Evaluation of a Group Therapy Program for Boys Who Have Experienced Sexual Abuse

by

Alana D. Grayston

A Thesis

Submitted to the Faculty of Graduate Studies

in Partial Fulfillment of the Requirements for the Degree of

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ALANA D. GRAYSTON

A Thesis submitted to the Faculty of Graduate Studies of the University of Manitoba in partial fulfillment of the requirements for the degree of

MASTER OF ARTS

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Abstract

The present study was designed to evaluate the utility of a group therapy program for boys who have experienced sexual abuse. Twelve boys, ranging in age from 7 to 10, participated in the study. Six of the boys attended a 12-week group treatment program at the University of Manitoba, while the remaining six children were assigned to a wait-list comparison group. Measurements of self-esteem, depression, social competence, and various behavioral and emotional problems were made for participating children on two separate occasions. Information regarding the social validity of the treatment program was also collected from group participants and their caregivers following group termination. It was hypothesized that boys involved in the treatment program would experience improvements in adjustment and behavior over the course of the group intervention, and that these improvements would be greater than those of boys in the comparison group. Although analyses indicated that children in the group therapy condition did experience improvements over the course of the intervention, the effects of the program tended to vary from child to child, with changes for group participants being statistically comparable to those for boys assigned to the wait-list comparison condition. Social validity data obtained from group participants and their caregivers following group termination indicated that the therapy program was both helpful and worthwhile. Implications of the present findings are discussed and suggestions are offered regarding future research and clinical work.

Evaluation of a Group Therapy Program for Boys

Who Have Experienced Sexual Abuse

In recent years, child sexual abuse has become an issue of major concern for clinicians and researchers in the field of mental health (Hiebert-Murphy, De Luca, & Runtz, 1992). Discussion and documentation of its alarming prevalence (e.g., Badgley, 1984; Finkelhor, Hotaling, Lewis, & Smith, 1990) and potentially deleterious mental health effects (e.g., Alter-Reid, Gibbs, Lachenmeyer, Sigal, & Massoth, 1986; Browne & Finkelhor, 1986; Finkelhor, 1990; Hiebert-Murphy & De Luca, 1992; Kendall-Tackett, Williams, & Finkelhor, 1993) have resulted in concerted efforts on the part of professionals to develop treatment strategies for children and adults who have experienced sexual abuse (e.g., Courtois, 1988; De Luca, Boyes, Furer, Grayston, & Hiebert-Murphy, 1992; Friedrich, 1990; Meiselman, 1990).

Although many therapeutic modalities have been used in the treatment of sexual abuse, group therapy has recently emerged as a popular intervention (Forseth & Brown, 1981; Sturkie, 1992). Several clinicians (e.g., Berliner & Ernst, 1984; Carozza & Heirsteiner, 1982; Sgroi, 1992) have outlined the potential benefits of group treatment for children who have been sexually abused, with many touting it as "the treatment of choice" (Steward, Farquhar, Dicharry, Glick, & Martin, 1986, p. 263) in cases of victimization.

Although many clinicians have described group therapy programs for girls who have been sexually abused (e.g., Berman, 1990; Carozza & Heirsteiner, 1982; Corder, Haizlip, & DeBoer, 1990; Delson & Clark, 1981; De Luca, Boyes, Cairns, Gilman, & Grayston, 1991; De Luca, Grayston, Boyes, & Romano, 1992; De Luca, Hazen, & Cutler, in press; Gagliano, 1987; Grayston, De Luca, Boyes, & Romano, 1992; Hazzard, King, & Webb, 1986; Hiebert-Murphy et al., 1992; Kitchur & Bell, 1989; Lubell & Soong,

1982; Mrazek, 1981; Nelki & Watters, 1989; Pescosolido & Petrella, 1986; Sturkie, 1983), relatively few practitioners have described group interventions for boys (Sturkie, 1992; for exceptions, see De Luca, Hiebert-Murphy, Runtz, & Wallbridge, 1989; Hack, Osachuk, & De Luca, in press; Leith & Handforth, 1988; Peake, 1987; Schacht, Kerlinsky, & Carlson, 1990). Likewise, although preliminary efforts have been made to evaluate group treatment programs for girls (e.g., De Luca et al., 1991, in press; De Luca, Boyes, Grayston, & Romano, 1993; De Luca, Grayston, Boyes, & Romano, 1992; Grayston, De Luca, Boyes, & Romano, 1992; Hiebert-Murphy et al., 1992), there is an overall paucity of empirical research examining treatment effects (De Luca, Boyes, Furer, Grayston, & Hiebert-Murphy, 1992; Friedrich, 1989; Friedrich, Luecke, Beilke, & Place, 1992; Haugaard & Reppucci, 1988; Hoier, 1987; Kolko, 1987; O'Donohue & Elliott, 1992; Sturkie, 1992; Waterman, MacFarlane, Conerly, Damon, Durfee, & Long, 1986), especially outcomes for males (Hack et al., in press; Watkins & Bentovim, 1992). Indeed, at the present time, there are few "published research studies which systematically evaluate the treatment of sexually abused boys" (Watkins & Bentovim, 1992, p. 233).

The present study was designed to systematically assess the effects of sexual abuse on boys and to evaluate the utility of a group therapy program in redressing these negative sequelae. Methodological controls which have been largely absent in previous treatment research (e.g., wait-list comparison groups; O'Donohue & Elliott, 1992) were employed in the present study, in an effort to more rigorously explore the effectiveness of group treatment techniques with this particular client population.

Sexual Abuse of Children

Over the past decade, there has been a surge of interest in the area of sexual abuse, with many professionals working to document its prevalence, nature, and effects. Until

very recently, however, most researchers and clinicians have devoted their attention to the abuse of women and girls, virtually ignoring and neglecting the needs of males who have experienced sexual abuse (Blanchard, 1986; Hunter, 1990; Lew, 1988; Nasjleti, 1980). As a result of this long period of professional neglect, there is a paucity of empirical and clinical work focusing on victimized boys (Finkelhor, 1981; Rogers & Terry, 1984; Watkins & Bentovim, 1992).

Research on abused boys has been limited, in large part, by professional and public perceptions that male victimization is a rare and uncommon event, and that sexual abuse of boys does not have deleterious effects (Watkins & Bentovim, 1992). Although few well-controlled studies have explored these issues in depth, preliminary evidence strongly suggests that boys are sexually abused at significant rates and that they frequently experience negative sequelae in childhood and later, in adulthood (Vander Mey, 1988; Watkins & Bentovim, 1992).

Prevalence of Sexual Abuse

Estimates of the prevalence of sexual abuse tend to vary widely, depending on the particular populations that are studied, the definitions of abuse that are used, and the types of questions that are asked regarding sexual victimization (Watkins & Bentovim, 1992). Prevalence rates for females, for example, range from 6% to 62%, while comparable rates for males vary from 3% to 30% (Peters, Wyatt, & Finkelhor, 1986). In Canada, recent research suggests that as many as one in two females and one in three males are "victims of unwanted sexual acts" (p. 175) at some point in their lives, with 80% of these acts first occurring when the person is a child or youth (Badgley, 1984). Research involving specialized populations, such as adolescent runaways (Janus, Burgess, & McCormack, 1987) and individuals receiving inpatient psychiatric care

(Kolko, Moser, & Weldy, 1988), also report relatively high rates of child sexual abuse (e.g., 28% to 38%).

Although these estimates suggest that sexual abuse is a problem of major proportions, there is a general consensus among professionals that abuse is underreported and that current figures underestimate the true scope of sexual abuse, especially for victimized boys (Finkelhor & Baron, 1986; Porter, 1986; Sebold, 1987; Watkins & Bentovim, 1992). Factors that may partially account for underreporting in children include insufficient language skills, immaturity, and intense fear of the consequences that disclosures of abuse may bring (Watkins & Bentovim, 1992). Additional factors that may contribute to underreporting in males include fears of being considered homosexual (Everstine & Everstine, 1989; Finkelhor, 1984; Nasjleti, 1980; Porter, 1986; Watkins & Bentovim, 1992) and cultural stereotypes regarding masculine roles and behavior (Nasjleti, 1980; Waterman & Lusk, 1986).

Nature of Sexual Abuse

According to recent reports, boys are generally abused by male sex offenders (Ellerstein & Canavan, 1980; Faller, 1989; Finkelhor, 1981, 1984; Reinhart, 1987; Vander Mey, 1988). Although sexual abuse by females also does occur (Banning, 1989; Chasnoff, Burns, Schnoll, Burns, Chisum, & Kyle-Spore, 1986; Johnson, 1989a, 1991), the bulk of existing evidence strongly suggests that there is a "male monopoly on child molesting" (Finkelhor, 1986a, p. 126) for boys as well as for girls.

Evidence regarding the types of abuse most commonly experienced by males is, unfortunately, much less conclusive. Although several studies of reported cases have found that boys are more likely than girls to experience extrafamilial sexual abuse (e.g., Finkelhor, 1981, 1984; Kendall-Tackett & Simon, 1992; Rogers & Terry, 1984; Vander Mey, 1988) and abuse by unknown offenders (e.g., Tong, Oates, &

McDowell, 1987), other investigations have found that boys are frequently abused by nonblood relations residing in their homes (e.g., Faller, 1989) as well as by family members (e.g., Kendall-Tackett & Simon, 1992). What does appear clear is that boys are often victims of adolescent sex offenders (Finkelhor, 1981; Reinhart, 1987; Rogers & Terry, 1984).

Preliminary evidence from a small number of studies suggests that several factors may distinguish between male and female children who have experienced sexual abuse (for a review, see Watkins & Bentovim, 1992). Boys, for example, may be more likely than girls to experience forceful abuse (Pierce & Pierce, 1985) and concomitant physical maltreatment (Finkelhor, 1984), may be less willing to disclose their victimization to others (Dimock, 1988), and may be more likely to experience specific forms of sexual abuse, such as anal intercourse (Kendall-Tackett & Simon, 1992) or orogenital contact (Pierce & Pierce, 1985). Although data are extremely limited, preliminary evidence also suggests that boys, as compared to girls, are less likely to be removed from their families following sexual abuse and are also likely to receive less therapeutic intervention (Pierce & Pierce, 1985).

According to Watkins and Bentovim (1992), these reported patterns of abuse are very different from those found in nonclinical community samples. What this may suggest is that "only the most severely sexually abused boys are being detected and referred" (Watkins & Bentovim, 1992, p. 214) at the present time.

Effects of Sexual Abuse

Over the past decade, a great deal of empirical research and clinical work has been conducted to ascertain the short- and long-term effects of child sexual abuse. Although much of this work is weakened by methodological problems (e.g., lack of standardized measures, small samples, absence of comparison groups; Browne & Finkelhor, 1986;

Hiebert-Murphy & De Luca, 1992; Watkins & Bentovim, 1992), rarely explores the effects of abuse on sexually victimized males (Hiebert-Murphy & De Luca, 1992; Watkins & Bentovim, 1992), and often fails to distinguish true effects of sexual abuse from factors that may potentially pre-date victimization, initial evidence seems to suggest "that sexual abuse is a serious mental health problem" (Browne & Finkelhor, 1986, p. 72) for many children and adults.

The effects of victimization vary substantially from child to child (Conte & Schuerman, 1987; Haugaard & Reppucci, 1988), but accumulating clinical and empirical evidence suggests that many sexually abused children may be prone to adjustment problems in childhood and adolescence, as well as later on, in adulthood (e.g., Alter-Reid et al., 1986; Browne & Finkelhor, 1986; Finkelhor, 1990; Hiebert-Murphy & De Luca, 1992; Kendall-Tackett et al., 1993). Low self-esteem (Cavaiola & Schiff, 1989; Grayston, De Luca, & Boyes, 1992; Singer, 1989) and multiple symptoms of depression (Briere, Evans, Runtz, & Wall, 1988; Dimock, 1988; Inderbitzen-Pisaruk, Shawchuck, & Hoier, 1992; Porter, Blick, & Sgroi, 1982) are among the short- and long-symptoms most commonly observed. Other commonly cited sequelae of child sexual abuse include impairments in social competence (Tong et al., 1987), internalizing and externalizing behavior problems (Einbender & Friedrich, 1989; Friedrich, Beilke, & Urquiza, 1988; Friedrich, Urquiza, & Beilke, 1986; Inderbitzen-Pisaruk et al., 1992; Tong et al., 1987), and disrupted sexual development and premature sexualization (Beitchman, Zucker, Hood, DaCosta, & Akman, 1991; Einbender & Friedrich, 1989; Friedrich, 1993; Friedrich et al., 1986, 1988; Gale, Thompson, Moran, & Sack, 1988; Inderbitzen-Pisaruk et al., 1992; Kolko et al., 1988; Tharinger, 1990; Yates, 1982).

Self-Esteem. Self-esteem, defined as one's customary self-evaluation (Coopersmith, 1967, 1981), is a critical component of a person's overall social-emotional adjustment (Pope, McHale, & Craighead, 1988), and can crucially affect many aspects of an individual's life (Phillips & Bernstein, 1989). Low self-esteem has been linked with host of serious problems, including self-destructive behavior (Dawson, 1984), loneliness and isolation (Peplau & Perlman, 1982), and feelings of anxiety and fear (Coopersmith, 1967). According to clinical and empirical reports, deficits in self-esteem are also commonly related to experiences of sexual abuse, with many abused children, adolescents, and adults exhibiting negative self-perceptions (German, Habenicht, & Futcher, 1990; Grayston, De Luca, & Boyes, 1992; Jackson, Calhoun, Amick, Maddever, & Habif, 1990).

Depression. Feelings of depression are commonly observed in victims of sexual abuse (Berliner & Ernst, 1984; Inderbitzen-Pisaruk et al., 1992; Pound, Koverola, & Heger, 1990), with almost all reporting some symptoms prior to or following disclosure of abuse (Porter et al., 1982). Existing evidence suggests that victims of all ages are prone to depressive symptoms, with many children, adolescents, and adults exhibiting these symptoms of emotional distress (Lusk & Waterman, 1986).

Social Competence. Deficits in social competence are also displayed by many children experiencing sexual abuse (Tong et al., 1987). Recent reports suggest that victimized boys and girls often exhibit more disturbed social behavior (Tong et al., 1987), less involvement in age-appropriate activities (Tong et al., 1987), and lower school competence (Tong et al., 1987) than do samples of boys and girls who have not been sexually abused.

Internalizing and Externalizing Behavior Problems. According to recent reports, children who have been sexually abused often exhibit more behavior problems than do

normative samples of children or those who have not experienced abuse (Cohen & Mannarino, 1988; Friedrich et al., 1986, 1988; Tong et al., 1987). Internalizing behaviors (e.g., depression, anxiety, and fear) are commonly seen in children (Cohen & Mannarino, 1988; Einbender & Friedrich, 1989; Friedrich et al., 1986; Inderbitzen-Pisaruk et al., 1992; Tong et al., 1987), with 35% to 46% of victims in one study displaying these negative reactions (Friedrich et al., 1986). Externalizing behavior problems (e.g., aggression, cruelty, and anger) are commonly observed as well (Cohen & Mannarino, 1988; Einbender & Friedrich, 1989; Friedrich et al., 1986; Inderbitzen-Pisaruk et al., 1992; Tong et al., 1987), with recent reports suggesting that at least 36% (Friedrich et al., 1986) to 52% (Einbender & Friedrich, 1989) of victims exhibit these symptoms of distress.

Sexual Behavior Problems. Sexual behavior problems (e.g., excessive or public masturbation, touching of others' private parts, imitation of sexual acts, exposure of one's private parts to others) are also displayed by many children experiencing sexual abuse (Einbender & Friedrich, 1989; Friedrich, 1993; Friedrich et al., 1986, 1988; Gale et al., 1988; Inderbitzen-Pisaruk et al., 1992). According to Everstine and Everstine (1989), "overt sexual behavior on the part of a child is frequently a cry for help" (p. 6) or a means of testing the "safety" of other children and adults. Such behaviors can also represent attempts to "work through" or master the sexual abuse (Everstine & Everstine, 1989), or may simply result from a child's confusion of sex with affection and love (Yates, 1982). Whatever their specific origins, these behaviors are very common, occurring in large numbers of children who have experienced sexual abuse.

Effects That May Be More Specific To Boys

Through their clinical work, Rogers and Terry (1984) have identified several additional reactions to experiences of sexual abuse that may be more or less specific to boys. Though suggestive, their observations are largely unconfirmed by empirical research, and may, in reality, apply equally well to girls who have been sexually abused.

Anxiety and Confusion Regarding Sexual Identity. Anxiety and confusion regarding sexual identity appear to be frequently observed in boys who have experienced sexual abuse (Blanchard, 1986; Johnson & Shrier, 1985; Rogers & Terry, 1984). According to Rogers and Terry (1984), these concerns commonly result from the tendency of boys to blame themselves for their selection as abuse victims. Such concerns can be exacerbated if boys perceive their failure to resist the abuse as a sign of weakness or complicity or if they experienced pleasurable sensations during homosexual abuse (Rogers & Terry, 1984; Watkins & Bentovim, 1992).

Inappropriate Attempts to Reassert Masculinity. Inappropriate attempts to reassert masculinity through aggressive forms of behavior may also be a common behavioral reaction in boys who have experienced abuse (Rogers & Terry, 1984). According to Rogers and Terry (1984), this aggressive behavior is an attempt by boys to re-establish their masculinity and thereby resolve some of their confusion and sexual identity concerns. For some boys, such aggressiveness may also represent an attempt to ward off further abuse (Rogers & Terry, 1984; Sebold, 1987). Although verbal and physical violence are the most common forms of aggression displayed by boys who have been sexually abused, Rogers and Terry (1984) have also observed other types of aggressive behavior, including destruction of property and chronic disobedience.

Recapitulation of the Victimization Experience. Recapitulation or repetition of the victimization experience, while less common than other reactions to child sexual abuse,

sometimes occurs among boys (and girls) who have experienced victimization (Rogers & Terry, 1984). According to several authors (e.g., Freeman-Longo, 1986; Napier-Hemy, 1991; Rogers & Terry, 1984; Ryan, 1989; Ryan, Lane, Davis, & Isaac, 1987), the apparent need of many children to reenact their abuse with someone else in the role of the victim appears to be an extreme attempt on their part to reassert their masculinity and regain a sense of power by identifying with the offender. Alternately, it may be construed as an attempt by boys to master their anxiety (Ellis, Piersma, & Grayson, 1990) or shame (Weille, 1992), to understand their experiences (Napier-Hemy, 1991; Rogers & Terry, 1984), or to impress upon significant others the impact of their victimization (Napier-Hemy, 1991; Rogers & Terry, 1984). Finally, recapitulation of the abuse may "reflect acceptance of a negative self-concept...with the child acting out the most negative behavior of which he is aware" (Rogers & Terry, 1984, p. 97).

Although recapitulation of abuse is said to be relatively rare (Conte & Schuerman, 1988), several recent studies of clinical populations (e.g., Cantwell, 1988; Chasnoff et al., 1986; Friedrich, 1991; Friedrich et al., 1988; Friedrich & Luecke, 1988; Johnson, 1988, 1989a, 1991; Johnson & Berry, 1989; Roane, 1992; Sansonnett-Hayden, Haley, Marriage, & Fine, 1987; Smith & Israel, 1987; Weille, 1992) have suggested that a substantial number of sexually abused children exhibit abusive behaviors to others. Offender-like behaviors, however, may be one of the major factors influencing referrals of children for treatment services, and as a result, may be less commonly found in nonclinical samples of children. Nevertheless, research with adolescent and adult sex offenders also suggests a potential link between offending behavior and early experiences of sexual abuse (Becker, 1988; Groth, 1979).

According to Watkins and Bentovim (1992), these findings are a source of great concern and considerable practical importance, and if confirmed by further research, suggest that "sexually abused boys need to have included in their therapy programmes a component which targets perpetrator prevention strategies" (p. 219). The treatment program used in the present study included activities that focused specifically on abusive behaviors, in an effort to reduce the short- and long-term likelihood of offending behavior in males.

Treatment of Sexual Abuse

Although many therapeutic modalities have been used in the treatment of sexual abuse, including individual and family therapy, group treatment programs have recently emerged as popular interventions (Forseth & Brown, 1981; Sturkie, 1992). While many methods of treatment may benefit children who have been sexually abused, there is a general consensus among practitioners "that group work is invaluable" (Watkins & Bentovim, 1992, p. 233), and that it may be "the treatment of choice" (Steward et al., 1986, p. 263) in cases of sexual abuse.

Several clinicians (e.g., Berliner & Ernst, 1984; Carozza & Heirsteiner, 1982; Sgroi, 1992) have recently outlined the potential benefits of group treatment for children who have been sexually abused, identifying a number of reasons why groups may be especially effective in meeting the needs of victimized boys and girls. Potential advantages of group programs may include cost-effectiveness (Haugaard & Reppucci, 1988), opportunities to meet others who have experienced similar abuse (which may help to reduce the sense of isolation and "differentness" reported by many victimized children; Berliner & Ernst, 1984), opportunities to develop support networks outside the family home (Peake, 1987), and opportunities to learn a variety of age-appropriate skills (e.g., social and problem-solving skills; Hall, 1978; Hazzard et al., 1986).

Although clinicians have recently supplied descriptions and preliminary evaluations of group therapy programs for girls who have been sexually abused (e.g., De Luca et al., 1991, 1993, in press; De Luca, Grayston, Boyes, & Romano, 1992; Grayston, De Luca, Boyes, & Romano, 1992; Hiebert-Murphy et al., 1992), there is an overall paucity of empirical research examining outcomes for boys (Hack et al., in press; Watkins & Bentovim, 1992). Moreover, in the few research studies which have offered evaluations of group treatment programs for boys (e.g., Leith & Handforth, 1988; Schacht et al., 1990), there is an overall absence of statistical analyses and standardized assessment techniques, with evaluations of treatment outcome based primarily on anecdotal impressions of therapists or other significant adults (e.g., parents).

This dearth of systematic quantitative research was one of the factors prompting the work of De Luca and her associates (De Luca et al., 1989; Hack et al., in press) at the University of Manitoba. Although this research is still in its preliminary stages, initial findings suggest that group treatment for males may be a promising means of reducing the negative sequelae of sexual abuse, as assessed by standardized scales. Boys, for example, generally experience increases in self-esteem and decreases in depression following group treatment, as well as reductions in parent-reported internalizing and externalizing behavior problems (e.g., Hack et al., in press). Similar findings have also been found in treatment outcome research with girls (e.g., De Luca et al., 1991, 1993, in press; De Luca, Grayston, Boyes, & Romano, 1992). Preliminary studies conducted by other professionals (e.g., Friedrich et al., 1992) also suggest that therapy groups, in combination with other treatment techniques, may be effective in reducing internalizing, externalizing, and sexual behavior problems in boys, although they appear to have limited effects on self-reports of emotional adjustment.

The present study was designed to build upon the preliminary work of De Luca and her associates (De Luca et al., 1989; Hack et al., in press) and thereby extend clinical knowledge regarding the utility of group treatment programs for boys who have been sexually abused. Unlike most previous group treatment research, the present study included a wait-list comparison group of sexually abused boys in an effort to more rigorously evaluate the effectiveness of group techniques with this particular client population. Although many practitioners contend that it is ethically indefensible to use wait-list controls to assess the utility of a given treatment (e.g., Friedrich, 1989), other professionals (e.g., Haugaard & Reppucci, 1988) have expressed an alternate point of view, suggesting that "treatment may not be beneficial to all child sexual abuse victims, and consideration of delaying treatment for some victims in order to test this hypothesis may be appropriate" (p. 184) at this time. Without increased use of methodological controls, "the field will be placed in a position of not knowing the extent to which the specifics of an intervention actually are helpful" (O'Donohue & Elliott, 1992, p. 226). Such "controls are also necessary to assess the possibility of iatrogenesis (i.e., unintended negative effects)" (O'Donohue & Elliott, 1992, p. 226) of the treatment procedures.

Like previous group treatment research at the University of Manitoba (e.g., De Luca et al., 1989, 1991, 1993, in press; De Luca, Boyes, Furer, Grayston, & Hiebert-Murphy, 1992; De Luca, Grayston, Boyes, & Romano, 1992; Grayston, De Luca, Boyes, & Romano, 1992; Hack et al., in press; Hiebert-Murphy et al., 1992), the present study employed a range of standardized and nonstandardized measures to assess the adjustment and progress of children referred to the therapy program and to evaluate the social validity of the therapy group. The standard assessment battery employed in previous research was modified in the present study to include measures tapping

additional areas of adjustment believed to be affected by experiences of child sexual abuse (e.g., social competence, sexually aggressive and provocative behavior, overall behavioral and emotional problems). In addition, the assessment battery included measures designed to evaluate participating children from multiple points of view (e.g., examining both children's and caregivers' perspectives of the children's adjustment). Finally, the assessment battery included normative assessment scales as well as more idiographic and molecular measures of children's behavioral adjustment (i.e., parent observations of specific behavioral problems). As noted recently by Hoier (1991), the use of molecular, individualized measures has been a neglected area in treatment outcome research.

