrew from the individual work out of anxiety over the developing relationship, but I believe Alison's resistance stemmed not from the individual treatment but with the possibly premature placement of her in group treatment.

The benefits of group therapy are many, but I believe that a look at the benefits of individual therapy over group therapy reveal why Alison missed subsequent individual appointments once group started. Alison may have found that the group format required a greater risk than individual treatment with me, and thus, after going to group each week she may have found herself overwhelmed and unable to tolerate individual appointments two days later. I think that a more extensive evaluation of Alison's identity and self-esteem issues may have given me a better idea of whether or not she was really ready for the intensity of the group format. The open discussion and presence of multiple people, including peers, make group treatment an intense and possibly overwhelming experience for an adolescent who is struggling to trust closeness with another adult, and possibly attempting to reveal further abuse for the first time. In essence, my mistake may have been in suggesting Alison start group when it may have taken all the trust and energy Alison had to initiate a

relationship with me.

Perhaps Alison experienced the referral as a signal that I was not interested in her. The benefits of group treatment are that it "successfully neutralizes the excessive feelings of blame or guilt that incest victims experience and lessens or eliminates the consequent depression during adulthood" (Gagliano, 1987, p. 108). In addition, group therapy provides a format for the adolescent to be viewed in a larger context by the practitioner, while the adolescents themselves have a chance to negotiate joining with a group, participating, maintaining boundaries and using the skills necessary to communicate their needs (Gil, 1996). Had group therapy been implemented when Alison was ready and able to attend it regularly, it might have helped her deal with guilt around the abuse in her family, lessened her feelings of isolation, and been an opportunity for her to learn and practice social skills in a safe setting.

It was recently found that as many as 49% of clients in substance abuse programs may have experienced incidents of incest (Glover et al., 1995, p. 47). Thus, substance abuse treatment is often a necessary part of therapy for survivors of abuse, and clinicians working with survivors should constantly reassess the need for either individual or group substance abuse treatment. Although the chemical dependency in Alison's family and Alison's history of abuse put her at risk for developing a substance abuse problem, since Alison neither reported use or showed any signs of use, substance abuse treatment was not indicated for Alison. It is appropriate to provide education about the dangers of substance abuse, coping strategies to avoid peers who use alcohol and drugs, as well as information about alternative ways to manage stress to all adolescent clients.

Additional interventions that can be used with abused adolescents are family therapy and pair therapy. Family therapy is possible through many different models and a therapist would need to decide which model works best for them in the context of an abusive or incestuous family. Gil recommends Minuchin's structural family therapy because of its emphasis on space configurations and the usefulness of this approach in families with dysfunctional boundaries (1996). Hans Steiner and Irvin Yalom cite at least three reasons why parents should be a part of the treatment with adolescents: "(1) the adolescent frequently perceives them to be part of the problem, (2) the adolescents' attachments to their families are usually strong, despite all their protestations to the contrary and their counterphobic avoidance of family members, and (3) since the family is the context in which recovery occurs, clinicians can help parents understand the nature of therapeutic progression and regression" (1996, pp. 33-34).

All three of these reasons apply to Alison's case, suggesting that family therapy may have been used to create a wider network of support for Alison. In fact, had I involved Alison's mother in the helping process from the beginning, Alison's treatment might not have been ended prematurely. Not only would it have been beneficial to have Alison's mother as an ally as a means to keep Alison in treatment, I think it might have interfered with the patterns of neglect that had existed between Alison and her mother for so long. To my knowledge, there was no family therapy done in the domestic violence agency where I worked with Alison. I do not know, therefore, if I would have run into resistance from staff at the agency had I attempted to engage Alison's family in treatment. I do know that the agency would not have allowed Alison's father to attend therapy with the family, which may not have been desirable anyway. On a practical level, there was only one room in the agency that could have accommodated a larger family session, and it was often in use and not available to interns. A significant issue that would have come up had I suggested family therapy is that I had no experience at the time with this difficult and complex form of treatment. In an agency where there are more resources, however, I think it would have been possible to call in more experienced staff to help me facilitate therapy for this family.

Pair therapy is the pairing of unrelated clients in sessions as a means of "bringing together two clients who could explore the concept of forming friendships in a therapeutic relationship" (Gil, 1996, p 192). This particular form of therapy is valuable when adolescents have disturbed interpersonal interactions (Gil). While I would not have called Alison's interactions disturbed, I would have still considered her difficulties at school as evidence that she could benefit from forming a friendship in a therapeutic setting. I think this type of therapy would have been a good match with Alison's wish to gain social skills and to have a confidant her own age. The first and most obvious reason this did not occur is because I did not know about this type of therapy at the time I saw Alison. Another constraint would have been the difficulty of finding another young adolescent within our agency who would have been appropriate for pair therapy, since we tended to have only a small number of adolescents seeking help through our agency's programs. Notably, pair therapy would have only been useful with Alison much further along in her treatment when she was no longer in the process of revealing abuse and when she felt comfortable with the introduction of a third party into her treatment.

There is no way to know all the factors that led to Alison's termination of treatment. I believe there were financial and practical concerns around

transportation but it is also likely that Alison found group therapy on top of individual therapy to be too much of an assault on her much-needed defenses. Clearly, Alison was prone to revealing a lot of information in individual and group treatment and all of the revelations and discussions of abuse at home may have left her overwhelmed without any additional resources. I regret not looking to the faculty at Alison's school for additional support for her throughout the week, since access to a school counselor would have helped to offset the limitations of my treatment with Alison. A counselor in the school setting, where she was having problems with peers and academics, would have been enormously helpful to Alison, and would not have been contingent on rides from her sister or mother, since she went to school every day anyway. Again, a lack of experience and supervision limited my knowledge about what I could do for Alison when she told me she no longer had a ride to the agency each week. Today, I would know to connect Alison with a school counselor so that she could continue to have someone to talk to. Steiner (1996) summarizes what I have learned about adolescent treatment:

> More often than not, the treatment of adolescents requires the close collaboration of several people and without such collaboration treatment will usually stall. Parents, teachers, pediatricians, and the mental health team need to compare notes frequently so they can change course or renegotiate contracts as needed (p. xvii).

At the very least, Alison's treatment required the supervision of an experienced clinician. The absence of this supervision meant Alison did not receive the benefits of professional collaboration described above, and in the end, her treatment did stall. Supervision helps train the intern to apply abstract theory to practice by helping her understand the nuances of each case and choose which interventions are most appropriate in terms of the client's presentation. In financially strapped agencies, it is not uncommon for social work interns to be treated like staff rather than trainees, to receive little supervision and minimal attention for the difficulty of assigned cases. Although interns need opportunities to work with difficult cases, they also need opportunities to experience success, particularly when working with a certain population for the first time. Alison was my first adolescent client. I was expected to see her without prior supervision, and as well, without concurrent supervision to guide me in which interventions would be most useful and which interventions would challenge her defenses too quickly. There is a profound need for research into just

how much supervision the average social work intern is getting in their field placements, the quality of care clients are getting from their counselors-in-training, and the level of difficulty interns are expected to handle in their first clinical cases.

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