Micro Theory paper

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History

Amy is a 6-year old girl who resides with her biological parents, two older sisters and one older brother. Her father, Mr. Harrison ran his own software company before retiring just a few months ago. Her mother, Mrs. Harrison is the director of sales for a major insurance company. The Harrison's jobs often called for them to travel out of state and they often used their friend and neighbor Mrs. James to watch their two youngest children, Amy and Adam, while away on business for a few days.

Almost a year ago Mrs. James revealed to Mrs. Harrison that when they were watching Amy overnight she had walked in and caught her 14-year old son touching Amy's private parts. Mrs. James insisted that they were kids and it was natural as they were just experimenting however, Mrs. Harrison rejected this and contacted the authorities. The local police department along with the Department of Children's Services came in to investigate the case. The social worker also tried to play with Barbie's in an effort to get Amy to divulge information. However, after an hour of this Amy had not told the social worker anything. The Department of Children services did enact guidelines that kept the James's 14-year old son away from Amy. The Harrisons are a very supportive family and wanted to ensure their daughter got the help she needed and entered her into therapy at a local counseling center.

Theories

The theories that I would consider using with Amy would be family emotional systems theory and the narrative theory. I would also use the cognitive theory and behavior theory combined (CBT). Due to the young age of the victim and her having a supporting family I

believe that these three theories would not only help the victim but also the family as they learn to function together after the incident. Active involvement of parents or other caregivers is essential to maximize the benefits of treatment for children after sexual assaults (Miller, Cardona, & Hardin).

Family emotional systems theory provides a comprehensive conceptual framework for understanding how emotional ties within the family influence the lives of the other individuals in the family (Walsh, 2010). The theory would be useful in helping the family and the victim interact with one another since the incident. Many times, families of the victim will face their own set of challenges such as a lack of understanding about the therapeutic process and the developmental limitations of the child. With the daughter being a victim of molestation she may be withdrawn from others as well as her family. Both the family and Amy may need some help in dealing with the incident and knowing how to talk about it should it arise in the future. A genogram could be used here to help the family gain insight into how they interact with one another and see how their support can enhance the other family members function. It could also help the members come up with ways in which to better enhance family functioning. The family could also be facing triangulation issues in that often times both parents will be focusing on the child and her problems and can cause conflict between their own relationship and that of their other children. The parents may also feel so overwhelmed by the incident and feel angry that it happen which can cause conflict between the two. They would need to be cautious not to use parental projection when these problems arise. Often time's children would be the focus of projection since they are vulnerable family members. The family emotional systems theory would be able to help the family deal with sensitive issues such as the molestation while at the

same time minimizing interpersonal tensions between members (Becker-Wiedman, & Hughes, 2008).

The Narrative therapy has also been shown to help victims of molestation. The narrative therapy is based on the idea that people's lives and relationships are shaped by their life stories and the ways of life they develop based on those stories (Miller, Cardona, &Hardin, 2006). This type of therapy gives the victim an opportunity to tell about the incident in their own words and from their perspective. Many times in child molestation cases the child will come away thinking they did something wrong or were "bad" for having any such involvement in the incident. The victim will often experience a loss of bodily integrity, a void of self-worth, and the destruction of any feelings of safety (Walsh, 2010). The narrative therapy has been successful in the treatment of painful memories and the consequences of the abuse (Miller, Cardona, & Hardin, 2006). Narrative therapy considers that the problem oppresses the individual and aims at liberating the victim from such oppression (Walsh, 2010). In narrative therapy a process of externalizing is often used with child sexual victims. Externalizing encourages the victim to identify the problems that they experience as oppressive. This can be extremely useful with victims who have feelings of guilt and shame. The narrative therapy has been useful in the treatment of child sexual assault victims and provides a road map for exploring the individual current stories of the victim and ways in which they live out their preferred stories (Miller, Cardona, & Hardin, 2006). This type of therapy cannot only be used with the victim but also with the other members of the family. Although both of the previous types of treatment could be beneficial to both the victim and the family I believe the type of therapy I would use with Amy would be cognitive behavior therapy.

Cognitive behavior therapy is derived from both the cognitive theory and the behavior theory and helps patients to understand the thoughts and feelings that influence behaviors. The main goal of CBT is to help the client understand that our thoughts and feelings play a fundamental role in our behavior (Walsh, 2010). Cognitive behavior therapy is used to treat many different disorders such as anxiety, depression, and post-traumatic stress. The main reason I chose this type of treatment for the victim is because it helps the client develop coping skills that can be useful both now and in the future, which is imperative to victims of child sexual assault (Becker-Weidman, & Hughes, 2008).