Based on the results of existing treatment research (e.g., De Luca et al., 1989, 1991, 1993, in press; De Luca, Grayston, Boyes, & Romano, 1992; Friedrich et al., 1992; Grayston, De Luca, Boyes, & Romano, 1992; Hack et al., in press; Hiebert-Murphy et al., 1992) and current knowledge regarding the effects of child sexual abuse (e.g., Alter-Reid et al., 1986; Browne & Finkelhor, 1986; Finkelhor, 1990; Hiebert-Murphy & De Luca, 1992; Kendall-Tackett et al., 1993), it was hypothesized that:

1. Children involved in the treatment program would experience improvements in self-reported adjustment and behavior over the course of the group intervention. More specifically, it was expected that boys would experience improvements in functioning in the areas of: (a) self-esteem and (b) depression.

2. Children involved in the treatment program would experience improvements in parent-reported adjustment and behavior over the course of the group intervention. More specifically, it was expected that boys would experience improvements in functioning in the areas of: (a) social competence, (b) internalizing behavior, (c) externalizing behavior, (d) total behavior, (e) sexual behavior, and (f) overall

behavioral and emotional concerns. In addition, it was hypothesized that children would experience improvements in other behaviors, as assessed by parent observations of behavioral problems at home.

3. Children involved in the treatment program would experience greater improvements in self-reported behavior over the course of the group intervention than would a comparable group of boys in a wait-list comparison condition. More specifically, it was expected that treated boys would experience greater improvements in functioning in the areas of: (a) self-esteem and (b) depression.

4. Children involved in the treatment program would experience greater improvements in parent-reported behavior over the course of the group intervention than would a comparable group of boys in a wait-list comparison condition. More specifically, it was expected that treated boys would experience greater improvements in functioning in the areas of: (a) social competence, (b) internalizing behavior, (c) externalizing behavior, (d) total behavior, (e) sexual behavior, and (f) overall behavioral and emotional concerns. In addition, it was hypothesized that children in the treatment group would experience greater improvements in other behaviors, as assessed by parent observations of behavioral problems at home.

Method

Participants

Two groups of children participated in the present investigation. Each group consisted of six males referred to the treatment program by provincial agencies mandated to protect and care for children, by individual parents, and by community organizations (e.g., Child Guidance Clinic, Child Protection Centre, Children's Home of Winnipeg, Manitoba Justice Child Abuse Witness Program). Referrals were included in the groups if: (a) they were males between the ages of 7 and 10 years; (b) they had

disclosed third-party or intrafamilial sexual abuse perpetrated by one or more offenders; (c) they were living in relatively stable family settings, away from the offender(s); (d) they were considered, based on information provided by caregivers and referral sources, and on a brief interview and assessment conducted by the therapists, to be suitable candidates for participation in the group treatment program, and to have no characteristics (e.g., severe behavioral problems or developmental disabilities) which would make group treatment an inappropriate intervention; (e) they were interested in joining a group to address issues surrounding their victimization; and (f) their parents or guardians consented to their involvement in the treatment program and related research study.

Fifteen boys were formally referred to the group therapy program, with 12 of these ultimately participating in the present investigation. Two of the initial 15 referrals were excluded from the program due to the severity of their behavioral problems, which therapists felt could be better addressed through individual treatment. A third referral did not participate in the program, as his family appeared reluctant to pursue treatment for him at the present time.

Although efforts were made to keep each group of children as homogeneous as possible and to either randomly assign children to groups or match them on such variables as age, relationship to the perpetrator, and type of abusive experience, practical realities greatly interfered with these attempts. Lengthy delays in obtaining referrals for the program, combined with the ethical problems inherent in withholding treatment from children for an extended period of time, necessitated adherence to a less rigorous research design in which children were assigned to groups on the basis of when they were referred to the program (i.e., the first group of children was composed of the initial six suitable referrals, while the second group consisted of the last six boys).

Although this method of group assignment was not the preferred approach, it was certainly very consistent with the practical realities of clinical work, and, ultimately appeared to produce groups that were reasonably comparable on major characteristics (see Tables 1 and 2; all names used are fictitious).

All of the participants involved in the present study were from families of low to medium socioeconomic status. Ten of the boys were Caucasian, while two children were of African-Canadian descent. With the exception of one child, all boys resided with one or more of their biological parents throughout the investigation (seven boys lived in single-parent homes with biological mothers, four children resided in two-parent homes with biological mothers and various father-figures, and one child lived in a two-parent foster home setting). At least seven of the children had experienced physical or psychological abuse in addition to sexual victimization, and at least four boys and their families were receiving additional therapeutic services (e.g., some individual or family therapy sessions) from sources external to the group treatment program.

Following completion of intake and assessment procedures (see procedure section below), the first group of boys (i.e., the first six suitable referrals) participated in a 12-week group therapy program at the Psychological Service Centre. The second group of boys (i.e., the second six referrals) was placed on a temporary waiting list and scheduled to receive group treatment services at a later point in time.

Therapists

The group therapy program was facilitated by the author and a male graduate student in the Clinical Psychology Program at the University of Manitoba. The decision to include therapists of both genders in the program was based on clinical wisdom

Table 1

Descriptive Data for the Children in the Group Therapy Condition

Child	Age	Offender	Type of Sexual Abuse	Duration
Avery	8	Stepfather	Fondling, oral sex, anal sex, exposure to pornography, physical violence, coercion	3 yrs
Alex	9	Male Peer	Anal sex, physical violence	Unknown
		Female Peer	Fondling, simulated intercourse, witness to abuse of others, coercion	Unknown
Andy	10	Father	Oral sex, possible physical violence, coercion	5-6 yrs
		Stepmother	Oral sex, genital contact, possible physical violence, coercion	5-6 yrs
		Peer?	Unknown	Unknown
Adam	10	Uncle	Fondling, coercion	5-6 wks
		Brother?	Unknown	Unknown
		Father?	Unknown	Unknown
		Mother's Partner?	Unknown	Unknown
Arthur	8	Foster Brother	Fondling, oral sex, anal sex, scalding of genitals, physical violence, coercion	6 mos
Allan	8	Father	Fondling, oral sex, coercion	2-3 yrs
		Male Neighbour	Fondling, oral sex, forced to witness abuse of others, physical violence, coercion	2-3 mos

Table 2

Descriptive Data for the Children in the Wait-List Comparison Condition

Child	Age	Offender	Type of Sexual Abuse	Duration
Brett	8	Male Peer	Grabbing of penis and scrotum, physical violence, coercion	2 incidents
Bill	9	Stepfather	Ritualistic abuse, oral sex, anal sex, forced to abuse and witness the abuse of others, physical violence, coercion	4 yrs
Bobby	10	Male Peer	Oral sex, physical violence, coercion	1 incident
		Male Cousin	Anal sex, physical violence, coercion	1 incident
Blair	7.5	Male Peer	Unknown	Unknown
		Male Babysitter?	Unknown	Unknown
Brad	7	Stepbrother	Fondling, attempted anal sex, witness to abuse of others, coercion	2 yrs
Byron	10	Stepfather	Fondling, physical violence, coercion	Unknown
		Foster Brother?	Digital penetration, physical violence, coercion	2-3 yrs
		Foster Brother?	Unknown	2-3 yrs
		Foster Sister?	Unknown	2-3 yrs

suggesting that mixed-gender dyads are the best approach when treating victimized males (Bruckner & Johnson, 1987; Schacht et al., 1990; Sgroi, 1992; Singer, 1989). Both therapists involved in the program had general group skills and previous experience working with abused children, and were familiar with pertinent issues related to the treatment of sexual abuse.

Therapists were supervised throughout the program by a registered clinical psychologist, whose area of research and clinical expertise was that of child sexual abuse. Therapists consulted with the supervisor on a weekly basis regarding the children's progress in group and the plans for upcoming sessions. Therapists also met separately for approximately one to two hours per week to discuss and prepare for the sessions.

In order to reduce the possibility of therapist bias, to provide evidence that the therapy program was, in fact, being implemented as intended, and to supply the therapists' supervisor with a full account of the content and process of sessions, it was intended that all group meetings would be audiotaped, with session tapes being reviewed during weekly supervision. Although the therapists initially attempted to tape therapy sessions, these efforts were abandoned after several meetings, when it became apparent that the tape recorder was a source of distraction and concern for many of the children in group and was also incapable of picking up sound from all parts of the therapy room.

Instruments

Several standardized and nonstandardized assessment measures were used in the present study in order to evaluate the effects of sexual abuse on the children and to monitor the course of these symptoms during the 12-week intervention phase. As recommended by various authors (e.g., Finkelhor, 1986b; Hoier, 1987; Kolko, 1987; Wolfe & Gentile, 1992; Wolfe & Wolfe, 1988), therapists conducted multimodal

assessments tapping generic adjustment problems as well as sequelae more specific to the experience of sexual abuse (e.g., sexual behavior problems). Data regarding these problems were gathered on multiple occasions throughout the study from multiple raters or sources (O'Donohue & Elliott, 1991), using global measures of adjustment as well as more molecular assessment techniques (Hoier, 1991).

Child-Report Measures. During individual interviews with a group therapist, children referred to the treatment program completed two self-report scales designed to assess their overall adjustment.

The Self-Esteem Inventory (SEI; Coopersmith, 1981) was used to measure children's self-evaluations in the spheres of social, family, academic, and personal experience (see Appendix A). The scale consists of 58 declarative statements (e.g., "I'm a failure") to which a child responds like me or unlike me. Scoring of the SEI yields an overall self-esteem index (Total Self) and scores on four separate subscales (General Self, Social Self-Peers, Home-Parents, School-Academic). In all cases, higher scores are indicative of greater self-esteem (Coopersmith, 1981). For purposes of the present study, only the Total Self score was employed. The SEI is a psychometrically sound assessment instrument for which reliability data have been well-documented (test-retest estimates for the scale range from .70 to .88; Coopersmith, 1967). In addition, the scale seems to be an effective means of discriminating abused from nonabused children (Grayston, De Luca, & Boyes, 1992) and appears to be a sensitive index of psychotherapy change (De Luca et al., 1991, 1993, in press; De Luca, Grayston, Boyes, & Romano, 1992; Hack et al., in press).

The Children's Depression Inventory (CDI; Kovacs, 1980/1981) was used to assess depressive symptoms in children (see Appendix B). The scale consists of 27 items, each describing a feature commonly associated with depression (e.g., suicidality,

disturbed interpersonal relations). Three possible answers are supplied for each item (e.g., "I am sad once in a while," "I am sad many times," "I am sad all the time"), and children are asked to select from among these responses the alternative that best describes them during the previous two weeks. Higher scores on the scale reflect higher levels of depression (Kovacs, 1980/1981). Overall, the CDI appears to be a fairly reliable assessment device, with test-retest correlations for various samples ranging from .38 to .87 (Saylor, Finch, Spirito, & Bennett, 1984). In addition, the scale appears to be a sensitive index of psychotherapy change (Hack et al., in press; for a differing view, however, see Friedrich et al., 1992).

Parent-Report Measures. During individual interviews with a group therapist, caregivers of children referred to the treatment program completed several measures designed to assess the overall adjustment of their sons.

The Child Behavior Checklist (CBCL; Achenbach & Edelbrock, 1983) was used to identify and monitor social competence and behavior problems in children (see Appendix C). The social competence scale consists of 20 items designed to assess the amount and quality of a child's participation in sports, activities, organizations or clubs, chores, and friendships, as well as a child's ability to interact with others, work or play alone, and perform effectively in school. Scoring of the social competence scale yields an overall social competence index and scores on three separate subscales (Activities, Social, School). In all cases, higher scores are indicative of greater social competence (Achenbach & Edelbrock, 1983). For purposes of the present study, only the overall social competence score was employed. The behavior problem scale of the CBCL consists of 118 items (e.g., "cries a lot," "runs away from home"), including several directly related to inappropriate sexual behavior, which is frequently displayed by children who have experienced sexual abuse (Einbender & Friedrich, 1989; Friedrich et al., 1986,

1988; Gale et al., 1988). Two additional items provide caregivers with an opportunity to list and rate any other behavior problems that they have observed in their children. Parents or parent-surrogates (e.g, foster parents, social workers) completing the scale are asked to indicate the extent to which each item applies to their child, using a 3-point Likert-type scale (where 0 indicates that the item is not true of the child, 1 indicates that it is somewhat or sometimes true of the child, and 2 indicates that the item is very true or often true of the child). The CBCL yields scores on Internalizing and Externalizing dimensions, as well as scores on several specific subscales (e.g., depression, hyperactivity). In all cases, higher scores reflect greater numbers of behavior problems (Achenbach & Edelbrock, 1983). For purposes of the present study, only the Internalizing, Externalizing, and Total Behavior Problem scores were employed. The CBCL is a psychometrically sound assessment instrument for which reliability data have been well-documented (reliability estimates for nonreferred samples for the behavior problems scale range from .838 to .952, while reliability estimates for the social competence scale range from .974 to .996; Achenbach & Edelbrock, 1983). In addition, the measure appears to be an effective means of identifying children who have been sexually abused (Friedrich et al., 1986) and seems to be a sensitive index of psychotherapy change (De Luca et al., 1991, 1993, in press; De Luca, Grayston, Boyes, & Romano, 1992; Friedrich et al., 1992; Hack et al., in press; Hiebert-Murphy et al., 1992).

The Child Sexual Behavior Inventory (CSBI; Friedrich, Grambsch, Broughton, Kuiper, & Beilke, 1991; Friedrich, Grambsch, Koverola, Hewitt, Damon, Lemmond, & Broughton, 1989, cited in Friedrich, 1990) was used to assess overt sexual behavior problems in children referred to the group treatment program (see Appendix D). The inventory consists of 35 items describing various sexual behaviors (e.g., "imitates the

act of sexual intercourse," "tries to undress others") which are rated by children's caregivers according to the frequency with which they occur (e.g., never, less than once a month, one to three times a month, at least once a week). One additional item provides caregivers with an opportunity to rate the frequency of any other sexual behaviors that they have observed in their children. Higher scores on the scale reflect greater numbers of sexual problems (Friedrich et al., 1989, cited in Friedrich, 1990; Friedrich et al., 1991). According to Friedrich and his associates (Friedrich, 1990; Friedrich, Grambsch, Damon, Hewitt, Koverola, Lang, Wolfe, & Broughton, 1992), the measure is an effective means of discriminating abused from nonabused children, although some items on the scale are endorsed by parents of children in both groups. Psychometric and normative data for the scale have recently been collected, with reliability estimates for normative samples of approximately .85 (Friedrich et al., 1991, 1992). In addition, the scale appears to be a sensitive index of psychotherapy change (Friedrich et al., 1992).

Caregivers of children referred to the group therapy program were also asked to rate the extent of behavioral and emotional problems in their sons, using simple 11-point rating scales, ranging from 0 to 10 (see Appendix E). Higher scores on the scales reflect greater numbers of behavioral and emotional problems. In addition, caregivers were asked to identify and describe up to three problematic behaviors that they had observed in their sons since the time of the sexual abuse (e.g., aggression, compulsive masturbation) and to complete daily frequency counts of these behaviors over a period of seven days (Minden, 1982; see Appendices F and G). Although all caregivers were assisted in the process of selecting behaviors to observe, were given detailed written and verbal instructions regarding the observational task (see Appendices F and G), and were strongly encouraged to call if they had questions about the instructions, none of the

caregivers correctly completed the assigned recording task, resulting in an absence of usable data for this particular measure (a total of eight caregivers "lost" or failed to complete their recording forms at the pre-treatment assessment, while the remaining four parents completed the recording task incorrectly, forgetting to collect some data, combining observations across different weeks, or recording different behaviors during separate observational sessions).

Social Validation Measures. Following group termination, group participants and their caregivers were asked to complete social validation measures designed to assess their perceptions of, and overall satisfaction with, the group therapy program.

The Child Feedback Questionnaire (see Appendix H), developed specifically for our group work at the University of Manitoba (e.g., De Luca, Boyes, Furer, Grayston, & Hiebert-Murphy, 1992; De Luca et al., 1993), was used to assess children's feelings about the group therapy program. The scale consists of seven questions (e.g., "What did you like about group?") which require children to provide a short verbal response. Feedback obtained from children on this particular scale was used to evaluate the utility of the treatment program and to refine and improve existing therapeutic interventions.

The Parent Feedback Questionnaire (see Appendix I), also developed for our group work at the University of Manitoba (e.g., De Luca, Boyes, Furer, Grayston, & Hiebert-Murphy, 1992; De Luca et al., 1993), was used to assess caregivers' perceptions of the group therapy program. The scale consists of nine questions, similar to those on the Child Feedback Questionnaire (e.g., "What did your child like about group?"), which require parents or parent-surrogates to provide a short verbal response. Feedback obtained from caregivers on this particular scale was used to evaluate the utility of the treatment program and to refine and improve existing therapeutic interventions.

Procedure

Prior to group commencement, therapists followed specific recruitment and assessment procedures adapted from previous research (e.g., De Luca, Boyes, Furer, Grayston, & Hiebert-Murphy, 1992).

Recruitment of Participants. Letters outlining the purpose, content, and format of the treatment program, and describing eligibility requirements for involvement in the groups (see Appendix J), were sent to agencies mandated to protect and care for children as well as community organizations in late 1992 (see Appendix K). Familiar mental health professionals (including social workers who had previously referred children to sexual abuse groups at the Psychological Service Centre) were also contacted at this time with information about the treatment program. Although a variety of sources expressed interest in the groups, very few boys were referred to the treatment program, necessitating additional recruitment efforts. Over the ensuing months, letters and circulars describing the program (see Appendix L) were re-distributed to previously contacted parties, and information regarding the groups was made available to additional organizations and agencies (see Appendix M). Once again, familiar mental health professionals were contacted at this time with information about the treatment program.

Service professionals wishing to make referrals to the group treatment program were asked to contact potential participants and their families and advise them about the group. In addition, workers were asked to complete a referral form for each identified child (see Appendix N).

As referrals became available, therapists contacted the parents or foster parents of the children to share general information about the program and to answer any questions. During the telephone calls, caregivers were informed about the research component of the groups and the fact that they would be expected to complete

questionnaires and observations periodically throughout the study. When a sufficient number of children (six to seven) had been referred to begin a treatment group, individual intake and assessment interviews were arranged with all parents and foster parents who had expressed interest in having their sons involved in the program.

Intake Procedures for the Group Therapy Condition. Intake interviews were conducted at the Psychological Service Centre up to two weeks prior to commencement of the therapy group. Children were seen with their parents or foster parents, and whenever appropriate, with their social workers or other significant adults (e.g., grandparents). During the 90-minute meetings, children and their caregivers had an opportunity to meet the therapists and to obtain further information about the therapy program (e.g., purposes and goals of the program, issues and themes to be addressed, group format and techniques, and evaluation procedures). In addition, therapists had an opportunity to advise children and their caregivers of therapy "regulations" and "rules" (e.g., confidentiality, regular attendance at sessions, notification of expected absences from group, respect for other group members), to obtain written consent for participation in assessment and treatment (see Appendices O and P), to obtain background information from caregivers regarding the children's experiences of abuse (see Appendix Q), and to identify and resolve any practical problems which might interfere with the children's attendance at weekly therapy sessions (e.g., lack of consistent transportation).

During the intake session, children and their caregivers also completed the scales and assessment procedures outlined above in individual interviews with a group therapist. Questionnaire items were read aloud to each child to control for differences in reading ability and to facilitate clarification of ambiguous phrases and words (e.g., double negatives), while caregivers generally completed the assessment measures on

their own. Caregivers who were unable to complete all measures during the assessment session were permitted to take outstanding forms home and return them to the therapists later in the week, either in person or by mail.

Results obtained from these initial assessments were used to evaluate the effects of sexual abuse on the children and to refine the therapeutic interventions. In addition, the assessments supplied a baseline of behaviors from which to assess the effects of the group treatment program.

During the intake sessions, parents or foster parents were also asked to begin daily observations of up to three problematic behaviors (e.g., aggression, compulsive masturbation) that they had observed in their sons (see above). Caregivers were instructed to return their completed recording forms to the therapists at the first group treatment session.

Intake Procedures for the Wait-List Comparison Condition. Intake interviews for the comparison group were conducted at the Psychological Service Centre as referrals became available, and followed procedures similar to those employed with the treatment group. During the intake interviews, however, the therapists informed participating children and their caregivers that a therapy group would be starting in approximately 12 weeks and that the therapists would be meeting with the family several times before group commencement to assess and monitor the children.

Group Therapy Condition. In order to maintain a consistent focus on abuse-related issues and themes (Pescosolido & Petrella, 1986), while not overemphasizing them (Carozza & Heirsteiner, 1982), the group treatment program was time-limited to 12 weeks' duration. Each group session was 90 minutes in length and took place at the Psychological Service Centre.

Each 90-minute session followed a similar four-part format, described by De Luca and her associates (De Luca, Boyes, Furer, Grayston, & Hiebert-Murphy, 1992). Complete details of the group program are presented in Appendix R.

For the first 15 minutes of each session, children participated in circle time, which was used to convene the group, help children make the transition from daily life to the group environment, review the events of the previous week, and outline the goals and agenda for the current therapy session.

Following circle time, 45 minutes were structured around specific activities designed to address abuse-related issues or themes (see below). Some of the approaches used during activity time were adapted from the work of De Luca and her associates (e.g., De Luca et al., 1991; De Luca, Boyes, Furer, Grayston, & Hiebert-Murphy, 1992; De Luca, Grayston, Boyes, & Romano, 1992), while other techniques used in the treatment of abused children and sex offenders, as well as nonabused children and adults (e.g., relaxation training), were also introduced to the group during weekly therapy sessions.

Group activities were followed each week by 20 minutes of diary time. During diary, therapists supplied children with large scrapbooks in which they could write or draw anything that they wished. The use of diaries provided children with opportunities to express thoughts, feelings, and concerns that may have been difficult for them to verbalize to other members of the group, and supplied therapists with opportunities to work individually with each of the boys. Diaries were collected by the therapists at the end of each session and were stored in a secure location.

The therapists attempted, early in group, to avoid imposing any structure on children during diary time. Although this seemed to be an effective strategy with some of the boys in group, other children tended to struggle during diary time, appearing to need

more structure. As a result, from the third session on, the therapists began to suggest or "assign" diary themes to the children.

The last 10 minutes of each session were reserved for snack time. Snack was used to: (a) promote nurturance within the group, through the regular sharing of food; (b) enhance children's self-esteem, by providing therapists with opportunities to summarize the progress of group members and praise them for their efforts; and (c) celebrate special occasions, such as holidays and birthdays.

Every group session was designed to address a particular issue or theme, with activities, discussions, and handouts focusing on the theme (see Appendix R). Given the interrelatedness of the themes, however, no topic was ever dealt with in isolation, with discussion of most issues and themes recurring throughout the entire group. Although the therapists made every effort to adhere to the general outline of themes presented in Appendix R, they also exercised flexibility in the selection and timing of various components, modifying planned procedures as necessary to meet the needs of each group member. If, for example, a child raised an important issue that was not specifically covered on the agenda for that week (e.g., uncertainty about custody arrangements or feelings about the death of the offender), therapists modified planned activities in order to allow the group sufficient time to address the child's concerns.

Behavior management techniques (e.g., positive reinforcement and extinction) were employed throughout the group to reduce disruptive behavior (e.g., aggressiveness) and to increase acceptable conduct (e.g., prosocial behavior) on the part of the boys. While these techniques appeared, at times, to be effective in promoting appropriate behavior within the group, disruptive conduct (e.g., shouting, play-fighting, refusing to listen to group discussions) was not uncommon in the initial weeks of the program, and seemed to intensify and spread as the weeks progressed and sessions

began to focus on more difficult issues and themes (e.g., feelings about sexual abuse, offenders). By the end of the fifth session, it seemed essential to institute a more formalized behavioral program to reduce inappropriate behavior, and thereby permit the children to feel safe in the group setting and to focus more directly on scheduled activities and events. Therefore, in the sixth session, therapists implemented a fixed interval reinforcement schedule similar to that described by Hack and his associates (Hack et al., in press). Other researchers and clinicians (e.g., De Luca, Boyes, Furer, Grayston, & Hiebert-Murphy, 1992; Schacht et al., 1990) have also emphasized the importance of employing concrete behavioral strategies to regulate high levels of affect and inappropriate conduct in group, and thereby ensure that the children feel safe within the group setting.

Following brief conversations with the children's caregivers, in which therapists informed them of the decision to develop a "reward program" that would recognize children for "their hard work and good behavior in group," therapists initiated the reinforcement schedule, with the help of a group assistant (an occasional student in the Psychology Graduate Program at the University of Manitoba). Several specific steps were involved in implementation of the program:

1. The boys were introduced to the group assistant and informed of the therapists' decision to reward the boys for "all of their hard work and good behavior in group."

2. The therapists explained the "rules" of the reward program, emphasizing that the assistant would set a timer and provide <u>each</u> boy with a "Teddy Graham" cookie (a primary reinforcer) when the timer rang if <u>all</u> boys were behaving appropriately and following group rules during the timed interval.

3. The boys were informed that they could either consume the cookies immediately or save them for consumption at a later time.

In order to ensure that the children would quickly come into contact with the contingencies of reinforcement, the group assistant was initially instructed to set the timer for very brief periods of time (approximately two to three minutes). After children had experienced some initial success in working with the program, the group assistant lengthened the timed intervals to five minutes for the remainder of the session. Although the children did not receive rewards for all timed intervals during this initial session, their behavior was markedly improved over that of previous weeks.

The reward program was continued during subsequent group sessions, with the requirements for reinforcement gradually being raised as the children's behavior improved. In the seventh session, for example, intervals were initially set at five minutes, and later extended to approximately 10 minutes when it became apparent that the children could cope effectively with the extended intervals. During this transition phase, children were often rewarded with "bonus cookies" for their hard work and appropriate behavior. In the weeks that followed, the group assistant set the timer for two or three brief periods (approximately five to seven minutes apiece) at the beginning of each session, subsequently lengthening the timed intervals to the amount scheduled for that week. Intervals were kept to approximately 10 minutes apiece for the eighth and ninth group sessions and were extended to approximately 15 minutes apiece for sessions 10 and 11. At the children's request, the reward program was discontinued during the final group therapy session.

Within four weeks of group termination, individual post-treatment meetings were conducted with all group members and their families. These 90-minute meetings allowed therapists to: (a) provide a positive review of the children's involvement in the group; (b) make recommendations regarding the need for additional treatment; and (c) provide caregivers with information regarding supportive resources available in the

community for parents of children who have experienced sexual abuse. The post-treatment meetings also allowed therapists to obtain feedback from caregivers and group participants and to collect assessment data using the measures described above. At this time, parents and foster parents were also asked to conduct daily observations of the three problematic behaviors (e.g., aggression, compulsive masturbation) that they had opted to monitor in their sons (see above).

Wait-List Comparison Condition. Boys in the comparison condition, as noted above, did not receive the group intervention until the end of a 12-week assessment phase. Nevertheless, they were assessed with the same measures as the boys in the treatment group, at comparable points in time.

Results

Complete child- and parent-report data were obtained for all boys in the group therapy condition and for four of the children assigned to the wait-list comparison group. Parent ratings of behavioral and emotional problems were unavailable for one child in the comparison condition as his caregiver failed to complete one of the questionnaires administered at the intake assessment. Data for a sixth child in the comparison group were not included in the study as his late referral to the treatment program precluded a second assessment.

Data were first analyzed for children in the group therapy condition. Subsequent analyses statistically compared group participants' data with information obtained from families in the wait-list comparison group.

Statistical Analyses for the Group Therapy Condition

Given the overall paucity of statistical analyses examining treatment outcome for children who have been sexually abused (Hack et al., in press), it was considered important to assess the statistical significance of changes in reported adjustment and

behavior over the 12-week intervention phase. This was accomplished by computing group means for each quantitative measure and then comparing the means in a series of repeated measures analyses of variance. Results of these analyses are presented below and are depicted graphically in Figures 1-9. All means are rounded to the nearest whole number.

Child-Report Measures. Children's scores on the Self-Esteem Inventory (Coopersmith, 1981) tended to increase from the pre- to post-treatment assessment (Ms = 69 and 74, respectively). Nevertheless, the change in average self-esteem scores was relatively small and failed to reach statistical significance, $F(1, 5) = .37$, $p > .05$. Graphical representations of children's self-esteem scores are presented in Figure 1.

Self-report scores on the Children's Depression Inventory (Kovacs, 1980/1981) tended to decline from the pre-treatment to post-treatment assessment (Ms = 8 and 4, respectively), although the change in average scores was not a significant result, $F(1, 5) = .90$, $p > .05$. Children's depression scores are presented graphically in Figure 2.

Parent-Report Measures. Parent reports on the Child Behavior Checklist (Achenbach & Edelbrock, 1983) suggested minimal change in children's social competence scores from the pre- to post-treatment assessment (M = 38 at both assessment times). Average social competence scores were similar prior to and following treatment, with no significant change, $F(1, 5) = .05$, $p > .05$. Figure 3 graphically depicts children's social competence scores.

Parent reports on the Child Behavior Checklist (Achenbach & Edelbrock, 1983) indicated that there were some changes in children's internalizing, externalizing, and total behavior problem scores over the course of the group intervention. Children's internalizing scores tended to decline from pre-treatment to post-treatment

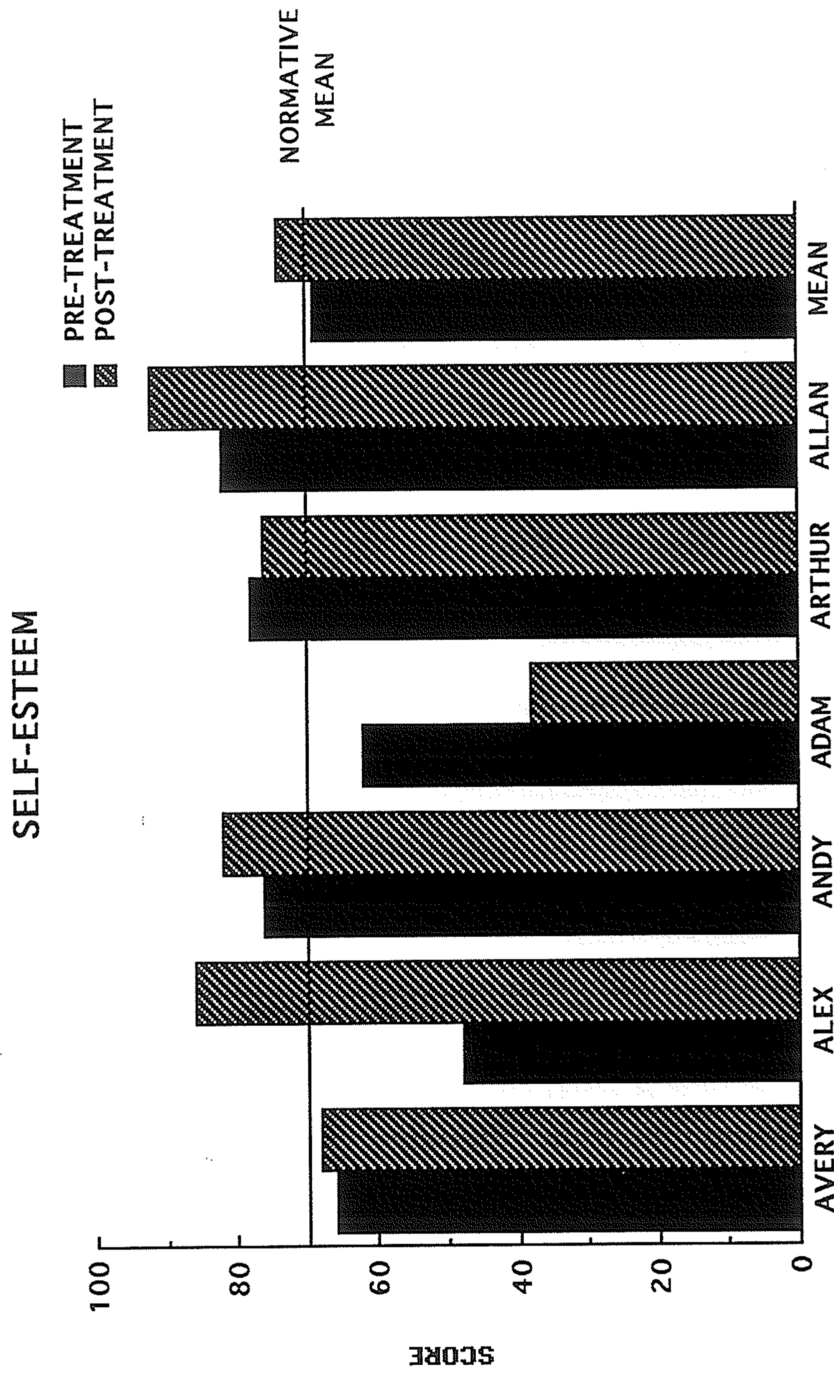

Figure 1. Pre-treatment and post-treatment self-esteem scores for children in the group therapy condition. All names used are fictitious.

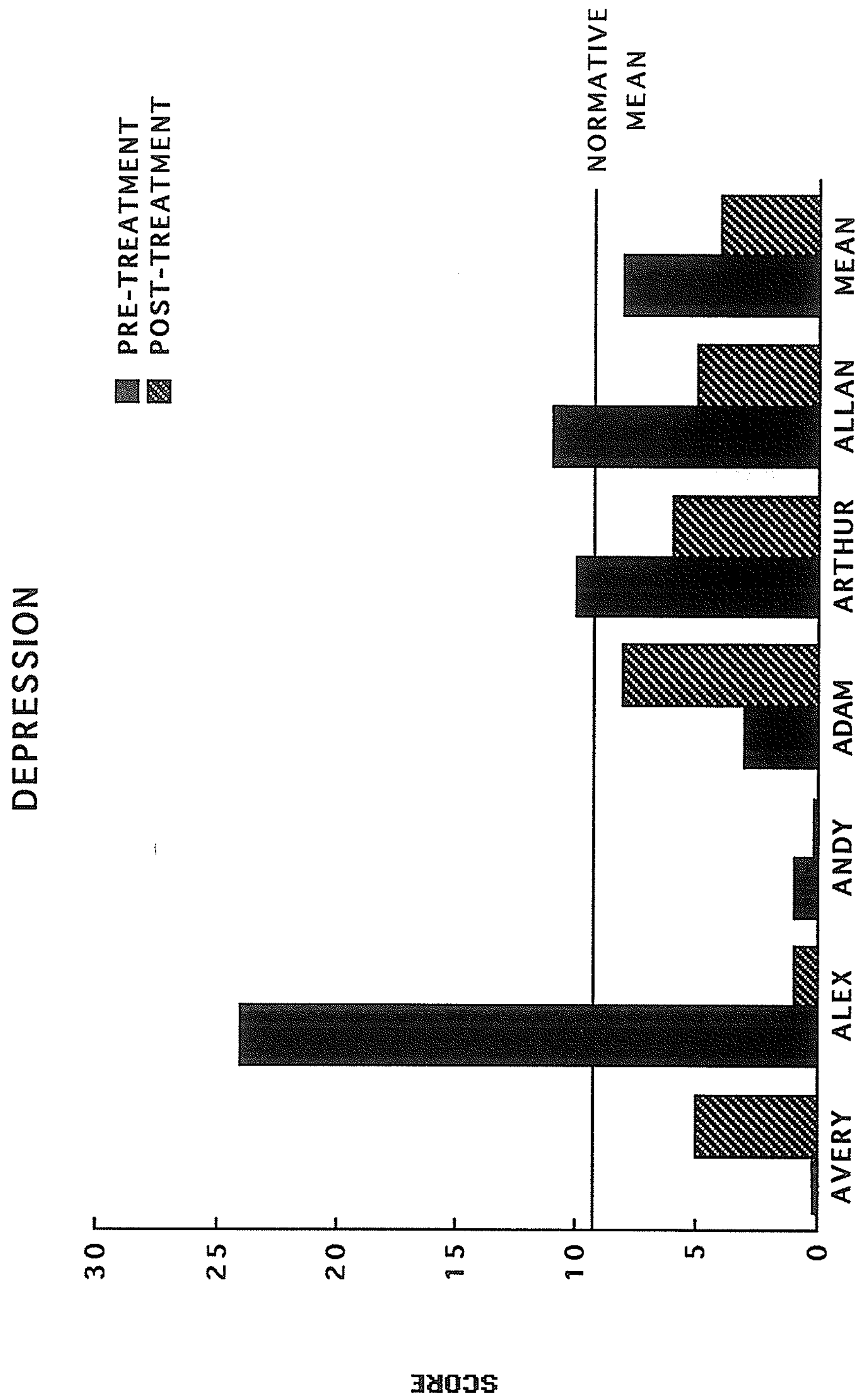

Figure 2. Pre-treatment and post-treatment depression scores for children in the group therapy condition. All names used are fictitious.

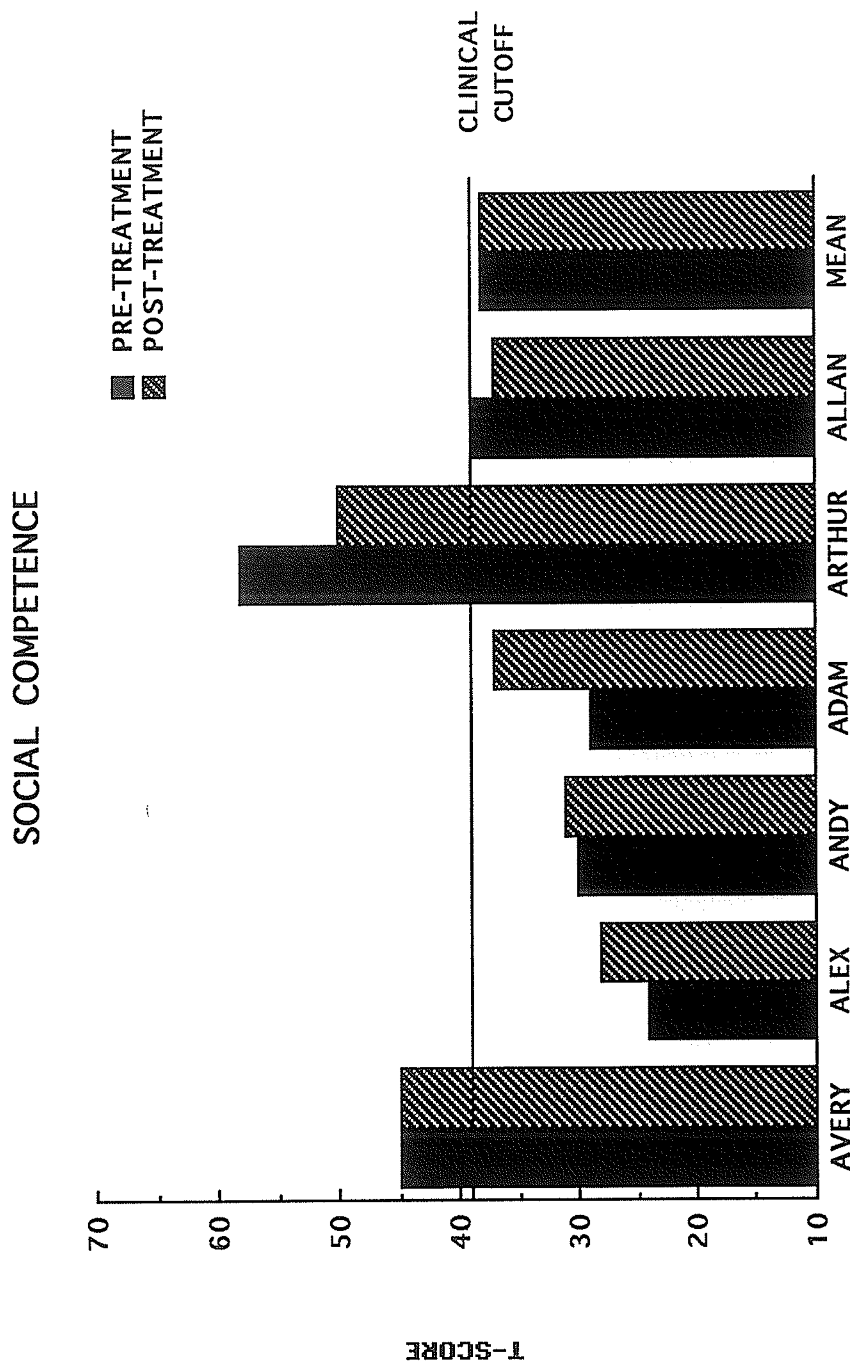

Figure 3. Pre-treatment and post-treatment social competence scores for children in the group therapy condition. All names used are fictitious.

assessments (Ms = 74 and 68, respectively), as did their externalizing (Ms = 80 and 71, respectively) and total behavior problem scores (Ms = 82 and 71, respectively). Although the change in average scores for internalizing and externalizing behavior problems failed to reach statistical significance [$Fs(1, 5) = 5.76$ and 5.08, respectively, $ps > .05$], the change in total behavior problems was a significant result, $F(1, 5) = 6.60$, $p < .05$. Graphical representations of children's internalizing, externalizing, and total behavior problem scores are presented in Figures 4-6.

Parent reports of sexual behavior problems on the Child Sexual Behavior Inventory (Friedrich et al., 1989, cited in Friedrich, 1990; Friedrich et al., 1991) also tended to decline from pre-treatment to post-treatment assessments (Ms = 25 and 10, respectively). Although the change in average scores was relatively large, it was not a significant result, $F(1, 5) = 3.55$, $p > .05$. Children's sexual behavior problem scores are presented graphically in Figure 7.

Parent ratings of behavioral and emotional problems in children using simple 11-point scales also suggested changes in adjustment and behavior during the 12-week intervention phase. Children's behavioral problem scores tended to decline from the pre- to post-treatment assessment (Ms = 7 and 5, respectively), as did their emotional problem scores (Ms = 7 and 5, respectively). The changes in average scores for both measures, however, failed to reach statistical significance, $Fs(1, 5) = 4.92$ and 1.04, respectively, $ps > .05$. Figures 8 and 9 graphically depict children's scores for behavioral and emotional problems.

Social Validity Data for the Group Therapy Condition

At the post-treatment assessment, all children and caregivers in the group therapy condition completed the Child and Parent Feedback Questionnaires (De Luca, Boyes, Furer, Grayston, & Hiebert-Murphy, 1992; De Luca et al., 1993). Generally speaking,

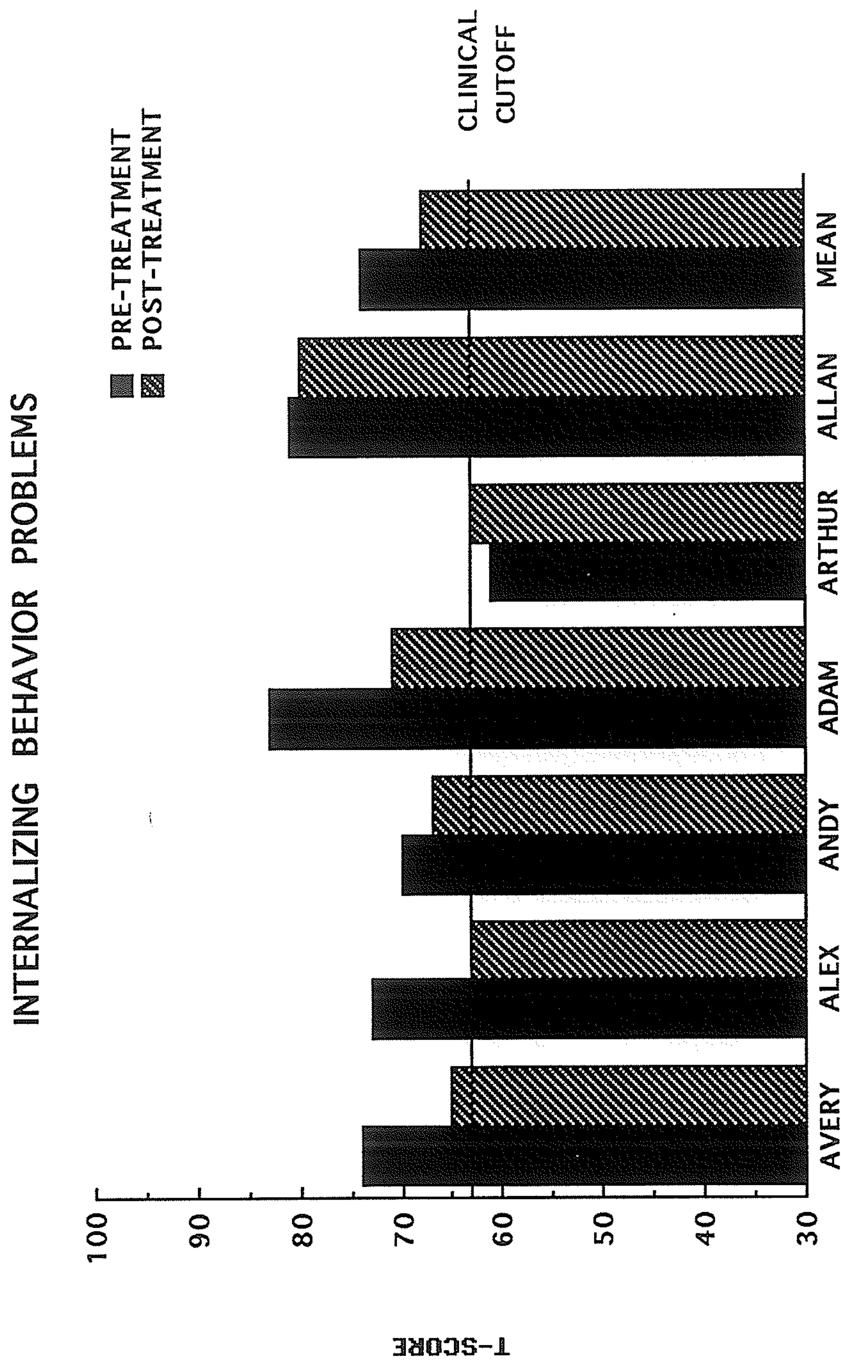

Figure 4. Pre-treatment and post-treatment internalizing behavior problem scores for children in the group therapy condition. All names used are fictitious.

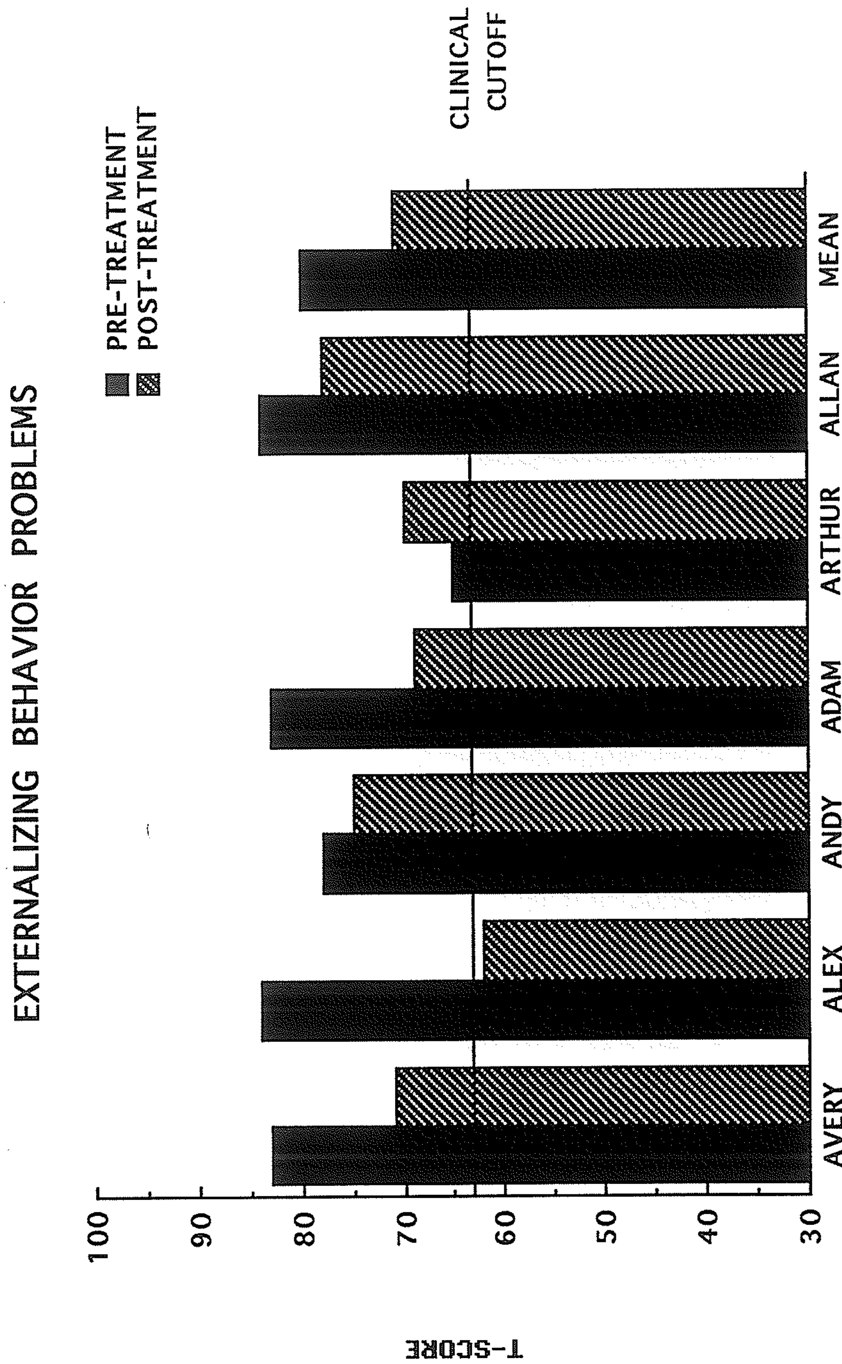

Figure 5. Pre-treatment and post-treatment externalizing behavior problem scores for children in the group therapy condition. All names used are fictitious.