Problem

Since the incident Amy has been experiencing problems such as fear and anxiety, nightmares, isolation, school difficulties, and low self-esteem. She has also been showing symptoms of Posttraumatic stress disorder and negative effects on her self-perception. Research has shown that childhood abuse disrupts the victim's development by creating cognitive distortions of themselves, others and the future (Ross, & O'Carroll). Using cognitive behavior therapy I would focus on her coping mechanisms for reducing her anxiety and fear at the onset of therapy due to that fact that recalling the trauma first could increase these symptoms. In CBT the role of the counselor is to help facilitate Amy's emotional growth, which has been disrupted by the incident (Walsh, 2010). I will focus on trying to reduce Amy's negative emotional and behavioral responses to the sexual abuse and correct maladaptive beliefs and attributions related to the trauma.

Concepts

The major concepts of CBT combine the fundamental concepts of both behavioral therapy and cognitive therapy. Behavioral therapy focuses on how an individual's behaviors are

contributing to and maintaining their symptoms and difficulties (Walsh, 2010). Cognitive behavior therapy addresses three factors such as cognition, emotion, and behavior, and how they relate to each other. When a cognitive distortion is observed with the client I would try and replace such thoughts with other acceptable, alternative thoughts (House, 2006). In Amy's case she has been feeling ashamed about the incident and this has led to her being isolated or withdrawing from others around her. In therapy I would attempt to try and change the way she viewed the trauma which in turn would change her feelings and behavior. If Amy saw the incident as no fault of her own and that adults are responsible for the safety of children then maybe her feeling would change and then her actions would also be altered.

Assessment Tools

When assessing Amy I used several different types of assessment tools such as assessment information from her parents, casual observations, clinical interviews, non-directive play sessions, and the Kaufman Assessment Battery for Children (K-ABC). I first met with Mr. and Mrs. Harrison and obtained information about Amy's functioning in a variety of settings such as home, school and neighborhood. I also had them fill out the Child Behavior Checklist which consisted of 118- item instrument that had them report the presence and frequency of a wide range of behavioral problems (Bacon, 2008). I then conducted some casual observations. This was done while Amy and her mother where in the waiting room prior to the appointment. I noted how she interacted with the other children in the waiting room as well as the agency personal. This allowed me to see how she engages with other individuals while not being formally evaluated. The Kaufman Assessment Battery for Children was also filled out. The test is structured for children 3 to 12 years old so Amy fit perfect for this test. This test gave me a better understanding of where Amy was intellectually which would help direct my meetings with

her (Ross, & O'Carroll, 2004). I then brought Amy in for a clinical interview. During our first session I had Mrs. Harrison join us in the room and although working with them both simultaneously created a challenge it was somewhat helpful to involve her so that she could reinforce the ideas outside the session (Jones, & Morris, 2007). She continued to want her mother in the room for the next couple sessions as this made her feel more comfortable. As the sessions progressed I meet with Amy one on one and we conducted some non-directive pay sessions in which Amy was free to talk as much as she felt comfortable doing as this was not imperative during these sessions. During these sessions there were no specific goals or objectives but I just conducted a careful observation and examination of her. During these sessions I let her lead the play session. This was done in an attempt to see how Amy acted when she had the ability and freedom to choose a pretend situation in which to play. This also gave me a chance to see if Amy can adopt roles and characteristics during play and did she have the capacity to engage in pretend or symbolic play (Bacon, 2008).

Interventions

The interventions I found were most appropriate for Amy's case concentrated on education which included Keeping Safe Work; Yes and No feelings, Good and Bad touches, who to tell, and saying No (Jones, & Morris, 2007). We then started to focus more on the impact of the incident. We implemented cognitive behavior strategies that addressed her thinking patterns about the issue. The gradual exposure of the abuse experiences helped Amy reduce her anxiety and embarrassment and provided her the opportunity to modify inaccurate or self-defeating thinking processes. We used cognitive restricting strategies to help deal with her thinking patterns that are distorted and contributed to her problem development. We looked at alternative ways of approaching challenges and talked about the ABC model. She seemed to comprehend

how the event or trauma led to her beliefs about what happened led to her emotions. We also talked about cognitive coping in which we looked at new ways of dealing with her stress and negative moods. Although she is too young to master these skills she will at least be able to identify when this happens and think about other ways in which to handle her emotions. We discussed problem-solving skills development however I don't believe she comprehended this although we will continue with this in the future (Walsh, 2010).

I encouraged her to express her feelings about the trauma and talked about abuse prevention skills. We also used specific drawing tasks in which she would draw "What Happened" (Becker-Weidman, & Hughes, 2008). This gave her the opportunity to recount the experience in detail. The drawing appeared to reduce her anxiety and helped her feel more comfortable in the meeting room. She seemed to be more comfortable using visual communication than talking about the painful feelings and experiences. I also used a pre-structured body outline in which Amy was given a piece of paper with a boy and girl on it and she would draw different body parts different colors. This helped Amy to talk and think about the event without embarrassment or significant anxiety. The most important aspect of the intervention was that I had to respect her need to take things at her own pace during therapy. In future sessions we also plan on discussing her relationships with other family members and her role in the family.

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