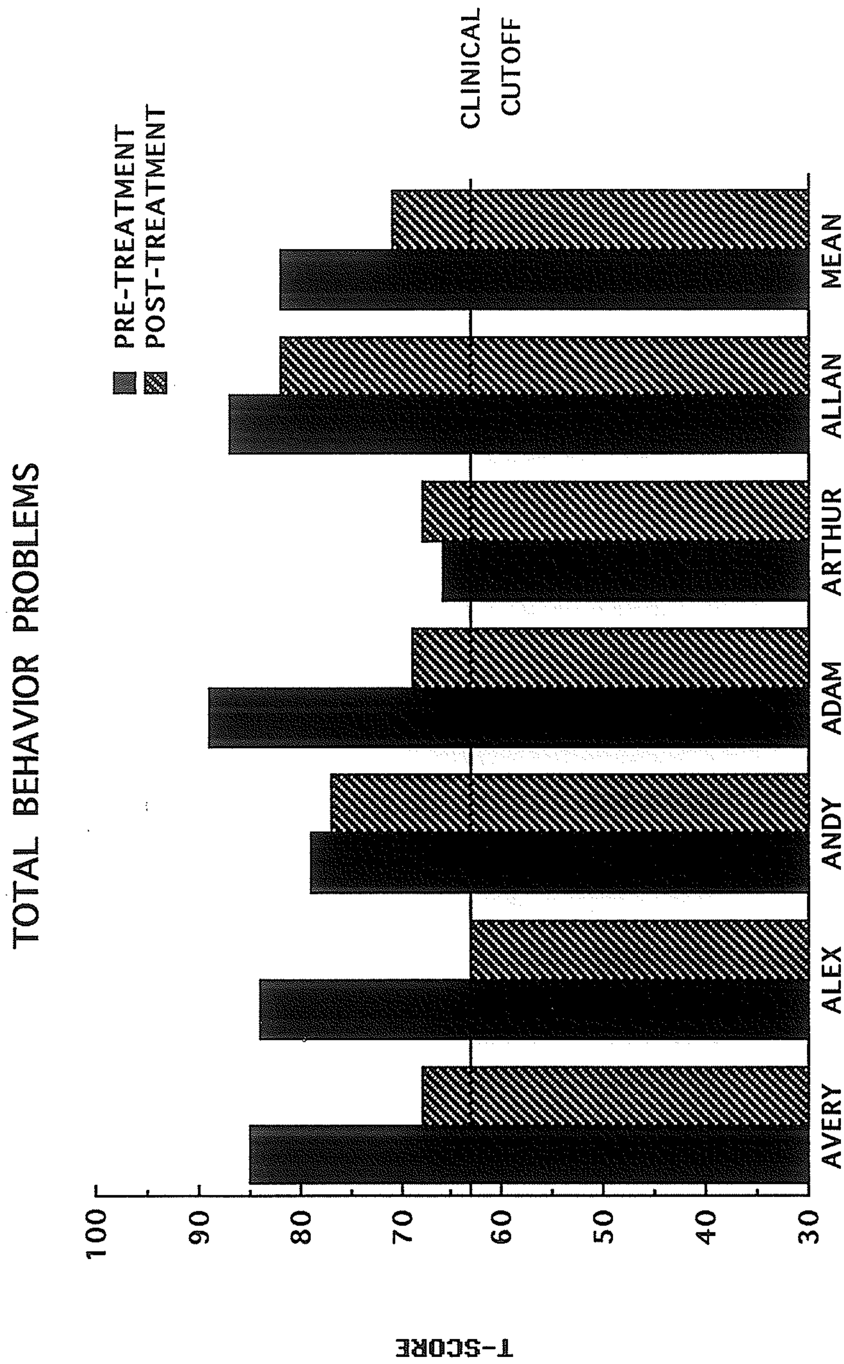

Figure 6. Pre-treatment and post-treatment total behavior problem scores for children in the group therapy condition. All names used are fictitious.

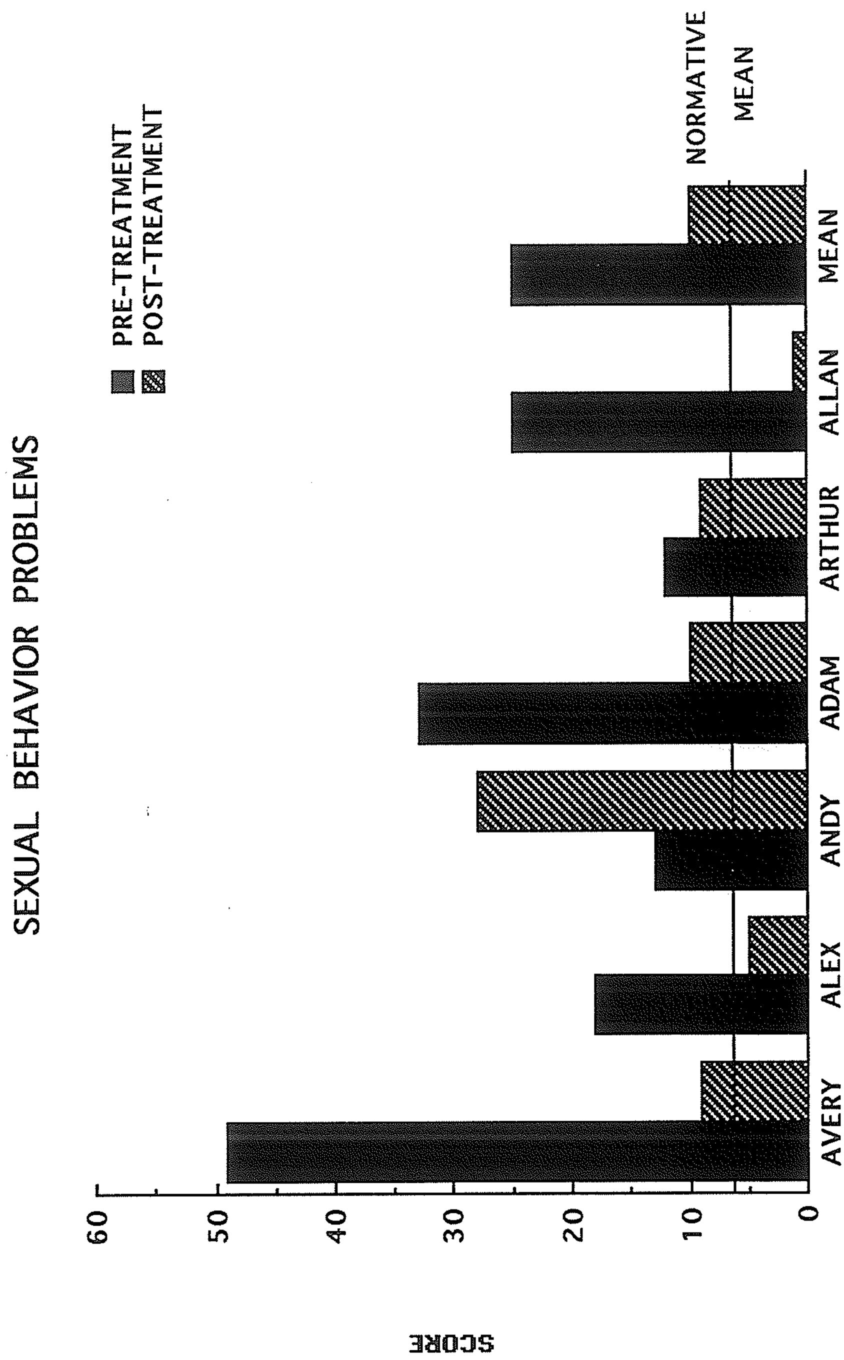

Figure 7. Pre-treatment and post-treatment sexual behavior problem scores for children in the group therapy condition. All names used are fictitious.

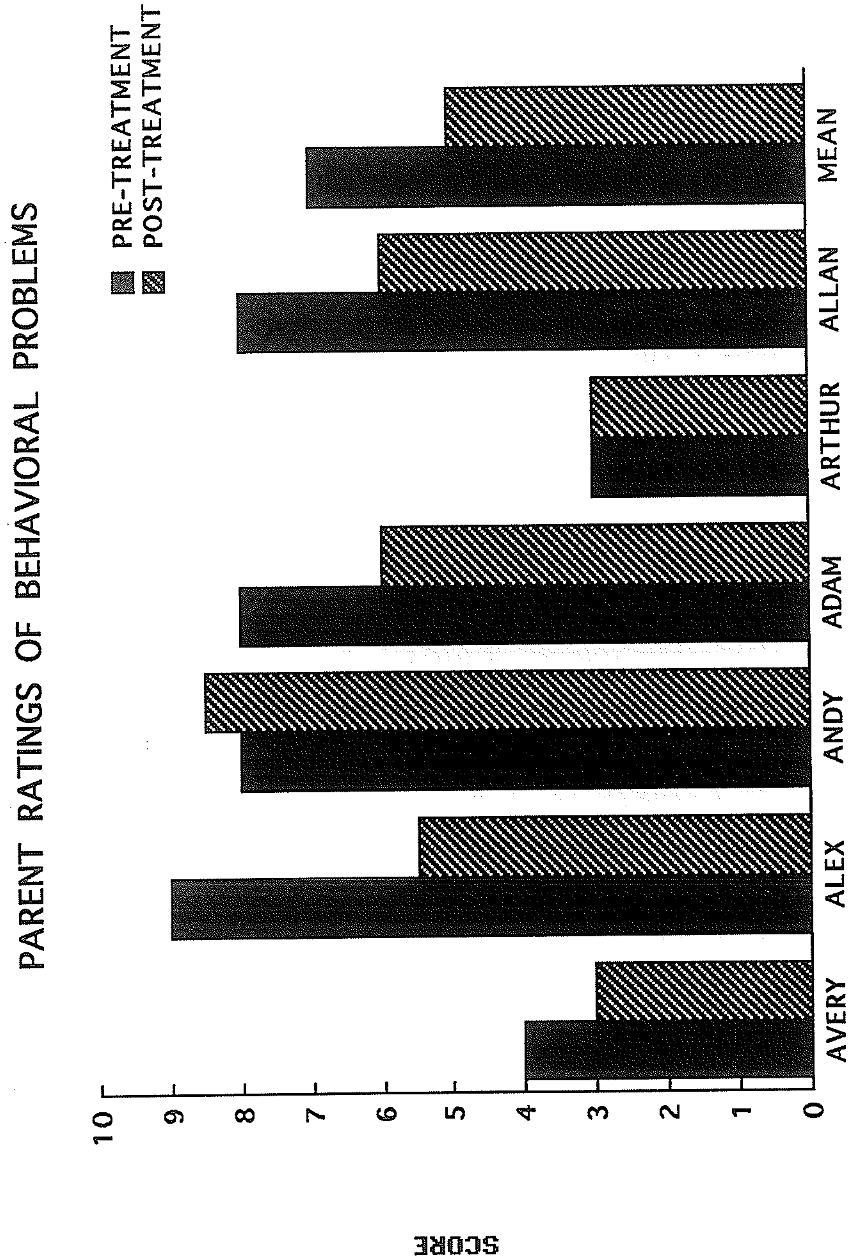

Figure 8. Pre-treatment and post-treatment parent ratings of behavioral problems for children in the group therapy condition. All names used are fictitious.

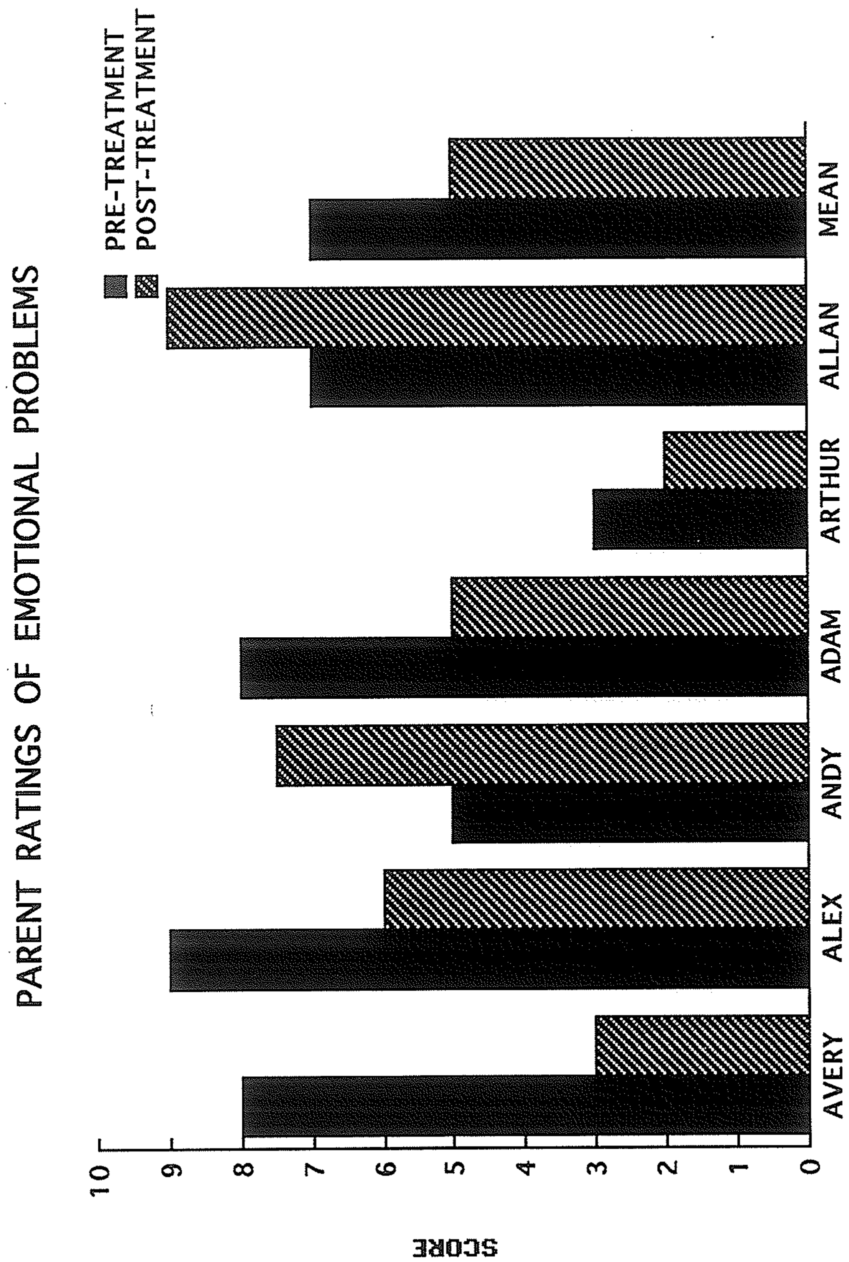

Figure 9. Pre-treatment and post-treatment parent ratings of emotional problems for children in the group therapy condition. All names used are fictitious.

the social validity data suggested that the group intervention was a positive and beneficial experience for the large majority of children. Tables 3 and 4 illustrate the major findings for each of these scales, as well as sample responses for each of the questions and items. Social validity data, pertinent to individual children, are also presented below.

Individual Analyses for the Group Therapy Condition

Although it was considered important, in the present study, to assess the utility of the treatment program for the therapy group as a whole, it was also deemed essential to examine the effects of the group intervention on individual children (Hack et al., in press). The results of treatment for each child in the group therapy program are presented in detail below, following procedures similar to those employed by Kuhn (1988). All names used are fictitious.

Avery. Avery was eight years old and of African-Canadian descent. He had experienced long-term sexual and physical abuse perpetrated by his mother's former spouse. Avery's experiences of abuse included a range of sexual acts, from exposure to pornography to oral and anal sex (for more detailed information, see Table 1).

As illustrated in Table 5, Avery's self-esteem score increased minimally over the course of group treatment (a change of 2%). Similarly, Avery's depression score increased slightly from the pre- to post-treatment assessments (a change of 9%; see Table 5). At post-treatment, Avery's self-esteem score closely approximated average or normative levels, while his depression score continued to fall within the normative range (see Figures 1 and 2).

According to parent reports completed by Avery's mother, Avery experienced no change in social competence scores from the pre- to post-treatment assessments (a change of 0%; see Table 5). Both before and after treatment, Avery's social competence

Table 3

Social Validity Data from the Child Feedback Questionnaire (n = 6)

Question	Sample Responses and Number of Children Endorsing
What did you like about group?	Liked being safe (1), liked everything (1), liked missing other activities to come to group (1), liked the party and snack time (1), liked the friendly kids (1), liked everything, especially diary (1)
What did you dislike about group?	Disliked nothing (5), disliked diary (1)
Would you say you liked group or disliked group?	Liked group (6) - e.g., it was fun, it helped more than anything else would
Did anything in group frighten you?	No (6)
Did anything in group confuse you?	No (5) Yes (1) - e.g., questions in a game were confusing
Did anything in group help you?	Yes (6) - e.g., the book, everything
Suggestions for things you would like to see changed or stay the same about group.	Keep it the same (3), keep the same kids (1), keep snack and change diary (1), move the table to the front of the room (1)

Table 4

Social Validity Data from the Parent Feedback Questionnaire (n = 6)

Question	Sample Responses and Number of Caregivers Endorsing
What did your child like about group?	Liked the facilitators and the other children (1), looked forward to coming each week (1), liked snack (1), liked snack and being with boys his own age (1), liked meeting with the other children (1), liked snack and making new friends (1)
What did your child dislike about group?	Disliked nothing (4), disliked how long it took to get to and from group (1), disliked the fact that others might overhear what he said in group (1)
Overall, would you say your child liked or disliked group?	Liked group (6)
Did your child seem to be frightened by anything in group?	No (4) Yes (1) - e.g., afraid to talk about the abuse initially Don't Know (1)
Did your child seem to be confused by anything in group?	No (4) Don't Know (2)
Do you think your child benefited from group?	Yes (5) - e.g., learned that the abuse is not his fault, learned about his body Don't Know (1) - e.g., there was no change
Were you satisfied with the way the group was run?	Yes (6)
Were you satisfied with the parental involvement?	Yes (6)
Please give any suggestions for things you would like to see changed or stay the same about group.	Keep it the same (3), change the location (1), provide more feedback to parents (1), have something for the parents while group is on (1)

scores fell within the normative range (see Figure 3). Avery, however, did experience parent-reported changes in internalizing and externalizing behavior problems over the course of group treatment, with changes in these behaviors ranging from -9% to -12% (see Table 5). At post-treatment, Avery's internalizing and externalizing scores more closely approximated normative or average levels, although both scores still fell within the clinical range (see Figures 4 and 5).

With respect to parent-reported total and sexual behavior problems, and parent ratings of behavioral and emotional concerns, Avery also experienced positive changes from the pre-to post-treatment assessments. According to parent report, Avery experienced a 17% decrease in total behavior problems and a decrease of 37% in sexual behavior problems over the course of the group treatment program (see Table 5). Although his total behavior problem score at post-treatment still exceeded average or normative levels, Avery's post-treatment score for sexual problems more closely approximated scores within the average or normative range (see Figures 6 and 7). Parent ratings of behavioral and emotional problems also revealed improvements in adjustment for Avery ranging from 10% to 50% (see Table 5 and Figures 8 and 9). In addition, Avery's mother reported anecdotal improvements in his behavior over the course of the group treatment program.

Social validity data obtained from Avery and his mother at post-treatment suggested that he and his mother were both satisfied with the therapy group and felt that it had been a beneficial experience for Avery.

Alex. Alex was a nine-year-old Caucasian child. He had experienced sexual abuse by two separate offenders, a male and a female peer. Alex's experiences of abuse were of unknown duration, and included a range of sexual acts, from fondling to anal sex (for more detailed information, see Table 1).

Table 5

Avery's Scores on All Measures at the Pre- and Post-Treatment Assessments

Measure	Pre-Treatment	Post-Treatment
Self-Esteem	66	68
Depression	0	5
Social Competence	45	45
Internalizing Behavior Problems	74	65
Externalizing Behavior Problems	83	71
Total Behavior Problems	85	68
Sexual Behavior Problems	49	9
Parent Ratings of Behavioral Problems	4	3
Parent Ratings of Emotional Problems	8	3

As illustrated in Table 6, Alex's self-esteem score increased substantially over the course of group treatment (a change of 38%). In contrast, Alex's depression score decreased substantially from the pre- to post-treatment assessments (a change of 43%; see Table 6). By post-treatment, Alex's self-esteem and depression scores had improved sufficiently to move him into the average or normative range (see Figures 1 and 2).

According to parent reports completed by Alex's mother, Alex experienced minimal change in social competence scores from the pre- to post-treatment assessments (a change of 5%; see Table 6). Both before and after treatment, Alex's social competence scores fell within the clinical range (see Figure 3). Alex, however, did experience parent-reported changes in internalizing and externalizing behavior problems over the course of group treatment, with changes in these behaviors ranging from -10% to -22% (see Table 6). By post-treatment, Alex's internalizing and externalizing scores had improved sufficiently to fall at the clinical cutoff or within the normative range (see Figures 4 and 5).

With respect to parent-reported total and sexual behavior problems, and parent ratings of behavioral and emotional concerns, Alex also experienced positive changes from the pre-to post-treatment assessments. According to parent report, Alex experienced a 21% decrease in total behavior problems and a decrease of 12% in sexual behavior problems over the course of the group treatment program (see Table 6). By post-treatment, Alex's scores on these measures fell at the clinical cutoff or within the normative range (see Figures 6 and 7). Parent ratings of behavioral and emotional problems also revealed improvements in adjustment for Alex ranging from 30% (for emotional problems) to 35% (for behavioral problems; see Table 6 and Figures 8 and

9). In addition, Alex's mother reported anecdotal improvements in his behavior over the course of the group treatment program.

Social validity data obtained from Alex and his mother at post-treatment suggested that he and his mother were both satisfied with the therapy group and felt that it had been a beneficial experience for Alex.

Andy. Andy was a ten-year-old Caucasian child. He had experienced long-term sexual and physical abuse perpetrated by his biological father and stepmother, and also may have experienced abusive interactions with a peer. Andy's experiences of abuse included a range of sexual acts, from oral sex to genital contact (for more detailed information, see Table 1).

As illustrated in Table 7, Andy's self-esteem score increased slightly over the course of group treatment (a change of 6%). In contrast, Andy's depression score decreased minimally from the pre- to post-treatment assessments (a change of 2%; see Table 7). At post-treatment, Andy's scores on both measures continued to fall within average or normative levels (see Figures 1 and 2).

According to parent reports completed by Andy's foster mother, Andy experienced minimal change in social competence scores from the pre- to post-treatment assessments (a change of 1%; see Table 7). Both before and after treatment, Andy's social competence scores fell within the clinical range (see Figure 3). Andy also experienced minimal parent-reported changes in internalizing and externalizing behavior problems over the course of group treatment, with decreases in these behaviors of only 3% (see Table 7). At post-treatment, Andy's internalizing and externalizing scores more closely approximated normative or average levels, although both scores still fell within the clinical range (see Figures 4 and 5).

Table 6

Alex's Scores on All Measures at the Pre- and Post-Treatment Assessments

Measure	Pre-Treatment	Post-Treatment
Self-Esteem	48	86
Depression	24	1
Social Competence	24	28
Internalizing Behavior Problems	73	63
Externalizing Behavior Problems	84	62
Total Behavior Problems	84	63
Sexual Behavior Problems	18	5
Parent Ratings of Behavioral Problems	9	5.5
Parent Ratings of Emotional Problems	9	6

With respect to parent-reported total and sexual behavior problems, and parent ratings of behavioral and emotional concerns, Andy also experienced some changes from the pre-to post-treatment assessments. According to parent report, Andy experienced a 2% decrease in total behavior problems over the course of the group treatment program (see Table 7). In contrast, however, Andy also experienced a parent-reported increase of 14% in sexual behavior problems from the pre- to post-treatment assessments (see Table 7). In addition, Andy's mother reported anecdotal increases in sexual behavior over the course of the therapy program. At post-treatment, Andy's scores on these measures continued to approximate those of clinical populations, with his total and sexual behavior problem scores falling outside the normative range (see Figures 6 and 7). Parent ratings of behavioral and emotional problems also revealed decrements in adjustment of 5% to 25% (see Table 7 and Figures 8 and 9).

Social validity data obtained from Andy at post-treatment suggested that he was satisfied with the therapy group and felt that it had been a beneficial experience. Andy's foster mother, while satisfied with the group, indicated that she was unsure if the group had helped her son, acknowledging that she thought his behavior had deteriorated since his involvement in the treatment program. Friedrich and his associates have obtained similar reports from parents in their clinical work (Friedrich et al., 1992).

Adam. Adam was a ten-year-old Caucasian child. He had experienced sexual abuse perpetrated by an uncle, and also may have experienced abusive sexual interactions with his brother and father, as well as a former partner of his mother. At a minimum, Adam's experiences of abuse included fondling by the offender (for more detailed information, see Table 1).

Table 7

Andy's Scores on All Measures at the Pre- and Post-Treatment Assessments

Measure	Pre-Treatment	Post-Treatment
Self-Esteem	76	82
Depression	1	0
Social Competence	30	31
Internalizing Behavior Problems	70	67
Externalizing Behavior Problems	78	75
Total Behavior Problems	79	77
Sexual Behavior Problems	13	28
Parent Ratings of Behavioral Problems	8	8.5
Parent Ratings of Emotional Problems	5	7.5

As illustrated in Table 8, Adam's self-esteem score decreased substantially over the course of group treatment (a change of 24%). In contrast, Adam's depression score increased slightly from the pre- to post-treatment assessments (a change of 9%; see Table 8). By post-treatment, Adam's self-esteem score had declined sufficiently to move further away from average levels, while Adam's depression score maintained its position within the normative range (see Figures 1 and 2).

According to parent reports completed by Adam's mother, Adam experienced a slight increase in social competence scores from the pre- to post-treatment assessments (a change of 10%; see Table 8). At post-treatment, Adam's social competence score more closely approximated normative or average levels, although it still fell within the clinical range of adjustment (see Figure 3). Adam also experienced parent-reported changes in internalizing and externalizing behavior problems over the course of group treatment, with changes in these behaviors ranging from -12% to -14% (see Table 8). At post-treatment, Adam's internalizing and externalizing scores more closely approximated normative or average levels, although both scores still fell within the clinical range (see Figures 4 and 5).

With respect to parent-reported total and sexual behavior problems, and parent ratings of behavioral and emotional concerns, Adam also experienced positive changes from the pre-to post-treatment assessments. According to parent report, Adam experienced a 20% decrease in total behavior problems and a decrease of 21% in sexual behavior problems over the course of the group treatment program (see Table 8). Although his total behavior problem score at post-treatment still exceeded average or normative levels, Adam's post-treatment score for sexual problems more closely approximated scores within the average or normative range (see Figures 6 and 7). Parent ratings of behavioral and emotional problems also revealed improvements in

adjustment for Adam ranging from 20% to 30% (see Table 8 and Figures 8 and 9). In addition, Adam's mother reported anecdotal improvements in his behavior over the course of the group treatment program.

Social validity data obtained from Adam and his mother at post-treatment suggested that he and his mother were both satisfied with the therapy group and felt that it had been a beneficial experience for Adam.

Arthur. Arthur was eight years old and of African-Canadian descent. He had experienced sexual abuse perpetrated by a male foster child residing in his home. Arthur's experiences of abuse included a range of sexual acts, from fondling to oral and anal sex (for more detailed information, see Table 1).

As illustrated in Table 9, Arthur's self-esteem score declined minimally over the course of group treatment (a change of 2%). Similarly, Arthur's depression score decreased slightly from the pre- to post-treatment assessments (a change of 7%; see Table 9). At post-treatment, Arthur's self-esteem score continued to fall within average or normative levels, while his depression score improved to move into the normative range (see Figures 1 and 2).

According to parent reports completed by Arthur's mother, Arthur experienced a slight decrease in social competence scores from the pre- to post-treatment assessments (a change of 10%; see Table 9). Both before and after treatment, Arthur's social competence scores fell within the normative range (see Figure 3). Arthur also experienced minimal parent-reported changes in internalizing and externalizing behavior problems over the course of group treatment, with increases in these

Table 8

Adam's Scores on All Measures at the Pre- and Post-Treatment Assessments

Measure	Pre-Treatment	Post-Treatment
Self-Esteem	62	38
Depression	3	8
Social Competence	29	37
Internalizing Behavior Problems	83	71
Externalizing Behavior Problems	83	69
Total Behavior Problems	89	69
Sexual Behavior Problems	33	10
Parent Ratings of Behavioral Problems	8	6
Parent Ratings of Emotional Problems	8	5

behaviors of 2% to 5% (see Table 9). At post-treatment, Arthur's internalizing and externalizing scores still closely approximated normative or average levels, although his internalizing score moved up to the clinical cutoff (see Figures 4 and 5).

With respect to parent-reported total and sexual behavior problems, and parent ratings of behavioral and emotional concerns, Arthur also experienced some changes from the pre-to post-treatment assessments. According to parent report, Arthur experienced a 2% increase in total behavior problems and a decrease of 3% in sexual behavior problems over the course of the group treatment program (see Table 9). Although his total behavior problem score at post-treatment still exceeded average or normative levels, Arthur's post-treatment score for sexual problems more closely approximated scores within the average or normative range (see Figures 6 and 7). Parent ratings of behavioral and emotional problems also revealed improvements in adjustment for Arthur ranging from 0% to 10% (see Table 9 and Figures 8 and 9). In addition, Arthur's mother reported anecdotal improvements in his behavior over the course of the group treatment program.

Social validity data obtained from Arthur and his mother at post-treatment suggested that he and his mother were both satisfied with the therapy group and felt that it had been a beneficial experience for Arthur.

Allan. Allan was an eight-year-old Caucasian child. He had experienced sexual abuse perpetrated by his biological father as well as an adult male neighbor. Allan's experiences of abuse included a range of sexual acts, from fondling to oral sex, to witnessing the victimization of others (for more detailed information, see Table 1).

As illustrated in Table 10, Allan's self-esteem score increased slightly over the course of group treatment (a change of 10%). In contrast, Allan's depression score decreased moderately from the pre- to post-treatment assessments (a change of 11%;

Table 9

Arthur's Scores on All Measures at the Pre- and Post-Treatment Assessments

Measure	Pre-Treatment	Post-Treatment
Self-Esteem	78	76
Depression	10	6
Social Competence	58	50
Internalizing Behavior Problems	61	63
Externalizing Behavior Problems	65	70
Total Behavior Problems	66	68
Sexual Behavior Problems	12	9
Parent Ratings of Behavioral Problems	3	3
Parent Ratings of Emotional Problems	3	2

see Table 10). At post-treatment, Allan's self-esteem score continued to fall within average or normative levels, while his depression score improved to move into the normative range (see Figures 1 and 2).

According to parent reports completed by Allan's mother and stepfather, Allan experienced minimal change in social competence scores from the pre- to post-treatment assessments (a change of approximately 3%; see Table 10). At post-treatment, Allan's social competence score still closely approximated normative or average levels, although it changed sufficiently to move into the clinical range (see Figure 3). Allan also experienced slight parent-reported changes in internalizing and externalizing behavior problems over the course of group treatment, with decreases in these behaviors of only 1% to 6% (see Table 10). At post-treatment, Allan's internalizing and externalizing scores more closely approximated normative or average levels, although both scores still fell within the clinical range (see Figures 4 and 5).

With respect to parent-reported total and sexual behavior problems, and parent ratings of behavioral and emotional concerns, Allan also experienced some changes from the pre-to post-treatment assessments. According to parent report, Allan experienced a 5% decrease in total behavior problems and a decrease of 22% in sexual behavior problems over the course of the group treatment program (see Table 10). Although his total behavior problem score at post-treatment still exceeded average or normative levels, Allan's post-treatment score for sexual problems fell within the average or normative range (see Figures 6 and 7). Parent ratings of behavioral and emotional problems also revealed changes in adjustment ranging from -20% to +20% (see Table 10 and Figures 8 and 9). In addition, Allan's mother reported anecdotal improvements in his behavior over the course of the group treatment program.

Social validity data obtained from Allan and his mother at post-treatment suggested that he and his mother were both satisfied with the therapy group and felt that it had been a beneficial experience for Allan.

Statistical Analyses for the Group Therapy and Wait-List Comparison Conditions

In order to assess whether overall changes in reported adjustment and behavior for group participants resulted from their involvement in the group treatment program or from other extraneous factors (such as maturation or the passage of time), changes in children's scores over the assessment phase were examined across the group therapy and wait-list comparison conditions. This was accomplished by computing group means for each quantitative measure and then comparing the means in a series of repeated measures analyses of variance. Results of these analyses are presented below. All means are rounded to the nearest whole number.

Child-Report Measures. Children's scores across time on the Self-Esteem Inventory (Coopersmith, 1981) were similar in the group therapy and wait-list comparison conditions (Ms = 71 and 76, respectively). Although children in the group therapy condition tended to have somewhat lower scores, the difference between the groups failed to reach statistical significance, $F(1, 9) = .28$, $p > .05$. Children's self-esteem scores were also similar across groups at the first and second assessments (Ms = 69 and 77, respectively). Scores tended to increase slightly with the passage of time, but the change, once again, failed to reach statistical significance, $F(1, 9) = 2.29$, $p > .05$. Changes in scores over time were similar for children in both groups, with statistical analyses of interaction effects yielding no significant results, $F(1, 9) = .28$, $p > .05$. Mean scores at the first and second assessments were 69 and 74 for the group therapy condition and 70 and 81 for the wait-list comparison group.

Table 10

Allan's Scores on All Measures at the Pre- and Post-Treatment Assessments

Measure	Pre-Treatment	Post-Treatment
Self-Esteem	82	92
Depression	11	5
Social Competence	39	37
Internalizing Behavior Problems	81	80
Externalizing Behavior Problems	84	78
Total Behavior Problems	87	82
Sexual Behavior Problems	25	1
Parent Ratings of Behavioral Problems	8	6
Parent Ratings of Emotional Problems	7	9

Self-report scores across time on the Children's Depression Inventory (Kovacs, 1980/1981) were similar in the group therapy and wait-list comparison conditions (Ms = 6 and 7, respectively). Although children in the group therapy condition tended to have somewhat lower scores, the difference between the groups failed to reach statistical significance, $F(1, 9) = .07$, $p > .05$. Children's depression scores were also similar across groups at the first and second assessments (Ms = 9 and 4, respectively). Scores tended to decrease somewhat with the passage of time, but the change, once again, failed to reach statistical significance, $F(1, 9) = 2.86$, $p > .05$. Changes in scores over time were similar for children in both groups, with statistical analyses of interaction effects yielding no significant results, $F(1, 9) = .01$, $p > .05$. Mean scores at the first and second assessments were eight and four for the group therapy condition and nine and five for the wait-list comparison group.

Parent-Report Measures. Parent reports of social competence across time were similar in the group therapy and wait-list comparison conditions (Ms = 38 and 44, respectively). Although children in the group therapy condition tended to have slightly lower scores, the difference between the groups failed to reach statistical significance, $F(1, 9) = 1.05$, $p > .05$. Children's social competence scores were also similar across groups at the first and second assessments (Ms = 39 and 42, respectively). Scores tended to increase somewhat with the passage of time, but the change, once again, failed to reach statistical significance, $F(1, 9) = .96$, $p > .05$. Changes in scores over time were similar for children in both groups, with statistical analyses of interaction effects yielding no significant results, $F(1, 9) = .65$, $p > .05$. Mean scores at the first and second assessments were 38 and 38 for the group therapy condition and 42 and 47 for the wait-list comparison group.

Parent reports of internalizing behavior problems across time were similar in the group therapy and wait-list comparison conditions (*Ms* = 71 and 68, respectively), as were reports of externalizing (*Ms* = 75 and 65, respectively), and total behavior problems (*Ms* = 76 and 69, respectively). Although children in the group therapy condition tended to have slightly higher scores on these measures, the differences between the groups failed to reach statistical significance [$F(1, 9) = .48$, $p > .05$, for internalizing; $F(1, 9) = 2.98$, $p > .05$, for externalizing; and $F(1, 9) = 1.81$, $p > .05$, for total behavior problems]. Children's scores across groups, however, did change from the the first to second assessments (*Ms* = 72 and 67, respectively, for internalizing; *Ms* = 74 and 67, respectively, for externalizing; and *Ms* = 77 and 69, respectively, for total behavior problems). Scores tended to decrease with the passage of time, with the changes achieving statistical significance [$F(1, 9) = 8.11$, $p < .05$, for internalizing; $F(1, 9) = 9.35$, $p < .05$, for externalizing; and $F(1, 9) = 9.64$, $p < .05$, for total behavior problems]. Changes in scores over time were similar for children in both groups, with statistical analyses of interaction effects yielding no significant results [$F(1, 9) = .10$, $p > .05$ for internalizing; $F(1, 9) = .43$, $p > .05$, for externalizing; and $F(1, 9) = .80$, $p > .05$, for total behavior problems]. Mean internalizing scores at the first and second assessments were 74 and 68 for the group therapy condition and 70 and 66 for the wait-list comparison group. Mean externalizing scores at the first and second assessments were 80 and 71 for the group therapy condition and 68 and 63 for the wait-list comparison group, while mean scores for total behavior problems at the first and second assessments were 82 and 71 for the group therapy condition and 72 and 66 for the wait-list comparison group.

Parent reports of sexual behavior problems across time were similar in the group therapy and wait-list comparison conditions (*Ms* = 18 and 13, respectively). Although

children in the group therapy condition tended to have somewhat higher scores, the difference between the groups failed to reach statistical significance, $F(1, 9) = .49$, $p > .05$. Children's scores across groups, however, did change from the the first to second assessments (Ms = 21 and 10, respectively). Scores tended to decrease with the passage of time, with the changes achieving statistical significance, $F(1, 9) = 5.81$, $p < .05$. Changes in scores over time were similar for children in both groups, with statistical analyses of interaction effects yielding no significant results, $F(1, 9) = .73$, $p > .05$. Mean sexual behavior problem scores at the first and second assessments were 25 and 10 for the group therapy condition and 17 and 10 for the wait-list comparison group.

Parent ratings of behavioral problems in children across time were similar in the group therapy and wait-list comparison conditions (Ms = 6 and 4, respectively). Although children in the group therapy condition tended to have somewhat higher scores, the difference between the groups failed to reach statistical significance, $F(1, 8) = 1.08$, $p > .05$. Children's scores across groups, however, did change from the the first to second assessments (Ms = 6 and 5, respectively). Scores tended to decrease with the passage of time, with the changes achieving statistical significance, $F(1, 8) = 5.52$, $p < .05$. Changes in scores over time were similar for children in both groups, with statistical analyses of interaction effects yielding no significant results, $F(1, 8) = 0$, $p > .05$. Mean scores at the first and second assessments were seven and five for the group therapy condition and five and four for the wait-list comparison group.

Parent ratings of emotional problems in children across time were similar in the group therapy and wait-list comparison conditions (Ms = 6 and 5, respectively). Although children in the group therapy condition tended to have somewhat higher scores, the difference between the groups failed to reach statistical significance, $F(1, 8) = .35$, $p > .05$. Children's emotional problem scores across groups were also similar at the

first and second assessments (Ms = 6 and 5, respectively). Scores tended to decrease slightly with the passage of time, but the change, once again, failed to reach statistical significance, $F(1, 8) = 2.35$, $p > .05$. Changes in scores over time were similar for children in both groups, with statistical analyses of interaction effects yielding no significant results, $F(1, 8) = .02$, $p > .05$. Mean scores at the first and second assessments were seven and five for the group therapy condition and six and five for the wait-list comparison group.

Discussion

The present study was designed to replicate and extend existing clinical knowledge regarding the utility of group treatment for boys who have been sexually abused. Analyses of overall scores on assessment measures for the group therapy condition indicated that children experienced improvements in adjustment and behavior over the course of the group treatment program. Although changes in scores from pre- to post-treatment assessments generally failed to reach statistical significance, changes were in the predicted directions for most assessment scales. Children, for example, experienced an increase in self-esteem over the course of group treatment, and a decrease in depression scores, as measured by self-report. With respect to parent reports, children also experienced improvements from the pre- to post-treatment assessments, exhibiting fewer internalizing, externalizing, total, and sexual behavior problems following group treatment, as well as lower scores on parent ratings of behavioral and emotional concerns. In contrast, parent-reported social competence scores did not appear to change over the course of the group intervention.

Several factors may help to account for this pattern of results. The absence of statistically significant findings on most measures, for example, may be due, in large part, to the small sample size employed in the present study, while the failure to detect

increases in social competence from the pre- to post-treatment assessments may reflect a true absence of improved functioning in this domain, delayed effects of the treatment program, or the potential influence of other extraneous factors (e.g, seasonal changes in children's sports, activities, and clubs). Definitive conclusions regarding these issues await the results of further research.

The findings from analyses involving the group therapy condition generally corresponded well with hypothesized results and with the findings of previous work examining the utility of group treatment for boys and girls who have been sexually abused (e.g., De Luca et al., 1991, 1993, in press; De Luca, Grayston, Boyes, & Romano, 1992; Friedrich et al., 1992; Hack et al., in press). While failing, in most cases, to reach statistical significance, overall findings suggested that group treatment was an effective means of reducing some of the negative sequelae of sexual abuse in preadolescent males.

The overall utility of the group treatment program was also reflected in the responses of group participants and caregivers to items on the Child and Parent Feedback Questionnaires (De Luca, Boyes, Furer, Grayston, & Hiebert-Murphy, 1992; De Luca et al., 1993). The social validity data obtained in the present study, as in previous research (e.g., De Luca et al., 1993), suggested that the group intervention was a positive and beneficial experience for the large majority of children. Given that participation in treatment may be influenced, at least in part, by the acceptability of treatment procedures, these are important findings. It is possible that caregivers and children who enjoy their involvement in therapy and who consider treatment procedures beneficial may be more likely to attend weekly sessions or to seek out other treatment resources if future problems arise (De Luca et al., 1991).

While the overall results of analyses for the group therapy condition suggested that the treatment program was a useful intervention for boys experiencing sexual abuse, closer examination of the results on a case-by-case basis indicated that the effects of the therapy group tended to vary considerably from child to child, with some boys improving, some deteriorating slightly, and some experiencing limited change over the course of the group intervention. Treatment gains, when realized, often represented clinically significant changes in the children's adjustment and behavior, with boys functioning at more normative levels following group intervention (Kazdin, 1982) and/or experiencing improvements in excess of 20% on several assessment scales (Barlow, O'Brien, & Last, 1984).

The findings regarding variability of treatment outcome were very similar to the results of previous work examining the utility of group treatment for boys who have been sexually abused (e.g., Hack et al., in press). Given the variability observed in the present study, as well as evidence linking treatment success with extra-group factors (e.g., social support, severity of abuse; Friedrich et al., 1992), it was considered important to discuss the results of therapy for each child in the program on an individual basis, attempting, wherever possible, to associate measured changes in adjustment and behavior with group attendance and personal circumstances.

Avery. Over the course of group treatment, Avery experienced slight increases in self-esteem and depression scores, as assessed by self-report. Parent reports revealed no change in social competence scores during the group intervention, and slight to substantial decreases in all behavioral and emotional problems. From the pre- to post-treatment assessments, greatest improvement was noted in the areas of sexual behavior problems and overall emotional concerns.

Despite improvements in Avery's adjustment and behavior over the course of the group treatment program, some improvements were quite small, and at post-treatment, his scores on several measures continued to fall outside the average or normative range. Several factors may help to account for this pattern of results. Avery, for example, was able to attend only nine group sessions over the course of the group treatment program. His frequent absences from group, combined with the limited duration of the program, may have resulted in insufficient time to completely process or address all of Avery's concerns. The involvement of Avery's family in a custody and access dispute with the offender during the course of the group intervention may also have had a significant impact on his behavior and adjustment, independent of the group treatment program. It is quite possible that ongoing concerns regarding his own safety and the welfare of his family members may have inhibited Avery's ability to benefit to a greater extent from the therapy group. In support of this assertion, Avery's mother reported that the custody dispute had created considerable stress for Avery and the family as a whole.

Alex. Over the course of group treatment, Alex experienced a substantial increase in self-esteem and a substantial decrease in depression, as assessed by self-report. Parent reports revealed minimal change in social competence scores during the group intervention, and slight to substantial decreases in all behavioral and emotional problems. From the pre- to post-treatment assessments, greatest improvement was noted in the areas of self-esteem and depression.

Despite major improvements in Alex's adjustment and behavior over the course of the group treatment program, at post-treatment, his scores on a small number of measures continued to fall outside the normative range or fell at the clinical cutoff. Thus, while the group assisted Alex in addressing a number of issues related to his experiences of sexual abuse, it may have been too short to completely address all of his

concerns. A longer group program or concurrent involvement in other forms of treatment may have resulted in even greater gains for Alex on the outcome measures employed. As suggested elsewhere, group treatment may be most useful as only one "part of a comprehensive treatment plan, employing multiple therapeutic modalities (e.g., individual, family, and dyad counselling) directed at multiple family members" (De Luca, Boyes, Furer, Grayston, & Hiebert-Murphy, 1992, p. 174).

Andy. Over the course of group treatment, Andy experienced a slight increase in self-esteem and a minimal decrease in depression, as assessed by self-report. Parent reports revealed minimal change in social competence scores during the group intervention, minimal decreases in internalizing, externalizing, and total behavior problems, and minimal to substantial increases in sexual behavior problems and overall behavioral and emotional concerns. From the pre- to post-treatment assessments, greatest change was noted in the areas of sexual behavior problems and overall emotional concerns.

In support of these results, Andy's scores on most measures at post-treatment continued to fall outside the average or normative range. These findings were of obvious concern to therapists, but were not entirely unexpected, given Andy's extensive history of sexual, physical, and psychological abuse. While the group appeared to help Andy in addressing some abuse-related issues and themes, it was very clear, from the initial weeks of the program, that Andy's needs went well beyond the scope of a 12-week therapy group, and that a concurrent referral for individual therapy was definitely required. Andy's attendance at group, while providing him with a safe forum in which to discuss his abusive experiences, may also have made him more aware of the implications and significance of his victimization (Kuhn, 1988), thus limiting treatment gains and increasing behavioral and emotional problems. Andy's apparent deterioration on some

measures over the course of group treatment may also have been a continuing downward trend in his adjustment and behavior, or a simple artifact resulting from increased parental attention to existing behavioral problems.

Adam. Over the course of group treatment, Adam experienced a substantial decrease in self-esteem and a slight increase in depression, as assessed by self-report. Parent reports revealed a slight increase in social competence scores during the group intervention, and moderate to substantial decreases in all behavioral and emotional problems. From the pre- to post-treatment assessments, greatest change was noted in the areas of self-esteem and overall emotional concerns.

Despite improvements in Adam's adjustment and behavior over the course of the group treatment program, some deterioration in self-esteem also occurred, and at post-treatment, his scores on most measures continued to fall outside the average or normative range. Adam, however, missed three sessions over the course of the group treatment program, including the meeting specifically devoted to issues of self-esteem. It is possible that limited group attendance greatly reduced Adam's ability to benefit more extensively from the therapy program. Alternately, Adam's attendance at group may have heightened his sensitivity to the implications and significance of his victimization (Kuhn, 1988), thus limiting treatment gains. Indeed, at several points throughout the group program, the therapists and their supervisor seriously questioned whether the group format was the most appropriate means of addressing Adam's needs, ultimately making a concurrent referral for individual treatment. The death of Adam's alleged perpetrator during treatment, combined with ongoing family conflict and periodic contact with other potential offenders, may also have had a significant impact on Adam's behavior and adjustment, independent of the group treatment program. It is quite

possible that concerns regarding his safety and ongoing family problems may have inhibited Adam's ability to benefit to a greater extent from the therapy group.

Arthur. Over the course of group treatment, Arthur experienced a minimal decline in self-esteem and a slight decrease in depression, as assessed by self-report. Parent reports revealed a slight decrease in social competence scores during the group intervention, minimal increases in internalizing, externalizing, and total behavior problems, and minimal to slight decreases in sexual behavior problems and overall behavioral and emotional concerns. From the pre- to post-treatment assessments, greatest change was noted in the areas of social competence and overall emotional concerns. Generally speaking, however, most changes in Arthur's adjustment and behavior over the course of the group treatment program were extremely small.

By post-treatment, Arthur's depression score had declined to average or normative levels, although his scores on several scales continued to fall within the clinical range. Thus while the group seemed to assist Arthur in addressing some issues related to sexual abuse, it appeared to be too short to fully process all important areas for this child. Financial problems and other difficulties in Arthur's family of origin, which required him to travel independently by taxi cab to and from therapy sessions, may also have had a significant impact on his behavior and adjustment, independent of the group treatment program. It is quite possible that limited material and emotional supports during group, combined with concerns regarding personal security and safety, may have inhibited Arthur's ability to benefit to a greater extent from the therapy program.

Allan. Over the course of group treatment, Allan experienced a slight increase in self-esteem and a moderate decrease in depression, as assessed by self-report. Parent reports revealed a minimal decrease in social competence scores during the group intervention, slight decreases in internalizing, externalizing, and total behavior

problems, substantial decreases in sexual behavior problems and overall behavioral concerns, and a substantial increase in overall emotional problems. From the pre- to post-treatment assessments, greatest change was noted in the areas of sexual behavior problems and overall behavioral and emotional concerns. Generally speaking, however, most changes in Allan's adjustment and behavior over the course of the group treatment program were quite small.

By post-treatment, Allan's depression and sexual behavior problem scores had declined to average or normative levels, although his scores on several scales continued to fall within the clinical range. Several factors may help to account for this pattern of results. Allan, for example, was able to attend only nine group sessions over the course of the group treatment program. His frequent absences from group, combined with the limited duration of the program, greatly reduced the amount of time available for Allan to work on his concerns. Improved attendance or a longer group program may have resulted in greater gains for Allan on the outcome measures employed. Uncertainty regarding custody arrangements, combined with the recent prosecution of Allan's offender and ongoing family issues, may also have had a significant impact on Allan's behavior and adjustment, inhibiting his ability to benefit to a greater extent from the therapy group.

The findings for the group therapy condition, taken as a whole, suggested that short-term therapy groups can have important benefits for boys who have been sexually abused, although the effects of treatment procedures may vary from child to child. Given the diversity of children's reactions to experiences of sexual abuse, however, as well as the variability of their life circumstances (e.g., the types of abuse they have experienced, the amount of familial support they have received), it is not entirely surprising to find that the effects of group treatment may be unique to every child.

Rather than discouraging clinicians' efforts to treat children using group techniques, these findings of variability should instead prompt therapists to devote even greater attention to assessing the different needs and capabilities of the children they see and carefully tailoring their treatment interventions to meet these differing needs.

In assessing children's therapeutic needs and overall capabilities, questions certainly arise concerning the specific measures and procedures that are most appropriate for use in screening referrals to therapy groups. Although comprehensive intake interviews and assessments were conducted in the present study prior to group commencement, in many cases, these procedures did not appear useful in determining which children were the most appropriate candidates for involvement in the group treatment program. Initial assessment procedures were also of limited value in discriminating children who ultimately derived benefits from the group treatment program (e.g., Avery and Alex), from those whose needs were more suited to individual treatment (e.g., Andy and Adam), and those who experienced generally smaller changes over the course of the therapy group (e.g., Arthur and Allan). Use of more sensitive and comprehensive assessment procedures and identification of the variables most commonly associated with treatment success in this particular population are clearly required if therapists are to effectively screen potential group referrals and accurately predict which children will and will not improve following group interventions. Alternately, therapists may find it helpful to conduct a "mini-group" experience as part of their assessment and screening process. In the present study, it was evident within the first two to three sessions which children were most likely to benefit from involvement in the group, and which children were more likely to require individual treatment. Including three preliminary sessions in the screening process that focus on such issues as feelings, coping strategies, self-esteem, social skills, or prevention of sexual abuse,

would not only allow therapists to better assess children's suitability for inclusion in the therapy group, but would also provide children with some practical skills and knowledge should they subsequently be viewed as more appropriate candidates for individual treatment. Such an approach to assessment and screening would also allow therapists to devote more of the "real" group sessions to other pertinent issues (e.g., offenders, family changes, sex education).

With respect to screening issues, the results for the group therapy condition also highlighted for therapists the importance of ensuring that group referrals have consistent and supervised transportation to and from weekly group sessions and that children are living in safe and stable family homes, away from potential offenders. Although these requirements for group participation were made very explicit to referral sources from the beginning of the study, one child (Adam) had periodic or extended contact with three potential offenders over the course of the group treatment program, while another group participant (Arthur) was required to travel to and from sessions by taxi-cab, as no other resources were available to assist with his transportation. These incidents may have provoked some anxiety in the children, as concerns were raised in their minds regarding personal security and safety. Arthur's independent travel to and from group sessions also served to reduce the amount of parental support that was available to him immediately prior to and following sessions. While the exact impact of these factors is unknown, it is quite possible that they impaired the ability of both boys to benefit more extensively from the therapy group.

Related screening and assessment questions concern the specific measures and procedures that are most appropriate for use in evaluating the utility of group interventions. Although children in group therapy condition often displayed measurable changes in questionnaire scores over the course of the group treatment program, the

subjective impressions of therapists and caregivers suggested that children's scores on assessment measures did not always reflect the gains that children had made during the group intervention. In the present study, therapists and caregivers observed many positive changes in all children over the course of the group treatment program that did not seem to be fully captured by the assessment measures employed. Parents, for example, often reported that their children were more willing to talk about their problems and concerns at home and were gradually beginning to realize that the abuse was not their fault. Within group sessions, therapists also observed significant improvements in children, with sometimes dramatic changes occurring in such areas as trust, self-control, communication, and cooperation. Though untapped by the objective measures used in the present study, these changes may represent the "real" or significant effects of the group therapy experience, laying a firm foundation for the children's future development and change. Realizing that the abuse was not their fault, that other children have had similar experiences, that there are some people they can trust, and that they are acceptable to others in their lives may go along way towards assisting children through the recovery process, planting a seed that will potentially have even greater implications later on for their performance on assessment scales. Development of more sensitive outcome measures that directly tap these subjective impressions of treatment gain, combined with long-term follow-up assessments of participating children, will greatly assist future therapists in their efforts to accurately assess the full impact of treatment procedures.

The findings for the group therapy condition, taken as a whole, suggested that short-term therapy groups can promote positive changes in overall adjustment and behavior in boys who have been sexually abused, although the effects of treatment procedures may vary from child to child. These conclusions, however, were tempered to

some degree by the results of analyses involving the wait-list comparison group. Examination of overall scores on assessment measures for both conditions indicated that children in the comparison group also tended to experience improvements on some measures from the first to second assessments. Wait-list children, for example, experienced a decrease in internalizing, externalizing, total, and sexual behavior problems from the first to second assessment, as well as lower scores on parent ratings of overall behavioral concerns. Analyses indicated that these changes were statistically comparable to those experienced by children in the group therapy condition, although improvements were generally larger for the children receiving treatment.

Several factors may help to account for this pattern of results. The absence of statistically significant differences across the conditions may be due, in large part, to the small sample size employed in the present study or to the fact that treatment effects may be delayed in some or all of the boys receiving the group intervention. Larger samples and longer follow-up periods are clearly required to appropriately evaluate these possibilities. Alternately, the changes in adjustment and behavior experienced by children in the wait-list condition may reflect true changes occurring over the 12-week assessment phase. As previously mentioned, several children were involved in other forms of treatment over the course of the present study. It is quite possible that these interventions had an impact upon their scores during the assessment phase. Perhaps for other caregivers and children, making a commitment to change (Corey & Corey, 1987) or simply having the opportunity to interact and consult with caring therapists may have been sufficient to promote some change in adjustment and behavior prior to commencement of the therapy group. During the assessment phase, for example, several parents in the comparison condition had fairly extensive contact with therapists to discuss their children's behavior and other assorted concerns. Knowing that help and

support were available and that there were potential solutions to their problems may have instilled a sense of hope and relief in some of these parents and children. Knowing too, that they would soon have an opportunity to meet other families who had experienced sexual abuse may have helped to universalize their current situations. Factors such as these have been found to be powerful curative forces (Yalom, 1985).

The findings from analyses involving the wait-list comparison condition generally did not correspond with hypothesized results. While failing to reach statistical significance, however, differences in improvements between treated and untreated children were in the predicted directions on most measures, tending to be slightly larger for children in the group therapy condition.

The results of the present study provide useful information regarding the utility of group treatment for boys who have been sexually abused. Nevertheless, the findings must be viewed as preliminary results, given the small number of participants in the study and the limitations of the research design (e.g., the lack of random assignment to treatment and comparison conditions, the lack of follow-up assessments to assess maintenance of treatment gains and delayed effects of the program).

Potential biases associated with parent-report data also suggest a need for caution in the interpretation of current results (Friedrich, 1990). Although changes on assessment measures from the first to second assessments may represent actual differences in children's adjustment and behavior, "parents who spend time and energy getting their children to treatment [or assessment] may have an investment in seeing improvement in their children..." (Hiebert-Murphy et al., 1992, p 211), even if no obvious improvement exists. Alternately, parents may scapegoat their children (Friedrich, 1990) or come to view them as "damaged goods" following experiences of sexual abuse, failing to acknowledge improvements in behavior and adjustment even

when positive changes are made. Caregivers wishing to obtain services for their children may also feel compelled to emphasize the extent of behavioral and emotional problems during pre- or post-treatment assessments (Hack et al., in press). Similar biases may also be present to some degree in child self-report data. The potential existence of such confounding factors highlights the importance of including multiple measures of adjustment and behavior in assessments of therapy outcome and assessing children's adjustment from multiple points of view (Rogers & Terry, 1984).

While it would certainly be advantageous, from both a research and clinical perspective, to assess children with many more measures over time, practical limitations can greatly interfere with this process. Attempts to include additional measures in the present study (e.g., observations of children's behavior at home) seemed to overburden the majority of caregivers in both groups, who either failed to complete the recording tasks or completed them incorrectly. Parental motivation to complete other questionnaires also seemed to wane as the study progressed, and therapists had to be very persistent in obtaining necessary data. Clearly, balancing the therapists' needs for information with the practical resources of clients is a challenging task that requires careful consideration (Hiebert-Murphy et al., 1992). Inclusion of assessment measures that can be completed by other sources familiar with group referrals (e.g., teachers, therapists) may be an option worth considering in future treatment research (Hiebert-Murphy et al., 1992).

The results of the present study suggest that group therapy may be a promising treatment strategy for use with boys who have been sexually abused, although further evaluation of this treatment approach with other groups of children is certainly required. While short-term group treatment programs may have a positive impact on some children's adjustment and behavior, they are clearly not the entire solution, as

some children may experience small improvements even without such intervention and others may require additional therapy to address issues surrounding their experiences of sexual abuse. Many families in which a child has been sexually abused are struggling with a multiplicity of issues that require more therapy than a short-term group can provide. Longer treatment groups for children, combined with additional therapeutic services for parents and other family members may prove instrumental in helping children and families to realize even greater treatment gains. Such interventions may also help to offset the effects of extra-group events (e.g., deaths, changes in custody) that can potentially influence the outcome of short-term therapy groups.

Comprehensive screening and assessment of children, combined with refinement of existing assessment and outcome measures, may also greatly enhance our ability as clinicians to accurately evaluate treatment outcome and to predict which children will and will not improve following group interventions. Continued evaluation of existing treatment programs using these and other strategies is essential if clinicians are to provide optimally effective interventions to those who have experienced sexual abuse.

References

Achenbach, T. M., & Edelbrock, C. (1983). Manual for the Child Behavior Checklist and Revised Child Behavior Profile. Burlington, VT: University of Vermont Department of Psychiatry.

Alter-Reid, K., Gibbs, M. S., Lachenmeyer, J. R., Sigal, J., & Massoth, N. A. (1986). Sexual abuse of children: A review of the empirical findings. Clinical Psychology Review, 6, 249-266.

Badgley, R. F. (1984). Sexual offenses against children. Ottawa: Supply and Services Canada.

Banning, A. (1989). Mother-son incest: Confronting a prejudice. Child Abuse & Neglect, 13, 563-570.

Barlow, D. H., O'Brien, G. T., & Last, C. G. (1984). Couples treatment of agoraphobia. Behavior Therapy, 15, 41-58.

Becker, J. V. (1988). The effects of child sexual abuse on adolescent sexual offenders. In G. E. Wyatt & G. J. Powell (Eds.), Lasting effects of child sexual abuse (pp. 193-207). Newbury Park, CA: Sage.

Beitchman, J. H., Zucker, K. J., Hood, J. E., DaCosta, G. A., & Akman, D. (1991). A review of the short-term effects of child sexual abuse. Child Abuse & Neglect, 15, 537-556.

Berliner, L., & Ernst, E. (1984). Group work with preadolescent sexual assault victims. In I. R. Stuart & J. G. Greer (Eds.), Victims of sexual aggression: Treatment of children, women, and men (pp. 105-124). New York: Van Nostrand Reinhold.

Berman, P. (1990). Group therapy techniques for sexually abused preteen girls. Child Welfare, 69, 239-252.

Blanchard, G. (1986). Male victims of child sexual abuse: A portent of things to come. Journal of Independent Social Work, 1, 19-27.

Briere, J., Evans, D., Runtz, M., & Wall, T. (1988). Symptomatology in men who were molested as children: A comparison study. American Journal of Orthopsychiatry, 58, 457-461.

Browne, A., & Finkelhor, D. (1986). Impact of child sexual abuse: A review of the research. Psychological Bulletin, 99, 66-77.

Bruckner, D. F., & Johnson, P. E. (1987). Treatment for adult male victims of childhood sexual abuse. Social Casework: The Journal of Contemporary Social Work, 68, 81-87.

Cantwell, H. B. (1988). Child sexual abuse: Very young perpetrators. Child Abuse & Neglect, 12, 579-582.

Carozza, P. M., & Heirsteiner, C. L. (1982). Young female incest victims in treatment: Stages of growth seen with a group art therapy model. Clinical Social Work Journal, 10, 165-175.

Cavaiola, A. A., & Schiff, M. (1989). Self-esteem in abused chemically dependent adolescents. Child Abuse & Neglect, 13, 327-334.

Chasnoff, I. J., Burns, W. J., Schnoll, S. H., Burns, K., Chisum, G., & Kyle-Spore, L. (1986). Maternal-neonatal incest. American Journal of Orthopsychiatry, 56, 577-580.

Cohen, J. A., & Mannarino, A. P. (1988). Psychological symptoms in sexually abused girls. Child Abuse & Neglect, 12, 571-577.

Conte, J. R., & Schuerman, J. R. (1987). Factors associated with an increased impact of child sexual abuse. Child Abuse & Neglect, 11, 201-211.

Conte, J. R., & Schuerman, J. R. (1988). The effects of sexual abuse on children: A multidimensional view. In G. E. Wyatt & G. J. Powell (Eds.), Lasting effects of child sexual abuse (pp. 157-170). Newbury Park, CA: Sage.

Coopersmith, S. (1967). The antecedents of self-esteem. San Francisco: Freeman.

Coopersmith, S. (1981). SEI: Self-Esteem Inventories. Palo Alto, CA: Consulting Psychologists Press.

Corder, B. F., Haizlip, T., & DeBoer, P. (1990). A pilot study for a structured, time-limited therapy group for sexually abused pre-adolescent children. Child Abuse & Neglect, 14, 243-251.

Corey, M. S., & Corey, G. (1987). Groups: Process and practice (3rd ed.). Pacific Grove, CA: Brooks/Cole.

Courtois, C. A. (1988). Healing the incest wound: Adult survivors in therapy. New York: Norton.

Cunningham, C., & MacFarlane, K. (1991). When children molest children: Group treatment strategies for young sexual abusers. Orwell, VT: Safer Society Press.

Dawson, R. (1984). Therapeutic intervention with sexually abused children. Journal of Child Care, 1(6), 29-35.

Deaton, W., & Johnson, K. (1991). No more hurt. Alameda, CA: Hunter House.

Delson, N., & Clark, M. (1981). Group therapy with sexually molested children. Child Welfare, 60, 175-182.

De Luca, R. V., Boyes, D. A., Cairns, S. L., Gilman, D. A., & Grayston, A. D. (1991, June). Group treatment for children who have been sexually abused. Workshop presented at the Annual Convention of the Canadian Psychological Association, Calgary, AB.

De Luca, R. V., Boyes, D. A., Furer, P., Grayston, A. D., & Hiebert-Murphy, D. (1992). Group treatment for child sexual abuse. Canadian Psychology, 33, 168-179.

De Luca, R. V., Boyes, D. A., Grayston, A. D., & Romano, E. (1993). Sexual abuse: Effects of group therapy on preadolescent girls. Manuscript submitted for publication.

De Luca, R. V., Grayston, A. D., Boyes, D. A., & Romano, E. (1992, October). A group therapy program for children who have been traumatized by sexual abuse. Workshop presented at the International Conference on the Child, Montreal, PQ.

De Luca, R. V., Hazen, A., & Cutler, J. (in press). Evaluation of a group counseling program for preadolescent female victims of incest. Elementary School Guidance & Counseling.

De Luca, R. V., Hiebert-Murphy, D., Runtz, M., & Wallbridge, H. (1989, June). Outcome of group treatment for sexually abused children. Paper presented at the Annual Convention of the Canadian Psychological Association, Halifax, NS.

Dimock, P. T. (1988). Adult males sexually abused as children. Journal of Interpersonal Violence, 3, 203-221.

Dlugokinski, E. (1987). Dealing with feelings [Card Game]. Raleigh, NC: Feelings Factory.

Dlugokinski, E. (1988). The boys' and girls' book of dealing with feelings. Raleigh, NC: Feelings Factory.

Dlugokinski, E., & Suh, H. (1989). My workbook: Dealing with feelings. Raleigh, NC: Feelings Factory.

Dossick, J., & Shea, E. (1988). Creative therapy: 52 exercises for groups. Sarasota, FL: Professional Resource Exchange.

Einbender, A. J., & Friedrich, W. N. (1989). Psychological functioning and behavior of sexually abused girls. Journal of Consulting and Clinical Psychology, 57, 155-157.

Ellerstein, N. S., & Canavan, J. W. (1980). Sexual abuse of boys. American Journal of Diseases of Children, 134, 255-257.

Ellis, P. L., Piersma, H. L., & Grayson, C. E. (1990). Interrupting the reenactment cycle: Psychotherapy of a sexually traumatized boy. American Journal of Psychotherapy, 44, 525-535.

Everstine, D. S., & Everstine, L. (1989). Sexual trauma in children and adolescents: Dynamics and treatment. New York: Brunner/Mazel.

Faller, K. C. (1989). Characteristics of a clinical sample of sexually abused children: How boy and girl victims differ. Child Abuse & Neglect, 13, 281-291.

Finkelhor, D. (1981). The sexual abuse of boys. Victimology: An International Journal, 6, 76-84.

Finkelhor, D. (1984). Child sexual abuse: New theory and research. New York: Free Press.

Finkelhor, D. (1986a). Abusers: Special topics. In D. Finkelhor (Ed.), A sourcebook on child sexual abuse (pp. 119-141). Beverly Hills, CA: Sage.

Finkelhor, D. (1986b). Designing new studies. In D. Finkelhor (Ed.), A sourcebook on child sexual abuse (pp. 199-223). Beverly Hills, CA: Sage.

Finkelhor, D. (1990). Early and long-term effects of child sexual abuse: An update. Professional Psychology: Research and Practice, 21, 325-330.

Finkelhor, D., & Baron, L. (1986). High-risk children. In D. Finkelhor (Ed.), A sourcebook on child sexual abuse (pp. 60-88). Beverly Hills, CA: Sage.

Finkelhor, D., Hotaling, G. T., Lewis, I. A., & Smith, C. (1990). Sexual abuse in a national survey of adult men and women: Prevalence, characteristics, and risk factors. Child Abuse & Neglect, 14, 19-28.

Forseth, L. B., & Brown, A. (1981). A survey of intrafamilial sexual abuse treatment centers: Implications for intervention. Child Abuse & Neglect, 5, 177-186.

Freeman-Longo, R. E. (1986). The impact of sexual victimization on males. Child Abuse & Neglect, 10, 411-414.

Friedrich, W. N. (1989, August). Psychotherapy research with sexually abused children and their families. Paper presented at the Annual Convention of the American Psychological Association, New Orleans, LA.

Friedrich, W. N. (1990). Psychotherapy of sexually abused children and their families. New York: Norton.

Friedrich, W. N. (1991). Therapy with a sexually aggressive young boy. In W. N. Friedrich (Ed.), Casebook of sexual abuse treatment (pp. 253-269). New York: Norton.

Friedrich, W. N. (1993). Sexual victimization and sexual behavior in children: A review of recent literature. Child Abuse & Neglect, 17, 59-66.

Friedrich, W. N., Beilke, R. L., & Urquiza, A. J. (1988). Behavior problems in young sexually abused boys: A comparison study. Journal of Interpersonal Violence, 3, 21-28.

Friedrich, W. N., Grambsch, P., Broughton, D., Kuiper, J., & Beilke, R. L. (1991). Normative sexual behavior in children. Pediatrics, 88, 456-464.

Friedrich, W. N., Grambsch, P., Damon, L., Hewitt, S. K., Koverola, C., Lang, R. A., Wolfe, V., & Broughton, D. (1992). Child Sexual Behavior Inventory: Normative and clinical comparisons. Psychological Assessment, 4, 303-311.

Friedrich, W. N., & Luecke, W. J. (1988). Young school-age sexually aggressive children. Professional Psychology: Research and Practice, 19, 155-164.

Friedrich, W. N., Luecke, W. J., Beilke, R. L., & Place, V. (1992). Psychotherapy outcome of sexually abused boys: An agency study. Journal of Interpersonal Violence, 7, 396-409.

Friedrich, W. N., Urquiza, A. J., & Beilke, R. L. (1986). Behavior problems in sexually abused young children. Journal of Pediatric Psychology, 11, 47-57.

Gagliano, C. K. (1987). Group treatment for sexually abused girls. Social Casework: The Journal of Contemporary Social Work, 68, 102-108.

Gale, J., Thompson, R. J., Moran, T., & Sack, W. H. (1988). Sexual abuse in young children: Its clinical presentation and characteristic patterns. Child Abuse & Neglect, 12, 163-170.

German, D. E., Habenicht, D. J., & Futcher, W. G. (1990). Psychological profile of the female adolescent incest victim. Child Abuse & Neglect, 14, 429-438.

Grayston, A. D., De Luca, R. V., & Boyes, D. A. (1992). Self-esteem, anxiety, and loneliness in preadolescent girls who have experienced sexual abuse. Child Psychiatry and Human Development, 22, 277-286.

Grayston, A. D., De Luca, R. V., Boyes, D. A., & Romano, E. (1992, June). Efficacy of assertiveness training with preadolescent girls who have been sexually abused. Paper presented at the Annual Convention of the Canadian Psychological Association, Quebec City, PQ.

Groth, A. N. (1979). Sexual trauma in the life histories of rapists and child molesters. Victimology: An International Journal, 4, 10-16.

Hack, T. F., Osachuk, T. A. G., & De Luca, R. V. (in press). Group treatment effects for pre-adolescent boys who have been sexually abused: Pre-, post-, and follow-up. Families in Society: The Journal of Contemporary Human Services.

Hall, N. M. (1978). Group treatment for sexually abused children. Nursing Clinics of North America, 13, 701-705.

Haugaard, J. J., & Reppucci, N. D. (1988). The sexual abuse of children: A comprehensive guide to current knowledge and intervention strategies. San Francisco: Jossey-Bass.

Hazzard, A., King, H. E., & Webb, C. (1986). Group therapy with sexually abused adolescent girls. American Journal of Psychotherapy, 40, 213-223.

Hessell, J., & Nelson, M. (1988). I'm glad I told Mum!: A parent and child's guide to coping with sexual abuse. London: Beaver Books.

Hiebert-Murphy, D., & De Luca, R. V. (1992). Initial effects of child sexual abuse: Methodological issues and implications for treatment. Manuscript submitted for publication.

Hiebert-Murphy, D., De Luca, R. V., & Runtz, M. (1992). Group treatment for sexually abused girls: Evaluating outcome. Families in Society: The Journal of Contemporary Human Services, 73, 205-213.

Hoier, T. S. (1987). Child sexual abuse: Clinical interventions and new directions. Journal of Child and Adolescent Psychotherapy, 4, 179-185.

Hoier, T. S. (1991). The course of treatment of a sexually abused child: A single-case study. Behavioral Assessment, 13, 385-398.

Hunter, M. (1990). Abused boys: The neglected victims of sexual abuse. New York: Ballantine.

Inderbitzen-Pisaruk, H., Shawchuck, C. R., & Hoier, T. S. (1992). Behavioral characteristics of child victims of sexual abuse: A comparison study. Journal of Clinical Child Psychology, 21, 14-19.

Jackson, J. L., Calhoun, K. S., Amick, A. E., Maddever, H. M., & Habif, V. L. (1990). Young adult women who report childhood intrafamilial sexual abuse: Subsequent adjustment. Archives of Sexual Behavior, 19, 211-221.

Janus, M. D., Burgess, A. W., & McCormack, A. (1987). Histories of sexual abuse in adolescent male runaways. Adolescence, 22, 405-417.

Johnson, R. L., & Shrier, D. K. (1985). Sexual victimization of boys: Experience at an adolescent medicine clinic. Journal of Adolescent Health Care, 6, 372-376.

Johnson, T. C. (1988). Child perpetrators--children who molest other children: Preliminary findings. Child Abuse & Neglect, 12, 219-229.

Johnson, T. C. (1989a). Female child perpetrators: Children who molest other children. Child Abuse & Neglect, 13, 571-585.

Johnson, T. C. (1989b). Let's talk about touching [Card Game]. Raleigh, NC: Feelings Factory.

Johnson, T. C. (1991). Treatment of a sexually reactive girl. In W. N. Friedrich (Ed.), Casebook of sexual abuse treatment (pp. 270-290). New York: Norton.

Johnson, T. C. (1992). Let's talk about touching in the family [Card Game]. Raleigh, NC: Feelings Factory.

Johnson, T. C., & Berry, C. (1989). Children who molest: A treatment program. Journal of Interpersonal Violence, 4, 185-203.

Kazdin, A. E. (1982). Single-case research designs: Methods for clinical and applied settings. New York: Oxford University Press.

Kendall-Tackett, K. A., & Simon, A. F. (1992). A comparison of the abuse experiences of male and female adults molested as children. Journal of Family Violence, 7, 57-62.

Kendall-Tackett, K. A., Williams, L. M., & Finkelhor, D. (1993). Impact of sexual abuse on children: A review and synthesis of recent empirical studies. Psychological Bulletin, 113, 164-180.

Kitchur, M., & Bell, R. (1989). Group psychotherapy with preadolescent sexual abuse victims: Literature review and description of an inner-city group. International Journal of Group Psychotherapy, 39, 285-310.

Kolko, D. J. (1987). Treatment of child sexual abuse: Programs, progress, and prospects. Journal of Family Violence, 2, 303-318.

Kolko, D. J., Moser, J. T., & Weldy, S. R. (1988). Behavioral/emotional indicators of sexual abuse in child psychiatric inpatients: A controlled comparison with physical abuse. Child Abuse & Neglect, 12, 529-541.

Kovacs, M. (1980/1981). Rating scales to assess depression in school-aged children. Acta Paedopsychiatrica, 46, 305-315.

Kuhn, B. A. (1988). Effects of group treatment on sexually abused young children. Unpublished master's practicum, University of Manitoba, Winnipeg, MB.

Leith, A., & Handforth, S. (1988). Groupwork with sexually abused boys. Practice, 2, 166-175.

Lew, M. (1988). Victims no longer: Men recovering from incest and other sexual child abuse. New York: Harper & Row.

Lubell, D., & Soong, W. T. (1982). Group therapy with sexually abused adolescents. Canadian Journal of Psychiatry, 27, 311-315.

Lusk, R., & Waterman, J. (1986). Effects of sexual abuse on children. In K. MacFarlane and J. Waterman (Eds.), Sexual abuse of young children: Evaluation and treatment (pp. 101-118). New York: Guilford.

Mayle, P. (1975). What's happening to me? New York: Carol Publishing Group.

Meiselman, K. C. (1990). Resolving the trauma of incest: Reintegration therapy with survivors. San Francisco: Jossey-Bass.

Minden, H. A. (1982). Two hugs for survival: Strategies for effective parenting. Toronto: McClelland and Stewart.

Mrazek, P. B. (1981). Group psychotherapy with sexually abused children. In P. B. Mrazek & C. H. Kempe (Eds.), Sexually abused children and their families (pp. 199-210). Oxford: Pergamon.

Napier-Hemy, J. (1991). When children act out sexually: A guide for parents and teachers. Vancouver, BC: Family Services of Greater Vancouver.

Nasjleti, M. (1980). Suffering in silence: The male incest victim. Child Welfare, 59, 269-275.

Nelki, J. S., & Watters, J. (1989). A group for sexually abused young children: Unravelling the web. Child Abuse & Neglect, 13, 369-377.

O'Donohue, W., & Elliott, A. N. (1991). A model for the clinical assessment of the sexually abused child. Behavioral Assessment, 13, 325-339.

O'Donohue, W. T., & Elliott, A. N. (1992). Treatment of the sexually abused child: A review. Journal of Clinical Child Psychology, 21, 218-228.

Ollendick, T. H., & Cerny, J. A. (1981). Clinical behavior therapy with children. New York: Plenum.

Peake, A. (1987). An evaluation of group work for sexually abused adolescent girls and boys. Educational and Child Psychology, 4, 189-203.

Peplau, L. A., & Perlman, D. (1982). Perspectives on loneliness. In L. A. Peplau & D. Perlman (Eds.), Loneliness: A sourcebook of current theory, research and therapy (pp. 1-18). New York: Wiley.

Pescosolido, F. J., & Petrella, D. M. (1986). The development, process, and evaluation of group psychotherapy with sexually abused preschool girls. International Journal of Group Psychotherapy, 36, 447-469.

Peters, S. D., Wyatt, G. E., & Finkelhor, D. (1986). Prevalence. In D. Finkelhor (Ed.), A sourcebook on child sexual abuse (pp. 15-59). Beverly Hills, CA: Sage.

Phillips, D., & Bernstein, F. A. (1989). How to give your child a great self-image. New York: Plume.

Pierce, R., & Pierce, L. H. (1985). The sexually abused child: A comparison of male and female victims. Child Abuse & Neglect, 9, 191-199.

Pope, A. W., McHale, S. M., & Craighead, W. E. (1988). Self-esteem enhancement with children and adolescents. New York: Pergamon.

Porter, E. (1986). Treating the young male victim of sexual assault: Issues and intervention strategies. Orwell, VT: Safer Society Press.

Porter, F. S., Blick, L. C., & Sgroi, S. M. (1982). Treatment of the sexually abused child. In S. M. Sgroi (Ed.), Handbook of clinical intervention in child sexual abuse (pp. 109-145). Lexington, MA: Lexington Books.

Pound, J., Koverola, C., & Heger, A. (1990, May). Severity of child sexual abuse and its relationship to depression. Paper presented at the Annual Convention of the Canadian Psychological Association, Ottawa, ONT.

Reinhart, M. A. (1987). Sexually abused boys. Child Abuse & Neglect, 11, 229-235.

RGA Publishing Group. (1984). It's O.K. to say no! [Coloring Book]. Hollywood, FL: Kid Stuff Records & Tapes.

Roane, T. H. (1992). Male victims of sexual abuse: A case review within a child protective team. Child Welfare, 71, 231-239.

Rogers, C. M., & Terry, T. (1984). Clinical intervention with boy victims of sexual abuse. In I. R. Stuart & J. G. Greer (Eds.), Victims of sexual aggression: Treatment of children, women, and men (pp. 91-104). New York: Van Nostrand Reinhold.

Ryan, G. (1989). Victim to victimizer: Rethinking victim treatment. Journal of Interpersonal Violence, 4, 325-341.

Ryan, G., Lane, S., Davis, J., & Isaac, C. (1987). Juvenile sex offenders: Development and correction. Child Abuse & Neglect, 11, 385-395.

Sansonnett-Hayden, H., Haley, G., Marriage, K., & Fine, S. (1987). Sexual abuse and psychopathology in hospitalized adolescents. Journal of the American Academy of Child and Adolescent Psychiatry, 26, 753-757.

Saylor, C. F., Finch, A. J., Spirito, A., & Bennett, B. (1984). The Children's Depression Inventory: A systematic evaluation of psychometric properties. Journal of Consulting and Clinical Psychology, 52, 955-967.

Schacht, A. J., Kerlinsky, D., & Carlson, C. (1990). Group therapy with sexually abused boys: Leadership, projective identification, and countertransference issues. International Journal of Group Psychotherapy, 40, 401-417.

Sebold, J. (1987). Indicators of child sexual abuse in males. Social Casework: The Journal of Contemporary Social Work, 68, 75-80.

Sgroi, S. M. (1992, September). Child sexual abuse: Investigative technique and clinical intervention. Workshop presented to Child and Family Services of Central Manitoba, Portage La Prairie, MB.

Singer, K. I. (1989). Group work with men who experienced incest in childhood. American Journal of Orthopsychiatry, 59, 468-472.

Smith, H., & Israel, E. (1987). Sibling incest: A study of the dynamics of 25 cases. Child Abuse & Neglect, 11, 101-108.

Steward, M. S., Farquhar, L. C., Dicharry, D. C., Glick, D. R., & Martin, P. W. (1986). Group therapy: A treatment of choice for young victims of child abuse. International Journal of Group Psychotherapy, 36, 261-277.

Sturkie, K. (1983). Structured group treatment for sexually abused children. Health and Social Work, 8, 299-308.

Sturkie, K. (1992). Group treatment of child sexual abuse victims: A review. In W. O'Donohue & J. H. Geer (Eds.), The sexual abuse of children: Clinical issues (pp. 331-363). Hillsdale, NJ: Lawrence Erlbaum.

Tharinger, D. (1990). Impact of child sexual abuse on developing sexuality. Professional Psychology: Research and Practice, 21, 331-337.

Tong, L., Oates, K., & McDowell, M. (1987). Personality development following sexual abuse. Child Abuse & Neglect, 11, 371-383.

Vander Mey, B. J. (1988). The sexual victimization of male children: A review of previous research. Child Abuse & Neglect, 12, 61-72.

Waterman, J., & Lusk, R. (1986). Scope of the problem. In K. MacFarlane & J. Waterman (Eds.), Sexual abuse of young children: Evaluation and treatment (pp. 3-12). New York: Guilford.

Waterman, J., MacFarlane, K., Conerly, S., Damon, L., Durfee, M., & Long, S. (1986). Challenges for the future. In K. MacFarlane & J. Waterman (Eds.), Sexual abuse of young children: Evaluation and treatment (pp. 315-332). New York: Guilford.

Watkins, B., & Bentovim, A. (1992). The sexual abuse of male children and adolescents: A review of current research. Journal of Child Psychology and Psychiatry and Allied Disciplines, 33, 197-248.

Weille, K. L. H. (1992, October). Use of group therapy for child victims and perpetrators of sexual abuse: The convergences of victimization, victimizing, and shame. Paper presented at the International Conference on the Child, Montreal, PQ.

Wolfe, V. V., & Gentile, C. (1992). Psychological assessment of sexually abused children. In W. O'Donohue & J. H. Geer (Eds.), The sexual abuse of children: Clinical issues (pp. 143-187). Hillsdale, NJ: Lawrence Erlbaum.

Wolfe, V. V., & Wolfe, D. A. (1988). The sexually abused child. In E. J. Mash & L. G. Terdal (Eds.), Behavioral assessment of childhood disorders (2nd ed., pp. 670-714). New York: Guilford.

Yalom, I. D. (1985). The theory and practice of group psychotherapy (3rd ed.). New York: Basic Books.

Yates, A. (1982). Children eroticized by incest. American Journal of Psychiatry, 139, 482-485.

Appendix A

Self-Esteem Inventory

Name: ___________________________ Age: _____ Date: ____________________

	Like Me	Unlike Me
1. Things usually don't bother me.	________	________
2. I find it very hard to talk in front of the class.	________	________
3. There are lots of things about myself I'd change if I could.	________	________
4. I can make up my mind without too much trouble.	________	________
5. I'm a lot of fun to be with.	________	________
6. I get upset easily at home.	________	________
7. It takes me a long time to get used to anything new.	________	________
8. I'm popular with kids my own age.	________	________
9. My parents usually consider my feelings.	________	________
10. I give in very easily.	________	________
11. My parents expect too much of me.	________	________
12. It's pretty tough to be me.	________	________
13. Things are all mixed up in my life.	________	________
14. Kids usually follow my ideas.	________	________
15. I have a low opinion of myself.	________	________
16. There are many times when I'd like to leave home.	________	________
17. I often feel upset in school.	________	________
18. I'm not as nice looking as most people.	________	________
19. If I have something to say, I usually say it.	________	________

Appendix A (con't)

	Like Me	Unlike Me
20. My parents understand me.	_______	_______
21. Most people are better liked than I am.	_______	_______
22. I usually feel as if my parents are pushing me.	_______	_______
23. I often get discouraged at school.	_______	_______
24. I often wish I were someone else.	_______	_______
25. I can't be depended on.	_______	_______
26. I never worry about anything.	_______	_______
27. I'm pretty sure of myself.	_______	_______
28. I'm easy to like.	_______	_______
29. My parents and I have a lot of fun together.	_______	_______
30. I spend a lot of time daydreaming.	_______	_______
31. I wish I were younger.	_______	_______
32. I always do the right thing.	_______	_______
33. I'm proud of my schoolwork.	_______	_______
34. Someone always has to tell me what to do.	_______	_______
35. I'm often sorry for the things I do.	_______	_______
36. I'm never happy.	_______	_______
37. I'm doing the best work that I can.	_______	_______
38. I can usually take care of myself.	_______	_______
39. I'm pretty happy.	_______	_______
40. I would rather play with children younger than I am.	_______	_______
41. I like everyone I know.	_______	_______
42. I like to be called on in class.	_______	_______

Appendix A (con't)

	Like Me	Unlike Me
43. I understand myself.	________	________
44. No one pays much attention to me at home.	________	________
45. I never get scolded.	________	________
46. I'm not doing as well in school as I'd like to.	________	________
47. I can make up my mind and stick to it.	________	________
48. I really don't like being a boy.	________	________
49. I don't like to be with other people.	________	________
50. I'm never shy.	________	________
51. I often feel ashamed of myself.	________	________
52. Kids pick on me very often.	________	________
53. I always tell the truth.	________	________
54. My teachers make me feel I'm not good enough.	________	________
55. I don't care what happens to me.	________	________
56. I'm a failure.	________	________
57. I get upset easily when I'm scolded.	________	________
58. I always know what to say to people.	________	________

Appendix B

Children's Depression Inventory

Name: __________________________ Age: _____ Date: ____________________

1. _____ I am sad once in a while

   _____ I am sad many times

   _____ I am sad all the time

2. _____ Nothing will ever work out for me

   _____ I am not sure if things will work out for me

   _____ Things will work out for me O.K.

3. _____ I do most things O.K.

   _____ I do many things wrong

   _____ I do everything wrong

4. _____ I have fun in many things

   _____ I have fun in some things

   _____ Nothing is fun at all

5. _____ I am bad all the time

   _____ I am bad many times

   _____ I am bad once in a while

Appendix B (con't)

6. _____ I think about bad things happening to me once in a while

_____ I worry that bad things will happen to me

_____ I am sure that terrible things will happen to me

7. _____ I hate myself

_____ I do not like myself

_____ I like myself

8. _____ All bad things are my fault

_____ Many bad things are my fault

_____ Bad things are not usually my fault

9. _____ I do not think about killing myself

_____ I think about killing myself but I would not do it

_____ I want to kill myself

10. _____ I feel like crying everyday

_____ I feel like crying many days

_____ I feel like crying once in a while

11. _____ Things bother me all the time

_____ Things bother me many times

_____ Things bother me once in a while

Appendix B (con't)

12. _____ I like being with people

_____ I do not like being with people many times

_____ I do not want to be with people at all

13. _____ I cannot make up my mind about things

_____ It is hard to make up my mind about things

_____ I make up my mind about things easily

14. _____ I look O.K.

_____ There are some bad things about my looks

_____ I look ugly

15. _____ I have to push myself all the time to do my schoolwork

_____ I have to push myself many times to do my schoolwork

_____ Doing schoolwork is not a big problem

16. _____ I have trouble sleeping every night

_____ I have trouble sleeping many nights

_____ I sleep pretty well

17. _____ I am tired once in a while

_____ I am tired many days

_____ I am tired all the time

Appendix B (con't)

18. _____ Most days I do not feel like eating

_____ Many days I do not feel like eating

_____ I eat pretty well

19. _____ I do not worry about aches and pains

_____ I worry about aches and pains many times

_____ I worry about aches and pains all the time

20. _____ I do not feel alone

_____ I feel alone many times

_____ I feel alone all the time

21. _____ I never have fun at school

_____ I have fun at school only once in a while

_____ I have fun at school many times

22. _____ I have plenty of friends

_____ I have some friends but I wish I had more

_____ I do not have any friends

23. _____ My schoolwork is alright

_____ My schoolwork is not as good as before

_____ I do very badly in subjects I used to be good in

Appendix B (con't)

24. _____ I can never be as good as other kids

_____ I can be as good as other kids if I want to

_____ I am just as good as other kids

25. _____ Nobody really loves me

_____ I am not sure if anybody loves me

_____ I am sure that somebody loves me

26. _____ I usually do what I am told

_____ I do not do what I am told most times

_____ I never do what I am told

27. _____ I get along with people

_____ I get into fights many times

_____ I get into fights all the time

Appendix C

Child Behavior Checklist

Name: ___________________________ Age: _____ Date: ____________________

I. Please list the sports your child most likes to take part in. For example: swimming, baseball, skating, skate boarding, bike riding, fishing, etc.

[ ] None

a. _____________________

b. _____________________

c. _____________________

Compared to other children of the same age, about how much time does he/she spend in each?

a. ____ Don't Know ____ Less Than Average ____ Average ____ More Than Average

b. ____ Don't Know ____ Less Than Average ____ Average ____ More Than Average

c. ____ Don't Know ____ Less Than Average ____ Average ____ More Than Average

Compared to other children of the same age, how well does he/she do each one?

a. ____ Don't Know ____ Below Average ____ Average ____ Above Average

b. ____ Don't Know ____ Below Average ____ Average ____ Above Average

c. ____ Don't Know ____ Below Average ____ Average ____ Above Average

Appendix C (con't)

II. Please list your child's favorite hobbies, activities, and games, other than sports. For example: stamps, dolls, books, piano, crafts, singing, etc. (Do not include T.V.).

[ ] None

a. ____________________

b. ____________________

c. ____________________

Compared to other children of the same age, about how much time does he/she spend in each?

a. ___ Don't Know ___ Less Than Average ___ Average ___ More Than Average

b. ___ Don't Know ___ Less Than Average ___ Average ___ More Than Average

c. ___ Don't Know ___ Less Than Average ___ Average ___ More Than Average

Compared to other children of the same age, how well does he/she do each one?

a. ___ Don't Know ___ Below Average ___ Average ___ Above Average

b. ___ Don't Know ___ Below Average ___ Average ___ Above Average

c. ___ Don't Know ___ Below Average ___ Average ___ Above Average

Appendix C (con't)

III. Please list any organizations, clubs, teams, or groups your child belongs to.

[ ] None

a. ____________________

b. ____________________

c. ____________________

Compared to other children of the same age, how active is he/she in each?

a. _____ Don't Know _____ Less Active _____ Average _____ More Active

b. _____ Don't Know _____ Less Active _____ Average _____ More Active

c. _____ Don't Know _____ Less Active _____ Average _____ More Active

IV. Please list any jobs or chores your child has. For example: paper route, babysitting, making bed, etc.

[ ] None

Compared to other children of the same age, how well does he/she carry them out?

a. ____ Don't Know ____ Below Average ____ Average ____ Above Average

b. ____ Don't Know ____ Below Average ____ Average ____ Above Average

c. ____ Don't Know ____ Below Average ____ Average ____ Above Average

Appendix C (con't)

V. About how many close friends does your child have?

___ None ___ 1 ___ 2 or 3 ___ 4 or more

About how many times a week does your child do things with them?

___ less than 1 ___ 1 or 2 ___ 3 or more

VI. Compared to other children of his/her age, how well does your child:

a. Get along with his/her brothers/sisters? _ Worse _ About the Same _ Better

b. Get along with other children? _ Worse _ About the Same _ Better

c. Behave with his/her parents? _ Worse _ About the Same _ Better

d. Play and work by himself/herself? _ Worse _ About the Same _ Better

VII. Current school performance-for children aged 6 and older:

[ ] Does not go to school

a. Reading or English _ Failing _ Below Average _ Average _ Above Average

b. Writing _ Failing _ Below Average _ Average _ Above Average

c. Arithmetic or Math _ Failing _ Below Average _ Average _ Above Average

d. Spelling _ Failing _ Below Average _ Average _ Above Average

Appendix C (con't)

Other academic subjects - for example: history, science, foreign language, geography.

e. _____________ _ Failing _ Below Average _ Average _ Above Average

f. _____________ _ Failing _ Below Average _ Average _ Above Average

g. _____________ _ Failing _ Below Average _ Average _ Above Average

Is your child in a special class? ___ No ___ Yes - what kind? _______________

____

Has your child ever repeated a grade? ___ No ___ Yes - grade and reason _______

____

Has your child had any academic or other problems in school?

___ No ___ Yes - please describe _____________________________________

When did these problems start? ____

Have these problems ended? ___ No ___ Yes - when? _____________________

Appendix C (con't)

VIII. Below is a list of items that describe children. For each item that describes your child now or within the past 6 months, please circle the 2 if the item is very true or often true of your child. Circle the 1 if the item is somewhat or sometimes true of your child. If the item is not true of your child, circle the 0. Please answer all items as well as you can, even if some do not seem to apply to your child.

0 = Not True (As Far As You Know)

1 = Somewhat or Sometimes True

2 = Very True or Often True

1. 0 1 2 Acts too young for his/her age
2. 0 1 2 Allergy (describe): ______________________________

   ____
3. 0 1 2 Argues a lot
4. 0 1 2 Asthma
5. 0 1 2 Behaves like opposite sex
6. 0 1 2 Bowel movements outside toilet
7. 0 1 2 Bragging, boasting
8. 0 1 2 Can't concentrate, can't pay attention for long
9. 0 1 2 Can't get his/her mind off certain thoughts; obsessions (describe): ______________________________

   ____

Appendix C (con't)

10.	0	1	2	Can't sit still, restless, or hyperactive
11.	0	1	2	Clings to adults or too dependent
12.	0	1	2	Complains of loneliness
13.	0	1	2	Confused or seems to be in a fog
14.	0	1	2	Cries a lot
15.	0	1	2	Cruel to animals
16.	0	1	2	Cruelty, bullying, or meanness to others
17.	0	1	2	Day-dreams or gets lost in his/her thoughts
18.	0	1	2	Deliberately harms self or attempts suicide
19.	0	1	2	Demands a lot of attention
20.	0	1	2	Destroys his/her own things
21.	0	1	2	Destroys things belonging to his/her family or other children
22.	0	1	2	Disobedient at home
23.	0	1	2	Disobedient at school
24.	0	1	2	Doesn't eat well
25.	0	1	2	Doesn't get along with other children
26.	0	1	2	Doesn't seem to feel guilty after misbehaving
27.	0	1	2	Easily jealous
28.	0	1	2	Eats or drinks things that are not food (describe):

____

____

Appendix C (con't)

29. 0 1 2 Fears certain animals, situations, or places, other than school (describe): ______________________________

____

30. 0 1 2 Fears going to school

31. 0 1 2 Fears he/she might think or do something bad

32. 0 1 2 Feels he/she has to be perfect

33. 0 1 2 Feels or complains that no one loves him/her

34. 0 1 2 Feels others are out to get him/her

35. 0 1 2 Feels worthless or inferior

36. 0 1 2 Gets hurt a lot, accident-prone

37. 0 1 2 Gets in many fights

38. 0 1 2 Gets teased a lot

39. 0 1 2 Hangs around with children who get in trouble

40. 0 1 2 Hears things that aren't there (describe):

____

____

41. 0 1 2 Impulsive or acts without thinking

42. 0 1 2 Likes to be alone

43. 0 1 2 Lying or cheating

44. 0 1 2 Bites fingernails

45. 0 1 2 Nervous, highstrung, or tense

Appendix C (con't)

46. 0 1 2 Nervous movements or twitching (describe):

____

____

47. 0 1 2 Nightmares

48. 0 1 2 Not liked by other children

49. 0 1 2 Constipated, doesn't move bowels

50. 0 1 2 Too fearful or anxious

51. 0 1 2 Feels dizzy

52. 0 1 2 Feels too guilty

53. 0 1 2 Overeating

54. 0 1 2 Overtired

55. 0 1 2 Overweight

56. Physical problems without known medical cause:

0 1 2 (a) Aches or pains

0 1 2 (b) Headaches

0 1 2 (c) Nausea, feels sick

0 1 2 (d) Problems with eyes (describe):

____

0 1 2 (e) Rashes or other skin problems

0 1 2 (f) Stomachaches or cramps

0 1 2 (g) Vomiting, throwing up

0 1 2 (h) Other (describe): ________________________

____

Appendix C (con't)

57. 0 1 2 Physically attacks people

58. 0 1 2 Picks nose, skin, or other parts of body (describe):

____

____

59. 0 1 2 Plays with own sex parts in public

60. 0 1 2 Plays with own sex parts too much

61. 0 1 2 Poor school work

62. 0 1 2 Poorly coordinated or clumsy

63. 0 1 2 Prefers playing with older children

64. 0 1 2 Prefers playing with younger children

65. 0 1 2 Refuses to talk

66. 0 1 2 Repeats certain acts over and over; compulsions

(describe): ________________________________

____

67. 0 1 2 Runs away from home

68. 0 1 2 Screams a lot

69. 0 1 2 Secretive, keeps things to self

70. 0 1 2 Sees things that aren't there (describe):

____

____

71. 0 1 2 Self-conscious or easily embarrassed

72. 0 1 2 Sets fires

Appendix C (con't)

73. 0 1 2 Sexual problems (describe): ____________________

____

74. 0 1 2 Showing off or clowning

75. 0 1 2 Shy or timid

76. 0 1 2 Sleeps less than most children

77. 0 1 2 Sleeps more than most children during day and/or night

(describe): ________________________________

____

78. 0 1 2 Smears or plays with bowel movements

79. 0 1 2 Speech problem (describe): ____________________

____

80. 0 1 2 Stares blankly

81. 0 1 2 Steals at home

82. 0 1 2 Steals outside the home

83. 0 1 2 Stores up things he/she doesn't need (describe):

____

84. 0 1 2 Strange behavior (describe): ____________________

____

85. 0 1 2 Strange ideas (describe): ______________________

____

86. 0 1 2 Stubborn, sullen, or irritable

87. 0 1 2 Sudden changes in mood or feelings

88. 0 1 2 Sulks a lot

Appendix C (con't)

89.	0	1	2	Suspicious
90.	0	1	2	Swearing or obscene language
91.	0	1	2	Talks about killing self
92.	0	1	2	Talks or walks in sleep (describe): ____
93.	0	1	2	Talks too much
94.	0	1	2	Teases a lot
95.	0	1	2	Temper tantrums or hot temper
96.	0	1	2	Thinks about sex too much
97.	0	1	2	Threatens people
98.	0	1	2	Thumb-sucking
99.	0	1	2	Too concerned with neatness or cleanliness
100.	0	1	2	Trouble sleeping (describe): ____
101.	0	1	2	Truancy, skips school
102.	0	1	2	Underactive, slow moving, or lacks energy
103.	0	1	2	Unhappy, sad, or depressed
104.	0	1	2	Unusually loud
105.	0	1	2	Uses alcohol or drugs (describe): ____
106.	0	1	2	Vandalism
107.	0	1	2	Wets self during the day
108.	0	1	2	Wets the bed

Appendix C (con't)

109.	0	1	2	Whining
110.	0	1	2	Wishes to be of opposite sex
111.	0	1	2	Withdrawn, doesn't get involved with others
112.	0	1	2	Worrying
113.				Please write in any problems your child has that were not listed above:
	0	1	2	____
	0	1	2	____
	0	1	2	____

Appendix D

Child Sexual Behavior Inventory

Child's Name: ______________________ Age: _____ Date: _________________

Please circle the number that tells how often your child has shown the following behaviors recently or in the last 6 months:

Never	Less than once a month	1-3 times a month	At least once a week
0	1	2	3

1.	0	1	2	3	Dresses like the opposite sex
2.	0	1	2	3	Talks about wanting to be the opposite sex
3.	0	1	2	3	Touches sex (private) parts when in public places
4.	0	1	2	3	Masturbates with hand
5.	0	1	2	3	Scratches anal or crotch area, or both
6.	0	1	2	3	Touches or tries to touch mother's or other women's breasts
7.	0	1	2	3	Masturbates with object
8.	0	1	2	3	Touches other people's sex (private) parts
9.	0	1	2	3	Imitates the act of sexual intercourse
10.	0	1	2	3	Puts mouth on another child's or adult's sex parts
11.	0	1	2	3	Touches sex (private) parts when at home
12.	0	1	2	3	Uses words that describe sex acts
13.	0	1	2	3	Pretends to be the opposite sex when playing

Appendix D (con't)

14.	0	1	2	3	Makes sexual sounds (sighing, moaning, heavy breathing, etc.)
15.	0	1	2	3	Asks others to engage in sexual acts with him or her
16.	0	1	2	3	Rubs body against people or furniture
17.	0	1	2	3	Inserts or tries to insert objects in vagina or anus
18.	0	1	2	3	Tries to look at people when they are nude or undressing
19.	0	1	2	3	Imitates sexual behavior with dolls or stuffed animals
20.	0	1	2	3	Shows sex (private) parts to adults
21.	0	1	2	3	Tries to view pictures of nude or partially dressed people (may include catalogs)
22.	0	1	2	3	Talks about sexual acts
23.	0	1	2	3	Kisses adults not in the family
24.	0	1	2	3	Undresses self in front of others
25.	0	1	2	3	Sits with crotch or underwear exposed
26.	0	1	2	3	Kisses other children not in the family
27.	0	1	2	3	Talks in a flirtatious manner
28.	0	1	2	3	Tries to undress other children or adults against their will (opening pants, shirts, etc.)
29.	0	1	2	3	Asks to view nude or sexually explicit TV shows (may include video movies or HBO-type shows)

Appendix D (con't)

30.	0	1	2	3	When kissing, tries to put tongue in other person's mouth
31.	0	1	2	3	Hugs adults he or she does not know well
32.	0	1	2	3	Shows sex (private) parts to children
33.	0	1	2	3	If a girl, overly aggressive; if a boy, overly passive
34.	0	1	2	3	Seems very interested in the opposite sex
35.	0	1	2	3	If a boy, plays with girls' toys; if a girl, plays with boys' toys
36.	0	1	2	3	Other sexual behaviors (please describe)

A. ___________________________________

B. ___________________________________

Appendix E

Parent Rating Scales for Behavioral and Emotional Problems

Child's Name: ______________________ Age: _____ Date: ________________

1. On a scale of 0 to 10, how would you rate your child:

0 1 2 3 4 5 6 7 8 9 10

____

No Behavioral Problems	Severe Behavioral Problems

2. On a scale of 0 to 10, how would you rate your child:

0 1 2 3 4 5 6 7 8 9 10

____

No Emotional Problems	Severe Emotional Problems

Appendix F

Observation Instructions

During the upcoming week, please record the frequency (that is, the number of times per day) that you directly observe your child engaging in the listed behaviors. At the bottom of the chart, please record any additional occurrences of the behaviors that are reported to you by others (for example, the child's teacher, father, etc.). Please record as well the amount of time that you spend with the child each day during the week. For an example of recording procedures, see the attached sample sheet.

If you have any questions about the recording task, please contact Alana at the PSC (474-9222).

Appendix G

Sample Recording Sheet for Behavioral Observations

Mary Smith is recording the number of times per day that her son John physically fights with his brother. On Monday, Mary spent six hours with John. During this six hour period, she observed John and his brother fighting on three separate occasions. She recorded this information on the chart by making three marks in the first row ("Behavior") and by writing the number six in the second row ("Time Interval") under the heading "Monday" (see below).

On Tuesday, John was ill, and spent the day in bed. Mary noted this on the chart under the heading "Tuesday" (see below).

On Wednesday, Mary observed John for two hours, during which time, he fought with his brother once. John's father also reported seeing John fight with his brother two times during the day. Mary recorded her observations on the chart by making one mark in the first row ("Behavior") and by writing the number two in the second row ("Time Interval") under the heading "Wednesday." She recorded the observations of John's father at the bottom of the chart (for example, "Wednesday--two fights reported by dad").

On Thursday, as well as Friday, Mary observed John for three hours. During her observations, John did not fight with his brother at all. Mary entered this information on the chart, as shown below, under "Thursday" and "Friday."

On Saturday and Sunday, John was away on a field trip with his school. Mary noted this on the chart, as shown below, under "Saturday" and "Sunday."

Appendix G (con't)

Date: March 15-21, 1989
Observer: Mary Smith

Name: John Smith

Behavior	Mon	Tues	Wed	Thurs	Fri	Sat	Sun
Physical Fighting With Brother	I I I	John III	I	0	0	John School	Away Trip
Time Interval	6 hrs	- - - -	2 hrs	3 hrs	3 hrs	- - - -	- - - -

Where does it occur? At home, on playground
When does it occur? Different times, usually early evening
Any cause? Being teased, overtired, having a bad day at school

Wednesday--two fights reported by dad

Appendix H

Child Feedback Questionnaire

Name: ____________________________ Age: _____ Date: ____________________

1. What did you like about group?

____

____

____

2. What did you dislike about group?

____

____

____

3. Would you say you liked group or you disliked group?

Liked group _____ Disliked group _____

Comments:

____

____

____

Appendix H (con't)

4. Did anything in group frighten you?

____

____

____

5. Did anything in group confuse you?

____

____

____

6. Did anything in group help you?

____

____

____

7. Suggestions for things you would like to see changed or stay the same about group:

____

____

____

Appendix I

Parent Feedback Questionnaire

Child's Name: ______________________ Age: _____ Date: _________________

1. What did your child like about group?

____

____

____

2. What did your child dislike about group?

____

____

____

3. Overall, would you say your child liked or disliked group?

Liked group _____ Disliked group _____

4. Did your child seem to be frightened by anything in group?

Yes _____ No _____ Don't Know _____

Appendix I (con't)

If yes, please comment:

____

____

____

5. Did your child seem to be confused by anything in group?

Yes _____ No _____ Don't Know _____

If yes, please comment:

____

____

____

6. Do you think your child benefited from group?

Yes _____ No _____ Don't Know _____

Please comment:

____

____

____

Appendix I (con't)

7. Were you satisfied with the way group was run?

Yes ______ No ______ Don't Know ______

If no, please comment:

____

____

____

8. Were you satisfied with the parental involvement?

Yes ______ No ______ Don't Know ______

If no, please comment:

____

____

____

9. Please give any suggestions for things you would like to see changed or stay the same about group:

____

____

____

Appendix J

Letter Sent to Recruit Participants

Psychological Service Centre
161 Dafoe Building
University of Manitoba
Winnipeg, Manitoba
R3T-2N2
Current Date

Dear Colleague:

At the present time, we are recruiting participants for a group therapy program for boys who have been sexually abused. The therapy program, which will be led by male and female co-therapists and conducted under the supervision of a registered clinical psychologist, will comprise part of an ongoing group treatment program at the University of Manitoba.

Children are eligible for participation in the program if they are males between the ages of 7 and 10 years, and they have disclosed sexual abuse by a family member or third party. Treatment groups will commence in __________ and __________, 1993 and will consist of twelve 90-minute sessions run on a weekly basis.

For purposes of the children's safety, several assurances are requested, including that: (a) the offenders do not currently reside in the homes of the children, and (b)

Appendix J (con't)

transportation of the children to and from group meetings will be supervised by adults who have been approved by a worker of the agency.

For your information, group membership will be limited to six boys. Prior to group commencement, each child will be interviewed with his parent(s) or guardian(s) and, whenever appropriate, with his social worker. During this intake procedure, the children, parents, and therapists will have an opportunity to get to know each other. In addition, children and parents will complete several questionnaires related to the behavior of each child, and become oriented to the treatment program.

Upon completion of the intake interview, children will attend group meetings once per week for 12 weeks at the Psychological Service Centre. For each session, therapists will adhere to the following general format: (a) group round or circle time, (b) focused activity time, (c) diary time, (d) snack time, and (e) group closure. During group meetings, issues related to group process and to sexual abuse and revictimization will be addressed by the therapists and the children. Examples of issues to be addressed include group goals and rules, safety, trust, blame, assertiveness, feelings, social skills, and sex education/prevention of abuse.

Although the co-therapists and their supervisor will plan a program for each group session, often group member needs will direct the content of sessions. Thus, topics addressed in group sessions will vary with the process of each session.

Appendix J (con't)

After the twelfth group session, interviews with children, parents, and therapists will be scheduled. At this time, each child and his parent(s) or guardian(s) will again complete sets of questionnaires related to the child's behavior. The purpose of this interview is to monitor the effects of the treatment on the children, to evaluate the treatment program, and to assess children's needs for additional therapeutic intervention.

We hope that we have highlighted the information you may require to make appropriate referrals to the therapy program. We will be contacting you shortly to answer any questions which you may have regarding the treatment program. In the meantime, if you require additional information, please feel free to contact us at the Psychological Service Centre (phone 474-9222). We look forward to hearing from you soon.

Sincerely yours,

Alana D. Grayston

Student Clinician

Dr. Rayleen V. De Luca

Supervising Clinician

Appendix K

Agencies Initially Contacted to Recruit Participants

Anishinaabe Child and Family Services, Inc.

Awasis Agency of Northern Manitoba

Child and Family Services Agencies

Child Protection Centre

Children's Home of Winnipeg

Family Services of Winnipeg

Jewish Child and Family Services

Ma Mawi Chi Itata Centre, Inc.

Appendix L

Circular Sent to Recruit Participants

Psychological Service Centre

THERAPY GROUPS FOR BOYS WHO HAVE BEEN SEXUALLY ABUSED

WHO CAN JOIN THE GROUPS?

Boys are eligible for participation in the program if: (a) they are between the ages of 7 and 10 years; (b) they have disclosed third-party or intrafamilial sexual abuse perpetrated by one or more offenders; (c) they are living in relatively stable family settings, away from the offender(s); and (d) they are considered by therapists, parents/guardians, and referring social workers to be emotionally ready for participation in the group treatment program.

WHAT IS THE PURPOSE OF THE GROUPS?

The purpose of the group treatment program is to help children begin to heal from the effects of sexual abuse. Children referred to the program will participate in therapy groups led by male and female co-therapists. Each group will meet for 12 90-minute sessions at the Psychological Service Centre and will address various issues and themes related to abuse and victimization.

ARE THERE ANY COSTS OR FEES?

There is no fee for participation in the therapy groups, but clients and their parents or guardians will be asked to complete several questionnaires from time to time throughout the program. The purpose of these questionnaires is to assess the effects of sexual abuse on the children and to help the therapists evaluate the usefulness of the group treatment approach.

WHERE CAN I GET MORE INFORMATION?

If you are interested in finding out more about the program or referring children for services, please contact:

ALANA GRAYSTON
PSYCHOLOGICAL SERVICE CENTRE
161 DAFOE BUILDING
UNIVERSITY OF MANITOBA
WINNIPEG, MANITOBA
R3T-2N2
(474-9222)

Appendix M

Additional Agencies Contacted to Recruit Participants

Child Guidance Clinic

Klinic

Knowles Centre

Manitoba Justice Child Abuse Witness Program

Marymound, Inc.

Appendix N

Psychological Service Centre Referral Form

Completed By: ____________________________ Date: ______________________

Agency: ____

Address: ____

Phone Number: _____________________________

Relationship to Child: ________________________

Child's Name: ____

Birthdate: __________________________ Age: ___ Male: ___ Female: ___

Address: ____

Phone Number: _____________________________

Mother's Name: ____

Address: ____

Phone Number: _____________________________

Age: ___________

Occupation: _______________________________

Father's Name: ____

Address: ____

Phone Number: _____________________________

Age: ___________

Occupation: _______________________________

Appendix N (con't)

Who has custody of the child? ______________________________

Is or has the child ever been in care? ______________________________

If yes, list dates of placement and termination: ______________________________

____

____

<u>School</u>: ______________________________ Grade: ______________

Functioning: ____

____

____

____

<u>Please list others who live in the home</u>:

Name	Age	Relationship to Child
______________________	_____	______________________
______________________	_____	______________________
______________________	_____	______________________
______________________	_____	______________________
______________________	_____	______________________

Appendix N (con't)

Are both parents supportive/believing of the child? ________________________

____

____

Frequency, duration, and type of abuse which has occurred. (Start with the most recent victimization and include historical details, such as age of child, medical attention, legal proceedings, etc. Indicate offenders, their relationship to child, and their current circumstances, such as age, residence, treatment, etc.):

____

____

____

____

____

____

____

Ability of child to discuss the abuse: ___________________________________

____

____

Support network: ____

____

Appendix N (con't)

Previous or current therapeutic involvement: ______________________________

____

____

____

Was the child ever seen at the Child Protection Centre? ______________________

If yes, please indicate when: ____

If referral source is not a Child and Family Services Agency:

Is Child and Family Services involved? __________________________________

Name of Worker: ____

Agency: ____

Phone Number: ____

Please include any relevant background or family information you wish to highlight

(i.e., divorce, alcohol abuse, etc.):

____

____

____

____

____

Appendix N (con't)

Please describe current level of functioning (e.g., peers, family, activities, etc.). Include any maladaptive behaviors (e.g., running, fighting, sexual acting-out, etc.):

____

____

____

____

____

Please outline concerns that you may have about the child's ability to function in a small group: ____

____

____

____

____

Please indicate any medical problems (e.g., allergies, medications, etc.):__________

____

____

Who will provide transportation to and from group sessions for the child? _________

____

Appendix N (con't)

Who will attend the parent-child intake and end-group interviews with the child and therapists? ____

Please ensure that all information has been provided, and mail to:

Alana D. Grayston

c/o Dr. Rayleen V. De Luca

Psychological Service Centre

161 Dafoe Building

University of Manitoba

Winnipeg, Manitoba

R3T-2N2

Appendix O

Consent for Assessment and/or Treatment

I hereby consent to permit the Psychological Service Centre of the University of Manitoba to assess and/or treat the following minor child:

____

____

____

I understand that treatment effects will be evaluated and that data may be used in group form for research purposes.

I also recognize that I can withdraw my child from assessment and/or treatment at any time, simply by informing the therapists of my wishes.

Signature: ____

(Parent or Guardian)

Witness: ____

Date: ____

Appendix P

Parental Consent for Participation

I, ____,

the parent or guardian of ____,

hereby consent to participate in the assessment of my child, completing observations and questionnaires as requested by the therapists.

I understand that treatment effects will be evaluated and that data may be used in group form for research purposes.

I also recognize that I can withdraw my consent to participate at any time, simply by informing the therapists of my wishes.

Signature: ____

(Parent or Guardian)

Witness: ____

Date: ____

Appendix Q

Parent Interview

Date: ____

Name of Interviewer: ____

Name of Interviewee: ____

Address: ____

Phone Number: ____

Relationship to Child: _______________________________________

Sociodemographic Information

Child's Name: ____

Birthdate: _______________ Age: ________ Male: ___ Female: ___

Ethnicity: ____________________ Religion: _________________

Address: ____

Phone Number: ____

School: ____

Grade: ________

Appendix Q (con't)

Mother's Name: ____

Birthdate: ________________ Age: ________

Ethnicity: ______________________ Religion: ___________________

Address: ____

Phone Number: ____

Occupation: ____

Education: ____

Father's Name: ____

Birthdate: ________________ Age: ________

Ethnicity: ______________________ Religion: ___________________

Address: ____

Phone Number: ____

Occupation: ____

Education: ____

Are the child's parents:

_____ married?

_____ separated?

_____ divorced?

_____ widowed?

_____ living common-law?

_____ re-married?

_____ unmarried?

Appendix Q (con't)

Who has custody of the child? ____

Is or has the child ever been in care? Yes _______ No _______

If yes, list dates of placement and termination:

____

____

____

____

Does anyone else live in the home? Yes _____ No _____ If yes, please describe:

Name: ____

Birthdate: ___________________ Age: _________ Male: ___ Female: ___

Relationship to Child: ____

Name: ____

Birthdate: ___________________ Age: _________ Male: ___ Female: ___

Relationship to Child: ____

Name: ____

Birthdate: ___________________ Age: _________ Male: ___ Female: ___

Relationship to Child: ____

Appendix Q (con't)

What is the family's approximate annual income?

_____ $10,000 or below

_____ $10,000 - $20,000

_____ $20,000 - $30,000

_____ $30,000 - $40,000

_____ $40,000 - $50,000

_____ $50,000 - $60,000

_____ $60,000 - $70,000

_____ $70,000 - $80,000

_____ $80,000 or above

Medical/Health History

Does the child have any medical problems? Yes _______ No _______

If yes, please specify:

____

____

____

____

Appendix Q (con't)

Is the child on a special diet? Yes _______ No _______

If yes, please specify:

____

____

____

____

Is the child allergic to any foods? Yes _______ No _______

If yes, please specify:

____

____

____

____

Appendix Q (con't)

History of Abuse

Has the child ever been physically abused by a relative or nonfamily member?

Yes _______ No _______

If yes, describe:

(a) the age of onset

____

(b) the nature and extent of the abuse

____

____

____

____

(c) the frequency and duration of the abuse

____

____

____

____

Appendix Q (con't)

(d) the relationship of the victim and perpetrator

____

____

____

____

(e) the number and age of perpetrators

____

(f) the type of injuries incurred (if any)

____

____

____

____

Has the child ever been sexually abused by a relative or <u>non</u>family member?

Yes ________ No ________

If yes, describe:

(a) the age of onset

____

Appendix Q (con't)

(b) the nature and extent of the abuse

____

____

____

____

(c) the frequency and duration of the abuse

____

____

____

____

(d) the relationship of the victim and perpetrator

____

____

____

____

(e) the number and age of perpetrators

____

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(f) the use of physical violence or coercion

____

____

____

____

(g) the type of injuries incurred (if any)

____

____

____

____

What types of services have been received by the child and family since the time of disclosure?

_____ medical services

_____ counselling services

_____ legal interventions

_____ other services (please specify) ____________________

Are any of these services ongoing? Yes _______ No _______

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If yes, please specify which:

____

____

____

____

How much time passed between disclosure of the abuse and initiation of these services?

____

Additional Comments:

____

____

____

____

Appendix R

Themes and Agendas for the 12 Group Therapy Sessions

Session 1

Theme(s):	Why are we here?
	Trust, safety, and cohesion
Circle Time:	Introductions
	Discussion of the group's purpose, format, and length
	Description of the current session's agenda
Activity Time:	Creation of goals and rules for the group
	Construction of nametags
Diary Time:	Unstructured writing or drawing
Snack Time:	Easter celebration, food, and conversation
	Sharing of diaries (optional)

Session 2

Theme(s):	Why are we here?
	Trust, safety, and cohesion
Circle Time:	Introductions
	Review of the previous session
	Sharing of the week's events (optional)
	Review of the group's goals and rules
	Description of the current session's agenda

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Activity Time:	Creation of more goals and rules for the group
	Nametag games (De Luca et al., 1991; De Luca, Grayston, Boyes, & Romano, 1992)
Diary Time:	Unstructured writing or drawing
Snack Time:	Food and conversation
	Sharing of diaries (optional)

Session 3

Theme(s):	Feelings
Circle Time:	Sharing of the week's events (optional)
	Review of the previous session
	Description of the current session's agenda
Activity Time:	Feelings games (De Luca et al., 1991; De Luca, Grayston, Boyes, & Romano, 1992)
	Feelings exercises (Dossick & Shea, 1988)
Diary Time:	Writing or drawing about feelings
Snack Time:	Food and conversation
	Sharing of diaries (optional)

Appendix R (con't)

Session 4

Theme(s):	Feelings about families, sexual abuse, and disclosure
Circle Time:	Sharing of the week's events (optional)
	Review of the previous session
	Description of the current session's agenda
Activity Time:	Story (Hessell & Nelson, 1988) and group discussion
	Use of "feelings cards" (Dlugokinski, 1987) to describe and list emotions that children may experience when they have been sexually abused
Diary Time:	Writing or drawing about feelings that children may experience when they have been sexually abused
Snack Time:	Food and conversation
	Sharing of diaries (optional)

Session 5

Theme(s):	Feelings about sexual abuse
	Causes and effects of sexual abuse
Circle Time:	Sharing of the week's events (optional)
	Review of the previous session
	Description of the current session's agenda
Activity Time:	Card games (Johnson, 1989b, 1992) and group discussion
Diary Time:	Writing or drawing about the card games and the issues they raised

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Snack Time:	Food and conversation
	Sharing of diaries (optional)

Session 6

Theme(s):	Feelings about sexual abuse
	Feelings about the offender(s)
Circle Time:	Introduction of the group assistant and reward program
	Sharing of the week's events (optional)
	Review of the previous session
	Description of the current session's agenda
Activity Time:	Writing a group letter to a hypothetical victim of sexual abuse
	Writing individual letters to the offender(s) (De Luca et al., 1991; De Luca, Grayston, Boyes, & Romano, 1992)
Diary Time:	Writing or drawing about offenders and victims of sexual abuse
Snack Time:	Birthday party, food, and conversation
	Sharing of offender letters and/or diaries (optional)

Session 7

Theme(s):	Dealing with feelings
Circle Time:	Sharing of the week's events (optional)
	Review of the previous session
	Description of the current session's agenda
Activity Time:	Relaxation training (Ollendick & Cerny, 1981).

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Diary Time:	Coloring of relaxation charts and handouts (Dlugokinski, 1988; Dlugokinski & Suh, 1989)
	Writing or drawing about relaxation (e.g., things that help people to relax, times when people might need to relax)
Snack Time:	Food and conversation
	Sharing of diaries (optional)

Session 8

Theme(s):	Prevention, problem-solving, and assertiveness
Circle Time:	Sharing of the week's events (optional)
	Review of the previous session
	Description of the current session's agenda
Activity Time:	Creation of sock puppets
	Puppet shows regarding sexual abuse prevention (using scenarios drawn from Johnson, 1989b and 1992, and RGA Publishing Group, 1984)
Diary Time:	Structured exercises on abuse prevention (Deaton & Johnson, 1991)
Snack Time:	Food and conversation
	Sharing of diaries (optional)

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Session 9

Theme(s):	Sex education
Circle Time:	Sharing of the week's events (optional)
	Review of the previous session
	Description of the current session's agenda
Activity Time:	Story (Mayle, 1975) and group discussion
	Anonymous "question box"
Diary Time:	Coloring of body development charts (Mayle,1975)
	Writing or drawing about sex education and body development
Snack Time:	Food and conversation
	Sharing of diaries (optional)
	Preliminary party-planning

Session 10

Theme(s):	Sex education
Circle Time:	Sharing of the week's events (optional)
	Review of the previous session
	Description of the current session's agenda
Activity Time:	Story (Mayle, 1975) and group discussion
	Anonymous "question box"
Diary Time:	Writing or drawing about sex education and body development

Appendix R (con't)

Snack Time: Food and conversation

Sharing of diaries (optional)

Review of party list

Session 11

Theme(s): Self-Esteem

Circle Time: Sharing of the week's events (optional)

Review of the previous session

Description of the current session's agenda

Activity Time: Group exercise on self-esteem (adapted from Cunningham & MacFarlane, 1991)

Diary Time: Structured exercises on self-esteem (Deaton & Johnson, 1991)

Snack Time: Food and conversation

Sharing of diaries (optional)

Review of party list

Session 12

Theme(s): Recap of group

Saying goodbye

Activities: Sharing of the week's events (optional)

Review of the group's progress and accomplishments

Termination exercises (Dossick & Shea, 1988)

Termination party and "awards ceremony"